CHAPTER 1
REVIEW OF CARDIOPULMONARY
RESCUITION FOR CERTIFIED
NURSING ASSISTANTS
(1 CONTACT HOUR)
NOTE: This course is for review purposes only. It is not intended for CPR certification or recertification.

Learning objectives
- Discuss the No. 1 cause of death in the United States.
- Identify the No. 1 reason CPR is performed.
- Describe the manner in which CPR needs to be performed.
- Compare and contrast the difference in performing CPR on the adult, child and infant.
- Identify a patient who requires immediate CPR.
- Describe how to identify a patient who is choking.
- Describe how to do a Heimlich maneuver on a choking adult or child.
- Describe how to intervene for a choking adult, child or infant.

Introduction to cardiopulmonary resuscitation (CPR)
Heart disease is the No. 1 cause of death in the United States. The Centers for Disease Control and Prevention (CDC) estimates that in 2010, 785,000 Americans had a first heart attack, and about 470,000 had a recurrent attack. To put this in perspective, every 25 seconds, an American has a heart attack, and every minute somebody dies from one (6).

Heart disease occurs when the coronary arteries (hollow blood vessels within the heart) become clogged with plaque. This is called atherosclerosis. Once the coronary arteries become clogged and narrowed, the heart is unable to receive adequate blood flow. Without adequate blood oxygen and vital nutrients it needs to work properly. Over time, the heart muscle begins to weaken, leading to heart failure, dangerous heart rhythms or a heart attack (10).

During a heart attack, the blood vessels become blocked, which interrupts the normal blood flow to the heart. Without adequate oxygenation and nutrients, the heart muscle will begin to die (10). To prevent imminent death, the patient requires prompt medical intervention. If the patient is unconscious, not breathing, and doesn’t have a pulse, he or she needs cardiopulmonary resuscitation (CPR) to restore oxygen and circulation to the heart muscle. Heart attack is the No. 1 reason patients suffer sudden cardiac arrest and require CPR. Other reasons include near drowning or other conditions that cause a person to stop breathing or his or her heart to stop beating (7,8).

Sudden cardiac arrest occurs when the heart’s electrical system malfunctions and the heart stops beating. The most common cause of sudden cardiac arrest is a disturbance in the heart rhythm called ventricular fibrillation. The majority of patients who are affected by sudden cardiac arrest typically die. However, death (mortality) can be significantly reduced if the patient receives proper CPR (7,8).

It is important that certified nursing assistants (CNA) who are responsible for providing daily care for patients in the hospital, assisted living facilities, nursing homes and in the home on a daily basis be trained in CPR. It is important for CNAs to recognize the signs of a patient having a heart attack or distress so they may be able to react appropriately and potentially save a patient’s life. CNAs must renew their CPR training according to the standards established in their states and by the organizations for which they work.

Symptoms of a heart attack
It is important to recognize symptoms that a patient may exhibit before or during a heart attack to ensure that CPR is delivered promptly. Many times, the CNA may be the first health care professional who recognizes the patient’s distress. Here are some signs and symptoms that a heart attack is happening (6,7):
- Chest pain or discomfort in the center of the chest that lasts more than a few minutes. It can go away and come back. Some people describe the pain as uncomfortable pressure, squeezing, fullness, or indigestion.
- Discomfort or pain in other parts of the body, such as pain in one or both arms, the back, neck, jaw or stomach.
- Shortness of breath that may occur with or without chest pain or discomfort.
- Nausea.
- Dizziness or light-headedness.
- Sweating.

It is important to note that women and elderly patients may not present the “typical” symptoms of a heart attack described above. They may not even have chest pain. This can make it harder to recognize if these patients are having a heart attack. They may exhibit symptoms such as the following (11):
- Pain between the shoulder blades.
- Pain in the arm (especially the left arm), back, neck and abdomen.
- Jaw or throat pain.
- Nausea and vomiting.
- Unusual, overwhelming fatigue.

If you suspect that a patient is having a heart attack, get help immediately. If your are a CNA working in the hospital or an area where nurses and doctors are present and help is available, press the call light and call for help immediately. If you are in the patient’s home, call 911 for immediate help.

If the patient is conscious, while you are waiting for assistance take the vital signs and encourage the patient to rest quietly. If the patient is truly having a heart attack, physical activity should be avoided and the patient should rest. During a heart attack, the patient’s heart is lacking adequate blood flow and oxygenation. If the patient stays active during a potential heart attack, the heart rate and blood pressure will increase, thus increasing the workload of the heart (6,7,10).

Recent changes in CPR guidelines
In 2010, the American Heart Association changed its CPR acronym from ABC to CAB. This means that the order in which you perform CPR has changed from addressing the airway, then breathing, then circulation to circulation first, then the airway, then breathing (CAB)! This change emphasizes how important it is to perform chest compressions to keep blood flowing through the heart and to the brain (4,8). Here are guidelines for performing CPR according to the 2010 AHA Guidelines for CPR and ECC (4).

Adult CPR
The order of CPR is CAB (3,5,8):
- Chest compressions.
- Airway.
- Breathing.

Before starting CPR, you need to: (8)
- First determine whether the person is conscious or unconscious. Tap or shake his or her shoulder or tap the collarbone and ask loudly, “Are you OK?” Check whether the person is breathing normally and whether she or he has a pulse. Note: Gasping is not considered to be normal breathing. Don’t take any more than five to 10 seconds to check for breathing. For example, is the patient’s chest moving up and down? Do you hear normal breath sounds? Is air coming out of the patient’s nose or mouth? And don’t take any more than 10 seconds to check whether a patient has a pulse.
- If the person does not respond, call out loudly for help if you are at work in a place where other people are available to help you (e.g., a hospital or long-term care facility). If you are alone (e.g., in a patient’s home) call 911.
- If the patient is breathing and has a pulse but does not respond, call for help, or if help is not available, call 911.
- If the person wakes up but is confused or unable to speak, call for help (if it is available) or call 911 if help is not available.

Now let’s review what to do if CPR is indicated. Remember that the new order of CPR performance is CAB (chest compressions, airway, breathing) (1,3,5,8,12).

Compressions
- If the patient is unresponsive and has no pulse and is not breathing, call for help or dial 911 if you are in a place where no help is available. When checking for a pulse, check the carotid pulse (on the side of the neck) in adults and children.
- Put the patient on his or her back on a firm service.
- Kneel next to the patient’s neck and shoulders.
- Put the heel of one hand over the center of the patient’s chest between the nipples. Place
your other hand on top of the first hand with your fingers interlaced. It is important that you keep your elbows straight and position your shoulders directly above your hands.

- Use the weight of your body, not just your arms, to push straight down (compress) the patient’s chest. You should push down on the adult’s chest to a depth of at least two inches (about five centimeters). Compress the patient’s chest at a rate of at least 100 compressions per minute.
- Give 30 chest compressions. This should take about 18 seconds.
- After you give 30 chest compressions, you need to check the patient’s airway.

**Airway**

- After you’ve given 30 chest compressions, open the patient’s airway using what is called the head-tilt, chin-lift maneuver. Put your palm on the patient’s forehead and gently and carefully tilt the head back. With your other hand, gently and carefully lift the chin forward to open the airway.
- Check whether the patient is breathing. Don’t take any more than five to 10 seconds to do so. For example, is the patient’s chest moving up and down? Do you hear normal breath sounds? Is air coming out of the patient’s nose or mouth? If the patient is not breathing, you need to begin rescue breathing for the patient.

**Breathing**

- If the patient is not breathing, maintain the open airway with the head-tilt, chin-lift maneuver.
- Pinch the nostrils shut and cover the patient’s mouth with yours, making a seal over the patient’s mouth.
- If available, use a CPR mask/face shield. This will allow you to perform rescue breathing but will protect you from possible contamination from bacteria in the patient’s mouth.
- Get ready to give two rescue breaths. Give the first rescue breath, giving a breath big enough to make the patient’s chest rise. If the chest rises, give the second breath. If it doesn’t rise, repeat the head-tilt, chin-lift maneuver and then give the second breath.

**Note:** If you are having trouble making the chest rise, look inside the patient’s mouth. There may be a foreign object lodged in the mouth (e.g., dentures that have come loose), making rescue breathing ineffective. If you see an object in the mouth, try to remove it, being careful not to push the object further down the throat. Do not do what is called a “blind sweep” of the mouth. In other words, don’t just sweep your fingers through the patient’s mouth to try to feel a foreign object. You must see the object before trying to remove it. But even if the chest isn’t rising, continue to do rescue breathing.

- After giving two rescue breaths, resume chest compressions.
- Repeat the process, performing 30 chest compressions, then two rescue breaths for about two minutes. Each time you perform 30 chest compressions and two rescue breaths, you have completed what is called a cycle. It takes about two minutes to perform four to five cycles.
- After you complete four to five cycles (or about two minutes of CPR), check for breathing and pulse. If breathing and pulse are not present, continue to perform CPR until help arrives.
- If you find a pulse but the patient is not breathing, continue rescue breathing, but you can stop chest compressions. Provide rescue breathing at a rate of one breath every five seconds.
- If the patient wakes up or starts breathing on his/her own and has a pulse, you can stop CPR. But do not leave the patient alone until help arrives! He or she may suddenly stop breathing or not have a pulse again, and you must be prepared to resume rescue breathing or CPR!

**Special note:** If you are in a location where help is not available, and if the patient has not responded (awakened or has a pulse and is breathing on his or her own), after about two minutes of CPR, if an automatic external defibrillator (AED) is available, apply it and follow the instructions on the device. If you do not know how to use an AED, the 911 operator may be able to guide you in using it (8).

**Key concepts with a second rescuer (1,3,4,5,8,12)**

Providing CPR may be very tiring if there is only one person doing everything. Therefore, if a second person is available, ask them to assist. In addition, if you ever arrive on a scene where somebody is performing CPR, inform them, “I can help, I know CPR.” Before the second rescuer begins, the first rescuer needs to complete the 30 compressions and two breaths currently in progress. The patient is checked for pulse and breathing. If there is no pulse and the patient is not breathing, CPR is resumed with the two rescuers.

The rescuers should be on opposite sides of the patient so that each rescuer has enough room to work. One rescuer performs rescue breathing and the other performs the chest compressions. In the event that the first rescuer is exhausted by the time the second rescuer arrives, the second rescuer may have to perform both chest compressions and rescue breaths.

The rescuer(s) continue CPR until other trained personnel arrive and assume responsibility for the patient (e.g., nurses, physicians, EMS personnel).

**Performing CPR on a child**

When performing CPR on a child ages 1 through 8, the procedure is about the same as that for an adult except for the following differences (1,4,5,8):

- If you are alone and no help is available, perform five cycles of compressions and breaths on the child (this takes about two minutes) before calling 911. If help is available, however, have them call 911 immediately.
- Use one hand to perform chest compressions. Place your hand on the breastbone directly between the child’s nipples.
- Compress to a depth of about two inches, or about a third of the thickness of the child’s chest.
- Note that the ratio of compressions is the same as for adults: about 100 per minute followed by two rescue breaths.
- If the child does not respond after two minutes of CPR, use an AED if it is available. Apply pediatric pads if they are available.

Here are the steps for infant CPR (1,4,5,8,12):

- Check whether the baby is responsive. Stroke the baby, especially the soles of his or her feet. Rubbing or tapping the soles of a small infant’s feet is a good way to check for responsiveness. If the baby is more than 2 months old, tap his or her shoulder or chest. Call out the baby’s name in a loud voice. However, do not shake the baby.
- Note that if you are alone and help is not available and the baby is not breathing and does not have a pulse, do CPR for two minutes, and then call 911. If help is available, have them call 911 immediately. An infant’s pulse is checked at the site of the brachial pulse (in the inner bend of the elbow) or the femoral pulse (in the groin).
- Place the baby on a firm surface, such as a table or on a floor.
- Imagine that you see a horizontal line drawn between the baby’s nipples. Place two fingers of one hand just below this line on the center of the baby’s chest.
- Push straight down about an inch and a half (about 4 cm) or about a third of the thickness of the baby’s chest. You should compress at a rate of 100 compressions per minute.
- After performing 30 chest compressions, gently tip the baby’s head slightly back by lifting the chin with one hand and pushing gently down on the forehead with the other.
hand. However, be careful not to push the head back too far. An infant’s neck is so small and pliable that pushing the head back too far can actually block the airway.

- For no more than 10 seconds, check for breathing. Is the baby’s chest moving up and down? Do you hear breath sounds? Is air coming out of the baby’s nose or mouth? If there are no signs of breathing, you need to breathe for the infant.
- Cover the baby’s mouth and nose with your mouth. If you have an infant-sized CPR mask or face shield, use it.
- Give two rescue breaths by delivering gentle puffs of air instead of deep breaths from your lungs, as you would do with an adult or child. Give one rescue breath and look to see whether the baby’s chest rises. If it doesn’t, repeat the head-tilt, chin-lift maneuver and give the second rescue breath.
- If the baby’s chest still doesn’t rise, check his or her mouth to make sure there is nothing inside the mouth that is blocking the airway. If you see a foreign object in the mouth, try to take it out of the mouth with your finger. If the airway is blocked, you will need to perform first aid for a choking baby. Do not do a “blind sweep” of the baby’s mouth.
- Give two breaths after every 30 compressions.
- Continue CPR until the baby responds or until trained help arrives (e.g., EMS personnel).
- If the baby has a pulse but is not breathing, perform rescue breathing at a rate of one breath every three seconds.

Choking

There are times when a patient may become unconscious from choking. Choking is a scary situation for the patient and anybody around him or her. Choking occurs when a foreign object becomes lodged in the throat or windpipe, blocking the flow of air. It is important to recognize the signs of choking, because it will affect the oxygen to the brain, then the rest of the body. The universal sign for choking is the patient clutching his or her hands to the throat. The patient may also have other symptoms, such as [5, 9]:
- Inability to talk.
- Difficulty breathing or noisy breathing.
- Inability to cough forcefully.
- Skin lips and nails turning blue or dusky.
- Loss of consciousness.

It is important to check whether the patient is conscious or unconscious. To do so, ask, “Are you choking?” If the patient responds (e.g., by nodding) or is obviously conscious, perform first aid for the choking conscious patient (5, 9, 12).

**Adult/child (5, 9, 12)**

- Give five back blows between the patient’s shoulder blades with the heel of your hand.
- If the patient is still choking, give five abdominal thrusts, also known as the Heimlich maneuver. To perform the Heimlich maneuver, stand behind the patient, wrap your arms around his or her waist, and tip the patient forward slightly. Make a fist with one hand and place it slightly above the person’s naval. Press hard into the abdomen with a quick upward thrust. Perform five abdominal thrusts. If the blockage still isn’t dislodged, repeat the five back blows followed by five abdominal thrusts.
- Keep repeating five back blows followed by five abdominal thrusts until the object or blockage is dislodged or until qualified help arrives.
- If the blockage is dislodged, be sure to stay with the patient until help arrives.
- If the patient becomes unconscious, perform first aid for the unconscious adult or child.
- If the patient becomes unconscious, lower him or her onto the floor on his back.
- Clear the patient’s airway if you can see a foreign object blocking the airway. Carefully reach a finger into the mouth and sweep out the object, but be careful not to push the object deeper into the airway. Don’t sweep the mouth unless you can see the foreign object.
- If you cannot remove the blockage and the patient remains unresponsive, perform five chest compressions followed by two rescue breaths.
- If the patient’s condition deteriorates (no pulse and no breathing), proceed to perform CPR.

**Infant (5, 9, 12)**

- Sit down and hold the infant face down on your forearm. Rest your forearm on your thigh.
- Thump the infant gently and firmly on the middle of the back, using the heel of your hand.
- If this doesn’t work, turn the infant face up on your forearm with his or her head lower than the trunk of the body. Place two of your fingers at the center of the infant’s chest over the breastbone and give five quick chest compressions.
- If you see an object in the baby’s mouth, try to remove it, but be careful not to push it further down the baby’s throat. Do not do a “blind sweep” of the baby’s throat.
- Repeat the back blows and chest thumps until the blockage is removed and the baby resumes breathing or until help arrives.
- If removing the object and/or performing back thumps and chest compressions do not work and breathing doesn’t resume, begin the CPR procedure for infants.

**Special note:** To perform the Heimlich maneuver on a pregnant woman or obese person, position your hands a little bit higher than usual, at the base of the breastbone (9).

**Closing**

In closing, nobody wants to see anybody choking, unable to breathe, unconscious or without a pulse. However, it is important that all health care professionals are adequately trained to handle any potentially dangerous emergency, should one occur. It is equally vital to understand the concepts, seriousness and specific techniques to deliver for any patient who is not able to breathe normally or who has no pulse. The prompt, adequate actions of a CNA may be the potential difference in life or death for an unfortunate patient.

**References**


**Difference in life or death for an unfortunate patient.**
Explain your role in maintaining confidentiality of medical documentation.

Introduction
Certified nursing assistants (CNAs) perform basic restorative and nursing services related to the safety, comfort, personal hygiene, basic mental health and protection of patient rights. As a CNA, you have important responsibilities to the facility where you work and the residents/patients you assist. This chapter explains your role in resident/patient documentation of daily care.

What is documentation?
Documentation is formal communication about a patient or resident, typically entered on a medical chart or similar form. It is a daily assessment of how the individual is doing. This information is reviewed by state agencies, and determines whether or not the facility will be reimbursed for medical expenses associated with recipients of Medicare and Medicaid.

What are Medicare and Medicaid?
Medicare is a federal insurance program for people age 65 and older and certain disabled people. The Centers for Medicare and Medicaid Services (CMS), which operates the program, is a part of the U.S. Department of Health and Human Services. The Medicare program consists of two parts, Medicare Part A (hospital insurance) and Medicare Part B (supplemental medical insurance). Part A covers hospital, skilled nursing facility, home health and hospice care. Part B covers doctors’ services, outpatient hospital services, durable medical equipment and a number of other medical services and supplies. Medicare also provides limited coverage for preventive services.

Medicaid was established in 1965; at the same time as Medicare, under Title XIX of the Social Security Act. It was designed to assist low-income families in providing health care for themselves and their children. It also covers certain individuals who fall below the federal poverty level. It covers hospital and doctor’s visits, prenatal care, emergency room visits, drugs and other treatments.

What are surveys?
The office of long-term care services, Assurance and Licensure Services Division, of each Department of Health Services, inspects nursing homes that provide care to Medicare and Medicaid clients using federal standards. Such inspections are called “surveys.” The surveys take place every nine to 15 months, with an average of every 12 months. Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with state requirements to receive payment under the Medicare or Medicaid programs. It determines to what extent the facility is following or not following required Medicare and Medicaid regulations.

Why are surveys performed?
Surveys are conducted to make sure that the nursing home is meeting state and federal standards, which spell out very specifically how care must be provided to nursing home residents. The areas looked at are quality of care and quality of life in the facility, whether residents’ rights are observed and whether the facility meets environmental standards of cleanliness and is hazard-free. Facilities that do not meet all these standards must correct these “deficiencies” or they face a variety of sanctions.

Who performs these surveys?
Surveys are performed by teams of state employees (usually three or four people) who are specialists in nursing home care. The surveyors have backgrounds in nursing, social work, dietetics, sanitation, health care administration and counseling. These individuals must pass a test administered by the federal government to qualify as nursing home surveyors.

How do surveys occur?
Prior to beginning a survey, team members review the nursing home’s background. They look at previous survey results, complaint investigations, incident reports and quality indicators that give information specific to each facility. They also consult with the long-term care ombudsmen assigned to that facility. This gives them an idea of whether there are special concerns or problems that they should be aware of during the survey.

About the survey
Each facility is evaluated on over 100 items that have been reviewed during the last three standard surveys. The survey tool reports the number of requirements in each category that are in compliance and total overall performance, and a new report is generated after each new survey or after an investigation that finds deficiencies in the key requirements. The facility’s score is adjusted to reflect the scope and severity ratings of all deficiencies cited, and a survey report is sent to the nursing home after each survey. If standards are not met, then the nursing home must submit a plan of correction to the division. In some cases, a follow-up survey is made to verify that standards that were initially found not met are corrected.

The division inspects nursing homes to assess compliance with federal standards of care such as adequacy of staffing, quality of care and cleanliness of facilities. In addition, as necessary, the division investigates complaints and serious incidents occurring within a nursing home. The division of health care quality makes this nursing home survey information available to the public, to help consumers evaluate the quality of care provided by the state’s Medicare and Medicaid certified nursing homes. The division evaluates and compares facilities in five categories:

- Administration.
- Nursing.
- Resident rights.
- Kitchen/food services.
- Environment.

Survey data may be referred to as The Long-Term Care Minimum Data Set (MDS). The MDS is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The long-term care MDS contains items that measure physical, psychological and psycho-social functioning. The items in the MDS give a multidimensional view of the patient’s functional capacities, and can be used to present a nursing home’s profile. The MDS now plays a key role in the Medicare and Medicaid reimbursement system and in monitoring the quality of care provided to nursing facility residents.

Why are they unannounced
The nursing home is not notified in advance of a survey unless it is an initial survey. When the team arrives at the nursing home, they place a sign in the lobby informing everybody that a survey is in progress. The idea of unannounced surveys is for the team to be able to see how the facility operates on a daily basis.

How do surveyors conduct their work?
Surveyors observe what is going on in the nursing home; they interview residents, family members and nursing home employees and they read medical records and other documents. They also meet with nursing home staff members for clarification of questions. The surveyors summarize their observations to the facility staff at the conclusion of the visit.

What kinds of questions do surveyors ask staff, resident, and their family members?
The surveyors want to know what life is really like in the nursing home. They spend time talking to residents asking how staff treat them, what the food is like; whether residents like and participate in the activities being offered; and how the nursing home responds when they have a concern or a complaint. Surveyors want to know whether the home provides help to people when they need it with such daily tasks as bathing, dressing, eating meals, going to the bathroom and getting in and out of bed. They also talk to family members of residents who are “not interviewable,” i.e., persons who can no longer speak or who have advanced dementia and other diseases which keep them out of touch with what’s going on.
**Why is it important for staff, residents, and family members to participate in interviews?**

It is important for residents and family members to participate in interviews because they know best what really happens in the nursing home. It is important they speak very frankly with the surveyors about the home’s performance. The home is evaluated primarily on how it cares for its residents.

**What happens after a survey is completed?**

Complete survey reports and nursing home plans of correction, edited to protect patient confidentiality, are available at each nursing home, as well as at the office of long-term care. The most recent federal inspection surveys are posted on the CMS website at: www.Medicare.gov/nursing/home.asp

After completion of the survey, the team meets briefly with nursing home staff to explain the outcome of the survey, including deficiencies and plans of correction. A deficiency is a determination by the office of long-term care that a nursing home has violated one or more specific licensure or certification regulations. Deficiencies range in scope and severity from isolated violations with no actual harm to residents to widespread violations that cause injuries or put residents in immediate jeopardy of harm. Deficiencies are cited as a result of an on-site inspection. When deficiencies are alleged, the facility is given an opportunity to rebut the findings. If deficiencies are cited, the office of long-term care requires the nursing home to submit a written plan of correction detailing how and when each deficiency will be corrected. In some cases, the office of long-term care will direct specific corrective measures that must be implemented. In situations where current conditions at the facility pose a serious risk to the health and safety of residents or staff, the office of long-term care can initiate immediate corrective actions.

**Medical records or “charts”**

A medical record or medical chart is the systematic documentation of the patient’s status and care including the plan of care and the results of that plan.

Over an individual’s life, every time he or she receives medical care, information is compiled into a health or medical record, which is used by doctors, nurses, and other medical staff to ensure the patient receives quality health care. It serves as:

- Basis for planning care and treatment.
- Means by which doctors, nurses, and others caring for patient can talk to one another about the resident’s/patient’s needs.
- Legal document describing the care received.
- Means by which patient or insurance company can verify that services billed were actually provided.
- An accurate health history to all health care providers who treat the individual.

The medical history usually includes a section listing injuries, accidents, illnesses, and surgical procedures in the patient’s life, and a checklist of conditions and symptoms, with a notation regarding whether these symptoms or conditions have ever been experienced, when, and if they are being experienced currently. The history should also explore what treatment has been used for conditions or symptoms in the past and currently, including prescription and nonprescription substances the patient is ingesting (such as nutritional supplements or vitamins). All health care workers with access to medical records or charts have a responsibility to take the necessary steps to make sure all information is correct and complete.

Medical records are written in many different styles. A goal of any facility should be to have a uniform record keeping system that is consistently used by all employees. A medical record should be “self contained,” that is, it should be easily understandable and not leave questions unanswered. One should be able to read a carefully written medical record and, without ever having seen the patient, be able to gain a comprehensive understanding of the patient’s medical care.

Each facility has its own, specific rules about documentation and special forms that must be filled out. Learn the rules of your facility, including common abbreviations used and any special documentation procedures required.

**Medical record documentation**

“If it isn’t documented, it hasn’t been done” is an adage that is frequently heard in the health care setting.

For documentation to be complete, you must include everything that you do and observe. This means all care and treatments, as well as things that you see, feel, and hear, especially if they are not normal or not normal for the patient that you are taking care of. Remember: If it is NOT documented, it was NOT done. So, if you have done it, you must also take the time to document it.

- If you took the resident/patient to and from the toilet, and he or she mentioned a stomachache, you must include the fact that you took the resident/patient to/from the toilet and also that he/she had a stomachache. You should also tell the nurse about the stomach pain as soon as possible. This observation, and all other observations that are unusual, or not considered normal, must be mentioned to the nurse right away, and should also be written in the person’s medical record as soon as possible.

**Here are some of the daily living tasks that should be documented:**

- Dressing (according to patients’ needs ranging from minimal assistance to totally dependent).
- Bathing (bed baths, tub baths, showers).
- Feeding (serving meals, physically feeding patients who are unable to do so themselves).
- Using the toilet (assisting with bedpans and urinals, helping patient to the bathroom, providing incontinent care if needed).
- Taking vital signs (blood pressure, pulse and so on).
- Doing catheter care (emptying, upkeep of intake and output sheets when necessary).
- Answering call lights in a timely fashion.
- Assisting patients with ambulation, when needed.
- Helping with range of motion exercises, as prescribed by physical therapy.
- Assisting patients in wheelchairs and checking for pressure sores.
- Making beds and keeping the patients’ rooms and belongings neat and organized.
- Ensuring that bedridden patients are turned at least every two hours to ensure comfort and to prevent bedsores.
- Reporting all changes, physical and mental, of patients to a nurse.
- Keeping an eye on people who wander and watching for potentially dangerous situations as part of safety awareness.
- Documenting daily care accurately and in a timely manner.
- Anything else that you do.

**Some observations that you must document are:**

- Orientation to time, place and person.
- Height and weight.
- Appetite (mention of hunger, amount of food eaten or left, and so on).
- Urinary drainage bag output.
- Temperature, pulse, respiration.
- Blood pressure or glucose readings (if you take them).
- Color of the skin and characteristics, such as warmth or dampness.
- Things that the patient or resident says (use quotation marks).
- Attitude and behaviors, including worry, anger, pain.
- Anything not normal.

Concise medical record documentation is critical to providing patients with quality care, as well as to receiving accurate and timely reimbursement for furnished services. It chronologically documents the care of the patient and is required to record pertinent facts, findings, and observations about the patient’s health history including past and present illnesses, examinations, tests, treatments and outcomes. Medical record documentation also assists physicians and other health care professionals in evaluating and planning the patient’s immediate treatment and monitoring his or her health care over time.

Medical records are used as legal documents. They must meet the specific law of your state and the policies of your facility. Times and dates must be accurate. Do not wait until the end of a shift to complete documentation. It is too easy to forget!
Payers review your documentation to ensure services are consistent with the insurance coverage provided in order to validate:

- The site of service.
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided.
- That services furnished have been accurately reported.

**General rules of documentation**

Certified nursing assistants provide the majority of activities of daily living and personal care to the assigned residents. CNAs play a critical part of the health care team and will need to participate in documenting their interactions with the residents/patients. Everything you do must be accompanied by the necessary documentation.

Document care provided, and facts and observations about how the resident/patient is doing. Document your own actions only, not others', and do not document opinions or complaints about other people unless it relates to quality of care in some way. All entries should be timely; document the full range of care provided, use appropriate abbreviations and legible (readable) writing. Always initial or sign (according to your facility’s policy) and date anything that you add to the medical record.

**Accuracy**

You must have the right patient, the right chart, and the right information in an understandable form to document correctly. Maintain accurate and truthful records by recording only factual information, observations, and actions. Don’t record your own opinions, or ideas about the client or his/her condition. When you are charting, write only pertinent verifiable details and avoid unclear or unnecessary information. Brevity (being brief) is important, but do not leave out important details. Be factual and concise. When recording statements made by the resident/patient, use quotation marks to demarcate the client’s words. Keep your own separate notebook for personal notes and other information you want to remember that doesn’t belong in the medical record. Remember that the information entered on a patient’s chart or flow sheet daily assessments are a kind of map that shows how the person was doing that day and over time. Medical personnel, family members, and administration need to know if the care plan for that person is appropriate, being followed, and working, and if not, why.

**Legibility**

It is critical that you keep chart information, as well as your own personal notes, if you take them, legible (able to be read and understood clearly). If it is ever necessary to refer to files some time in the future (in a medical emergency or legal proceedings, for example), the context and details of your notes should be clear. Other health care personnel will need to know the background, status, actions taken and the results. Don’t use pencil or something that can be smudged easily. Permanent ink pen is best. Pay attention to your handwriting and use clearly written and recognized abbreviations. Clarity is important, and payment can be denied based on illegibility of notes. Notes are considered illegible if two users cannot read or understand what it means.

**Timeliness**

Document what care is given, as often as required by your facility. Time notations must be accurate. If you remember not documenting something, follow the directions your facility uses regarding late entry. Use the time format approved by your facility (military time, special notation, etc.). Never chart “in advance”: Enter information and initials only after completing the action.

**Consistency**

Chart entries should be consistent over time, using the same language and format. Information should reflect what really happened and when, and give nurse supervisors an accurate assessment of the resident’s needs and the care given. Make entries short and sweet, but not so short that you don’t mention something important or useful to other caregivers. It is critical that you quantify, or measure, detailed information about the patient over a period of time, to document his or her injury/illness and degree of rehabilitation. Insurance companies will be determining need of continued care based on this information.

**Changes in the patient**

Record how the resident is doing, and any progress or decline in abilities. A resident’s health may change on a daily basis. It is absolutely essential that documentation notes these changes, small or large, improvement or decline. Note changes you observe, such as changes in skin condition or nail color, changes in appetite, elimination, weight, strength, or anything unusual. Dramatic or drastic changes can be a sign that the patient health is at high-risk. Seek help immediately.

**Pain or discomfort**

Note complaints, and indications of pain or discomfort. Also note postures or behaviors that suggest a problem.

**Initial/signature and date**

Sign or initial and date every chart entry. Do not use nicknames as these notes are legal documents. In some cases, you may need to note your credentials. Individuals in training, students, or apprentices must also have a supervising professional sign chart notes.

**Refusal of services**

Document a resident/patient’s refusal of services, or other noncompliance with the care plan, including failure to follow health care instructions or take needed medication, or any other activity or behavior that poses a risk to the resident/patient’s health. Also report this information to your supervisor.

**Documentation errors and legalities**

It is crucial, for insurance reimbursement purposes, that any changes made on an entry be dated, and initialed by the individual doing so. In some cases, it may be necessary to attach another piece of paper with the amended information to the form, which should also be dated and signed. Don’t alter anyone else’s documentation. If you think it’s wrong, see your supervisor about it.

Don’t document opinions or ideas unrelated to your job or function. If you have concerns, discuss them with other caregivers. Don’t document what you aren’t sure of. Always confirm the answer before documenting. Don’t document false information: If it is not true, it shouldn’t be documented.

Changes to documentation should be kept to a minimum; avoid recopying forms in cases of error – recopying often creates the possibility for more error.

Areas on a form that do not apply to a specific resident/patient should be marked “N/A” (non applicable) rather than left blank. Go to your supervisor if entries are missing or blank spaces are left on forms. Do not write in the margins. To amend mistakes, use the method your facility requires: For example, some facilities require the following if you chart on the wrong file: “Draw a line through the entry; mark “wrong chart” and initial; then make the correct notation above the entry; do not white out or use an erasable pen.”

The following guidelines were established for litigation (legal) purposes and should be standard practice in all health care environments:

- Alter records as minimally as possible, and only when necessary.
- If you find something in error, do not erase. Cross out the error using a single line, so as not to conceal what is written underneath, and write the word “error” above the incorrect statement.
- Do not use “white-out”.
- If you review your records and feel the need to clarify a point, write the date and the additional comments with the note (labeled “addendum”).
- If litigation is threatened, do not make any kind of change to the records.

**Abbreviations**

Use correct spelling and approved abbreviations only. Avoid jargon, slang, or complicated medical terminology, and define terms as needed. Your facility should review forms on a regular basis, and revise or simplify confusing formatting or content. It is also important to become well acquainted with common abbreviations, but do not use abbreviations that are not approved, or try abbreviating phrases that are not generally known.

Many useful learning materials provide standard abbreviations used in most health care facilities. You will likely develop your own descriptions and abbreviations to suit your specific needs. Too much shorthand can be detrimental however, because others must be able to interpret everything you have written on the chart. Insurance company personnel will be depending on your notes. If you include abbreviations that
are unusual, add a key with a list of words you have abbreviated and what they stand for. Here are some commonly used abbreviations in health care:

- Blood Pressure – BP.
- Bowel Movement – BM.
- Enema – E.
- No known drug allergies – NKDA.
- Not applicable – N/A.
- Pain – Pn or Px.
- Range of motion – ROM.
- Respiratory or Respirations – Resp.
- Shortness of breath – SOB.
- Urinary tract infection – UTI.

Only use abbreviations that are supported by your workplace. Some common abbreviations are no longer used because they were found to be associated with medical error. For example, “U” is no longer used to mean “Units” because it was mistaken as a zero or a four (4), resulting in overdose. It was also mistaken for “cc” (cubic centimeters) when poorly written; Similarly “Q.D.” a Latin abbreviation for “every day,” is no longer used because the period after the “Q” has sometimes been mistaken for an “ I, “ and the drug has been given “QID” (four times daily) rather than daily. For a list of dangerous abbreviations that should no longer be used, see: http://www.nccmerp.org/dangerousAbbrev.html

Consider how your documentation will appear to reviewers

Inaccurate or unreliable documentation undermines a facility’s ability to care for patients/residents.

Medical professionals aren’t able to accurately or reliably assess how the resident is doing and whether he or she is getting the care and services he/she needs. In addition, a survey resulting in a statement of deficiency hurts the nursing home’s reputation, and may affect reimbursement rates. The nursing home is reimbursed for Medicare and Medicaid patients based on information documented by you. People reviewing your charting will be asking:

- Does the care plan match the assessments?
- Are the assessments and care plan appropriate for the individual?
- Are there any deficiencies in the plan or the provision of services?

Remember that your facility is “graded” based on this information. Surveyors consider a specific random group of patients/residents and do the following:

- Review each item of the survey.
- Review periodic reviews of each resident.
- Assess whether the care plan was carried out as intended.
- Assess whether the care plan was appropriate for the resident.

A note about confidentiality of medical information

Share information only in cases where disclosure is required by law, court order, or another appropriate, professionally approved manner, according to legal requirements. Confidentiality of information about the resident/patient is crucial. All information and matters relating to a client’s background, condition, and treatment are strictly confidential and should not be communicated to a third party. (even one involved in the patient’s care) without the client’s written consent or a court order. Treat clients with respect and dignity: Handle personal information with sensitivity and keep the content of written records a private matter. CNAs who can’t resist telling secrets or repeating gossip in their personal lives should be aware of the heavy penalties associated with jeopardizing client confidentiality in a professional context.

Using specific forms or “flow sheets”

Many institutions have their own special forms or “flow sheets” or computerized processes for documentation. A flow sheet is a one or two-page form that gathers a range of important data regarding a patient’s condition. It often refers to a specific condition or set of conditions. A flow sheet is housed in the patient’s chart and serves as a reminder of care and a record of whether care expectations have been met (if the care plan was carried out at the right time and in the right manner.) Flow Sheets are commonly added to a patient’s chart to assess lab results and vital statistics. Every time lab work is done or test results are made available, it is entered into the appropriate space on the flow sheet, so that you can easily see the resident’s progress/status relating to each item.

Medical flow sheets usually allow you to track several aspects of a patient’s health at one time. Hospitals, medical centers, nursing home facilities, home health care providers, clinics, cancer centers, research centers, and private health care providers are facilities that use medical flow sheets.

Medical flow sheets are most commonly used for tracking vital statistics, diabetic insulin dosages, pain assessment, lab results, blood pressure, medication start and stop dates, physical assessment, and drug frequency. Commonly used flow sheets often include:

- Vital signs.
- Weight.
- Meals.
- Using the toilet (including bowel movements).
- Transportation/transfers.
- Activities of daily living (ADL).

Vital signs

Vital signs show an individual is alive. They include heart beat, breathing rate, temperature, and blood pressure (systolic and diastolic). These signs are watched, measured, and monitored to check an individual’s level of physical functioning. Normal vital signs change with age, sex, weight, exercise tolerance, and condition.

For an example of a Vital Signs Flow Chart, go to:

http://www.gsa.gov/Portal/gsa/ep/formslibrary.do?viewType=DETAIL&formId=7FA8FBABF1BE336B85257005004AAD4E

Activities of daily living (ADL)

ADL refers to “activities of daily living,” routine activities that people need to do everyday. There are six basic categories of ADLs:

1. Eating.
2. Bathing.
3. Dressing.
4. Using the toilet.
5. Transferring (walking/transporting to another position or location).
6. Continence.

About half of all Americans will eventually enter a nursing home as a result of being unable to perform ADLs. While the majority of those nursing home admissions will be for a short-term (less than a year), about a quarter will stay longer than a year. An individual’s ability to perform ADLs is important for determining what type of long-term care (e.g., nursing-home care or home care) and coverage the individual needs (i.e., Medicare, Medicaid or long-term care insurance). Typically, coverage for nursing costs covers an individual who is unable to perform two or more of the six basic ADLs. There are many different types of ADL flow sheets. Two different formats follow:

(On following page)
SAMPLE FORM 1: ADL Data Tracking Tool by Shift

Instructions: Fill in the appropriate codes for resident self-performance and support provided.

<table>
<thead>
<tr>
<th>Self-performance key</th>
<th>Support provided key</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = Independent – No help or oversight</td>
<td>0 = No setup or physical help from staff</td>
</tr>
<tr>
<td>1 = Supervision – Oversight, encouragement or cueing provided</td>
<td>1 = Setup help only</td>
</tr>
<tr>
<td>2 = Limited assistance – Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance</td>
<td>2 = One person physical assist</td>
</tr>
<tr>
<td>3 = Extensive assistance – Resident performed part of activity but help of the following type(s) were provided</td>
<td>3 = Two+ persons physical assist</td>
</tr>
<tr>
<td>*Weight-bearing support</td>
<td>4 = Total dependence – Full staff performance during entire shift</td>
</tr>
<tr>
<td>*Full staff performance</td>
<td>8 = Activity did not occur on this shift</td>
</tr>
<tr>
<td>4 = Total dependence – Full staff performance of activity during entire shift</td>
<td>8 = Activity did not occur</td>
</tr>
<tr>
<td>8 = Activity did not occur</td>
<td>8 = Activity did not occur</td>
</tr>
</tbody>
</table>

The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident’s ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.

<table>
<thead>
<tr>
<th>Date</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>A3a</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Bed Mobility – How resident moves to and from lying position, turns side to side, and positions body while in bed.

<table>
<thead>
<tr>
<th>Self Perform</th>
<th>N</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Provided</td>
<td>N</td>
<td>D</td>
<td>E</td>
</tr>
</tbody>
</table>

Transfer – How resident moves between surfaces-to/from bed, chair, wheelchair, standing position (Excludes to/from bath/toilet).

<table>
<thead>
<tr>
<th>Self Perform</th>
<th>N</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Provided</td>
<td>N</td>
<td>D</td>
<td>E</td>
</tr>
</tbody>
</table>

Eating – How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (tube feeding, total parenteral nutrition).

<table>
<thead>
<tr>
<th>Self Perform</th>
<th>N</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
</table>

Toilet use – How resident uses the toilet room (commode, bedpan, or urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

<table>
<thead>
<tr>
<th>Self Perform</th>
<th>N</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Provided</td>
<td>N</td>
<td>D</td>
<td>E</td>
</tr>
</tbody>
</table>

Signatures required on back of Tracking Tool.

Signature Sheet

<table>
<thead>
<tr>
<th>Int</th>
<th>Signature</th>
<th>Int</th>
<th>Signature</th>
</tr>
</thead>
</table>
## SAMPLE FORM 2: ADL DOCUMENTATION TOOL

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
<th>Initial</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder</td>
<td></td>
<td></td>
<td>Initial only after charting is completed</td>
</tr>
<tr>
<td>C = Continent</td>
<td>Shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I = Incontinent</td>
<td>N = Night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B = Both</td>
<td>D = Day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E = Evening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel</td>
<td>Shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C = Continent</td>
<td>N = Night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I = Incontinent</td>
<td>D = Day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B = Both</td>
<td>E = Evening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily Pain Screening</td>
<td>Shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td>N = Night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication (s)</td>
<td>D = Day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E = Evening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily Skin Inspection</td>
<td>Shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td>N = Night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New skin issues (report to supervisor)</td>
<td>D = Day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E = Evening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bottoming Out</td>
<td>Shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Ulcer Prevention)</td>
<td>N = Night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed:</td>
<td>D = Day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chair:</td>
<td>E = Evening</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key for resident performance – Code for resident performance

<table>
<thead>
<tr>
<th>Score</th>
<th>Shift</th>
<th>Initials</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key for Staff Assistance – Code for most support provided

<table>
<thead>
<tr>
<th>Score</th>
<th>Shift</th>
<th>Initials</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Bed mobility: How resident moves to and from lying, turning side to side, and positioning in bed

<table>
<thead>
<tr>
<th>Score</th>
<th>Shift</th>
<th>Initials</th>
<th>Notes</th>
</tr>
</thead>
</table>

### Eating/tube feeding:
Manner and amount of eating and drinking

### Toileting (includes bedpan, commode, bedpan):
Include transfers on/off
Cleaning/wiping
Changing pad
Managing catheter/ostomy
Replace clothes

### Transfers:
To/from bed or chair
(Do not include to/from toilet/bath/shower)

### Personal hygiene
How resident maintains personal hygiene:
Combing hair, brushing/flossing teeth, shaving, makeup, washing up, etc.

### Walking:
How resident walks within the room
How resident walks in the hallway
Extent of assistance required; late loss ADL
It is very important to accurately document just how much you are doing for the patient and how much he/she can do for him/herself. Incorrect coding of ADLs is one of the most common reasons for refusing reimbursement. As the level of reimbursement your facility receives depends largely on how accurately you code activities of daily living (ADLs) such as bed mobility, transferring, eating, and toileting, the coding of these ADLs ultimately determines the amount of reimbursement your facility receives.

Recent changes in policy (RUGs 53) requires that Section G of the Minimum Data Set split up necessary actions into understandable segments. This means you must distinguish all transfers to/from the toilet, bath, bed, or chair from one another. Know how to properly perform and code each of the four late-loss ADLs—eating, bed mobility, transfer, and toileting, as required by your facility.

Bed mobility self-performance – How the resident moves to and from lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture the resident sleeps in, rather than a bed.

Transfer self-performance – How resident moves between surfaces – i.e., to/from: bed, chair, wheelchair, standing position. Excluded from this definition of movement is to/from bath or toilet, which is covered under toilet use and bathing.

Eating self-performance – How resident eats and drinks, regardless of skill. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

Toilet use self-performance – How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Do not limit assessment to bathroom only. Elimination occurs in many settings. Because reimbursement is based on correct definition of the activity; each part of bed mobility, transfer, eating, and toileting must be broken down to distinguish coding differences. Bed mobility, for example, has three components that staff should consider when coding:
- How the resident moves to or from the reclining position.
- How the resident turns from side to side.
- How the resident positions his/her body in bed or other location where the resident sleeps.

CNAs who don’t understand how critical proper documentation is are likely to have more miscoded ADLs than any other minimum data set (MDS) items. Ensuring that you properly document ADLs so they can be correctly coded on the MDS will make certain that the facility gets the appropriate reimbursement.

Introduction to SOAP notes
Medical documentation of patient complaint(s) and treatment must be consistent, concise, and comprehensive. Many medical offices use the SOAP note format to standardize medical evaluation entries made in clinical records. SOAP notes are a form of documentation used by medical professionals. While you are probably not required to use SOAP notes, knowing a little about them can help you communicate better with other health care providers to maintain the best resident care.

The acronym SOAP stands for subjective, objective, assessment, and plan. It is a brief report in the patient’s chart, completed the day of the appointment when the patient is seen. It is different from a comprehensive progress note which may accompany a diagnosis. The SOAP note briefly expresses the following:
- Date and purpose of the visit.
- The patient’s symptoms and complaints.
- The current physical exam.
- New lab data and results of studies, reports, assessments.
- The current formulation and plan for the patient.

Charting is a critical way for all health care workers to coordinate their care; to speak in the same clinical language, organize and record information, and chart progress together. SOAP notes also act as legal documents, for potential use in litigation of personal injury cases, proof of improvement or restoration to pre-injury status, and completion of functional outcomes.

Glossary of terms
Certification – A determination that a nursing home meets the federal care standards for operating a home with Medicaid or Medicare funding.

Deficiency – A failure to meet a federal and/or state standard for care. The most serious deficiencies pose an immediate threat to resident health or safety.

Exit conference – A meeting at that end of a survey where surveyors review their findings with the nursing home’s administrator and key staff.

Center for Medicare and Medicaid services (CMS) - A federal agency that oversees the regulation of nursing facilities that are paid by Medicare or Medicaid funds.

Licensure – A determination that a nursing home meets the state standards for operating a home.

Ombudsman – A federally-mandated program with offices throughout the country. Ombudsman representatives are trained to receive questions and complaints and to advocate for residents and families.

Endnotes
CHAPTER 3
COMMUNICATION WITH COGNITIVELY IMPAIRED RESIDENTS/PATIENTS
(2 CONTACT HOURS)

Learning objectives
- Define “cognitive impairment” and name some different types of cognitive impairment.
- Distinguish between cognitive impairment and dementia.
- List and describe strategies to improve poor communication with cognitively impaired individuals.
- Name other conditions that negatively affect communication with elderly individuals.

Introduction
As a CNA, you are likely to care for an individual with cognitive impairment, as many institutions take care of adults with this condition. Individuals with moderate to severe cognitive impairment often require special care, including supervision round the clock, specialized communication techniques, and management of difficult behavior. They commonly need help with activities of daily living (ADLs), such as bathing, eating, transferring from bed to a chair or wheelchair, using the toilet and/or other personal care.

Cognitively impaired people have difficulty with one or more of the basic functions of their brain, such as perception, memory, concentration and reasoning skills. Common causes of cognitive impairment include Alzheimer’s disease and related dementias, stroke, Parkinson’s disease, brain injury, brain tumor or HIV-associated dementia. Although each disorder has its own unique features, caregivers often share common problems, situations and strategies in working with this population.

Cognitive and memory impairments can change how a person thinks, acts and/or feels. These changes often present special challenges for caregivers and family members. One common complaint is difficulty communicating with cognitively impaired individuals. An ordinary conversation, for example, can be quite difficult when the resident has difficulty remembering from one moment to the next what has been said.

Because communication is essential to good care, CNAs must be able to overcome some of the common obstacles to communication that they encounter. This chapter will discuss strategies to make communication with cognitively impaired individuals more effective.

What is cognitive impairment?
Cognitive impairment is a problem associated with the brain that may affect thinking, speaking, understanding or remembering. These problems may be permanent or they may come and go depending on whether they are the result of Alzheimer’s disease, stroke, brain injury or illness. In some cases, individuals suffer loss of cognitive function due to mental illness, while others experience it as a side effect of some medications. The following section will discuss different types of cognitive impairments and the special challenges they raise.

What is dementia?
The term “dementia” describes a group of symptoms that are caused by changes in brain function (cognitive impairment), and refers to brain disorders that significantly affect a person’s ability to carry out daily activities. Dementia symptoms may include asking the same questions repeatedly; becoming lost in familiar places; being unable to follow directions; getting disoriented about time, people, and places; and neglecting personal safety, hygiene, and nutrition. People with dementia lose their abilities at different rates.

Damage to brain cells that occurs with aging causes dementia in some people. It creates language and communication difficulties along with disturbed cognition, loss of memory, altered personality traits, poor decision-making, and poor coordination/balance. Dementia is caused by multiple factors. Some conditions that cause dementia can be reversed, and others cannot. The two most common forms of dementia in older people are Alzheimer’s disease and vascular dementia. These types of dementia are irreversible, which means they cannot be cured. Reversible conditions with symptoms of dementia can be caused by a high fever, dehydration, vitamin deficiency and poor nutrition, bad reactions to medicines, problems with the thyroid gland, or a minor head injury. In these cases, conditions should be treated as soon as possible.

What is multi-infarct (vascular) dementia?
In multi-infarct dementia (MID), a series of small strokes or changes in the brain’s blood supply results in the death of brain tissue. The location in the brain where the small strokes occur determines the seriousness of the problem and the symptoms that arise. Symptoms that begin suddenly may be a sign of this kind of dementia. People with multi-infarct dementia are likely to show signs of improvement or remain stable for long periods of time, then quickly develop new symptoms if more strokes occur. In many people with multi-infarct dementia, high blood pressure is to blame. One of the most important reasons for controlling high blood pressure is to prevent strokes.

What is mild cognitive impairment (MCI)?
MCI is different from both Alzheimer’s disease and normal age-related memory change. People with MCI have ongoing memory problems but do not have other losses like confusion, attention problems, and difficulty with language. Mild cognitive impairment (MCI) represents a transitional state between the cognitive changes of normal aging and very early dementia and is becoming increasingly recognized as a risk factor for Alzheimer’s disease (AD).

What is Alzheimer’s disease (AD)?
The most common form of dementia among older people is Alzheimer’s disease (AD), which initially involves the parts of the brain that control thought, memory, and language. Although scientists are learning more every day, right now they still do not know what causes AD, and there is no cure. AD usually begins after age 60, and risk increases with age. While younger people also may get AD, it is much less common.

AD begins slowly. At first, the only symptom may be mild forgetfulness, which can be confused with age-related memory change. Most people with mild forgetfulness do not have AD. In the early stage of AD, people may have trouble remembering recent events, activities, or the names of familiar people or things. They may not be able to solve simple math problems. Such difficulties may be a bother, but usually they are not serious enough to cause alarm.

However, as the disease progresses, symptoms are more easily noticed and become serious enough to cause people with AD or their family members to seek medical help. Forgetfulness begins to interfere with daily activities. People in the middle stages of AD may forget how to do simple tasks like brushing their teeth or combing their hair. They can no longer think clearly. They can fail to recognize familiar people and places. They begin to have problems speaking, understanding, reading, or writing. At some point, people with AD may become anxious or aggressive, or wander away from home. Eventually, patients need total care.

How does cognitive impairment affect communication?
Communication is the means by which we transfer messages or information. It requires the use of thought (cognition), and is dependent on memory, the use of language and the abilities to make, hear and understand words. These abilities are damaged with many types of cognitive impairment or dementia. This can be challenging for both caregivers and residents who need to communicate with one another to take care of daily needs.

A resident may not understand what you are saying, or not be able to express what’s on his/her mind. Impeded communication is aggravating, often contributing to further frustration and agitation, as well as increasingly difficult situations. Additionally, mood swings and personality changes can be a symptom of cognitive impairment, itself a risk factor for charged interactions. Because misunderstanding or not receiving messages from the resident is potentially detrimental to him/her, it is important that you learn about dementia so you can make communication easier and reduce difficult behavior.

Each individual confronts his/her own obstacles to communication. Different terms are used to describe the types of problems encountered with cognitive impairment. Communication difficulties include dysarthria: difficulty articulating words; agnosia: difficulty recognizing people and things; and apraxia: difficulty with...
voluntary movements. Aphasia, which literally means “no speech,” refers to the complete or partial loss of the ability to use or understand words, and may be the result of a stroke or other damage to the brain. Less severe forms of aphasia may be called dysphasia.

Expressive aphasics are able to understand communication but have difficulty sending a message, while receptive aphasics have difficulty understanding a message from others. Individuals with cognitive impairment may know what word they want, but not be able to recall it, or may know what they want to say, but not be able to say the word in such a way that others will understand. Individuals often experience a combination of impairments. Other types of aphasia include:

- Anomic: Able to understand and speak, but may have difficulty with word retrieval.
- Broca’s: Able to understand others and speak slowly with small number of words; apraxia.
- Conductive: Able to understand speech, but may confuse sounds and words.
- Global: Unable to understand words or communicate with words; may repeat meaningless syllables.
- Wernicke’s: Able to speak but may be poorly understood and inclined to repetition; difficulty understanding others.

**Alzheimer’s disease, language and memory**

Alzheimer’s disease eats away at an individual’s ability to communicate. It damages pathways in the brain, making it more difficult to recall and to understand words. Individuals with Alzheimer’s disease may feel like they have a word “on the tip of their tongue” but are unable to recall it. In some cases, a word is incorrectly substituted for another, or the individual repeats the same word or question again and again. Cognitive impairments can be especially challenging because an affected person’s words and behavior may make little or no sense to you. Normal communication channels become increasingly difficult, frustrating both the resident and the caregiver.

As people with Alzheimer’s disease are increasingly unable to organize thoughts in a meaningful way, they grow more likely to lose their train of thought and require more time to interpret what you’re saying. They may get frustrated or angry with their barriers to communication, getting agitated, cursing or using offensive language. Remember, this is not the person, but the disease.

**Common behaviors associated with cognitive impairment/dementia**

Dementia is often associated with incontinence. Understandably, getting to the bathroom is very difficult if you don’t remember where the bathroom is or don’t think of it in time. Be matter of fact about pads and other products that protect clothing. Some medications are very effective in helping incontinence, so consulting a urologist may be in order. If the individual does not make it to the bathroom in time, be understanding and do your best to maintain the individual’s dignity and reduce embarrassment.

Because individuals with dementia may forget to go to the bathroom, it is useful to develop a routine for using the bathroom. Be sure to remind the individual at reasonable intervals. Every two hours is usual, but some individuals will not need the facilities as frequently. Some residents find it easier to use a commode, which can remain in the bathroom overnight. Drinks with a diuretic effect (including coffees, teas, sodas, or some alcoholic beverages) should be limited, especially in the evening. Reduced intake of beverages of all kinds before bed may also be helpful.

Clothing can be another obstacle for the individual with cognitive impairment who needs to use the bathroom. Knots, belts and buttons can be difficult to navigate. Clothing with elastic waistbands or Velcro closures can facilitate the process of disrobing and dressing before and after using the toilet.

**Dressing**

Getting dressed and undressed is often problematic for individuals with severe dementia. Choose comfortable, practical clothes with easy to open and close devices like snaps, Velcro, zippers and few, if any, buttons. Limit the individual’s choices of clothes, as decision-making with too many options can be overwhelming for someone with dementia. Put each item of clothing out, one at a time, in the order in which it should be put on, and encourage the individual to dress him/herself as much as is possible. Check with your institution for a strategy for addressing the situation in cases where the resident wants to wear the same outfit repeatedly. Soiled clothing should be taken away and cleaned.

**Agitation and frustration**

Agitation is a term that refers to a number of behaviors commonly seen in individuals with dementia. It may include irritation, anger, and animosity or violence in spoken words or behavior. The individuals may feel “revved up” at night, restless and unable to sleep. He or she may try to get up during the night, putting him/her at risk of falls.

A tendency toward agitation increases as the dementia progresses. Like other behaviors, agitation is triggered by specific factors, which may be environmental or situational. The better you know a resident, the better you will be at anticipating difficult interactions. In many cases, the trigger is associated with the loss of control that comes with dementia, with behaviors like agitation expressing themselves when control is threatened, which may occur in carrying out ADLs.

Individuals prone to agitation should be limited in their consumption of caffeine and refined sugar, which can increase agitated behaviors. Other common triggers include loud noises and too many people or things in the room.

A feeling of security, achieved through a structured environment and familiar people and surroundings (including furniture, bedding and photographs), can be soothing, as can quiet and familiar music, a gentle speaking voice, reading aloud to the patient or taking walks to dispel the nervous energy.

Frustration occurs when the individual encounters obstacles, finding him/herself unable to do or say what he/she wants. Acknowledging the frustration is important. Empathize and validate the resident’s experience by acknowledging the individual’s frustration or agitation, and express care and concern regarding the situation. A gentle touch may be soothing, but do not attempt to physically control or restrain the individual as this can contribute to out-of-control feelings that can further agitate him or her.

A better strategy is to distract the resident by offering another activity that the resident enjoys, like having a snack or taking a walk. Don’t allow yourself to be drawn into an emotional exchange or argument, as it will only increase agitation. Allow the individual to move on to a different topic, and do not dwell on the unpleasant incident. Encourage as much independence as possible with ADLs, but do not let the activity become a frustrating or overwhelming experience.

**Yelling, cursing, threatening,**

Many emotional outbursts have feelings of stress and loss of control at their center. Remain calm and comforting, speak in a low voice, acknowledge (validate) the resident’s feelings (“I know it’s very frustrating to lose or misplace items. I’ll help you look for it.”) Then use the strategy of distraction with a pleasant activity or snack.

**Inappropriate sexual behavior**

Sexual comments, public nudity or public masturbation are an unpleasant side effect of some types of cognitive impairment. In rare cases, behavior may be sexually harassing or feel threatening. Most institutions have specific measures for addressing this behavior. If this is a pattern, try to determine the triggering behavior. In some cases, medication may be an option.

**Hallucination/delusions**

Cognitive impairment sometimes takes the form of hallucinations or delusional thinking, in which the individual sees or hears something that others don’t see or hear or remembers an incident that didn’t occur. Their frequency may increase as the disease progresses. Do not get drawn into arguments about what did or didn’t happen. Instead, state what you perceived and do not dwell on the incident. Keep rooms bright to reduce shadows, which may contribute to “seeing things.” Medication may be in order if there is risk that the individual might hurt him/herself because of hallucinations or delusional thinking.

**Paranoia**

One of the unfortunate byproducts of dementia is increased suspicion or paranoia, sometimes in
the form of accusations against other individuals, including caregivers. The disease may accentuate tendencies such as a competitive nature, or feelings, like jealousy. Let family members know that expressions of paranoia or delusional thinking are a recognized side effect of the cognitive impairment.

Individuals with dementia may misplace things frequently; they may, for example, hide money and forget where it is. It is sometimes helpful to have the resident keep a small amount of money in a purse, pocket or hiding place, and remind him or her where it is if he/she is concerned it is missing. When an item is missing, help the resident look for it or remember where he/she put it. A resident may have a customary hiding place for money or jewelry, and the “lost” items may appear there.

Do not get drawn into an argument about what happened to the lost item or try to convince the individual that the item was just misplaced (rather than stolen). Let the resident know you are concerned on their behalf and take their emotions seriously. Accusations are often an expression of fear and loss of control. Imagine how scary and frustrating it would be to feel that your personal possessions were being taken or moved and you couldn’t trust the people around you.

Repetitive speech and actions

Individuals with cognitive impairment may repeat sounds or words over and over, or ask the same questions repeatedly. This uncontrollable repetition of a sound or gesture is called “perseveration,” and is sometimes made worse by anxiety. Be patient and continue to answer the question in an even tone, or try to distract the resident or change the topic. Getting the individual engaged in a new activity can reduce repetitive questioning.

Stay even-tempered and don’t allow yourself to get annoyed or tell the patient he already asked that question before. Urge patience on the part of family members and tell them that this, too, is a side effect of the condition. In some individuals, this effect is made worse by nervousness, boredom, fear or other environmental or situational triggers. In some cases, certain behaviors signal fatigue or the need to use the toilet.

Questions repeated continually, like “What time is lunch?” can also be answered on paper and put where the resident can refer to it. For example, writing “Your daughter is visiting at three,” or drawing a picture of a clock showing 3 o'clock on a piece of paper and putting it where the individual can refer to it can contribute to a greater sense of control.

Shadowing

An individual with dementia may follow or mimic a caregiver, or speak nonstop to him or her. This behavior is usually more pronounced later in the day. Stay calm and reassuring, and attempt to distract the resident or redirect attention to something else. Suggest an activity or ask the individual whether he or she can help you, then give them a simple task that they are able to carry out.

Wandering

A common symptom associated with Alzheimer’s disease is wandering, an activity in which the individual walks away from home without an apparent goal. A “critical wanderer” is an individual with dementia who has voluntarily wandered away, leaving the care of a caregiver. This kind of behavior presents special problems for institutions and individuals responsible for the resident’s safety, as the individual may not act rationally and can be at great risk of getting hurt or suffering from exposure (hypothermia, dehydration). Residents may exhibit no concern for their own safety.

About three out of every four individuals with AD wander during the course of the disease. The degree of risk experienced by the individual is typically affected by the severity of the dementia. As the disease progresses, verbal and nonverbal communication become more difficult. Wanderers who get lost outdoors may become injured or even die of exposure. A critical wanderer can be hard to locate because they act unpredictably, do not call for help, and do not respond when their name is called. When found, a person with dementia may not remember their current address or even their own name. They may be frightened and disoriented, found far from where they started.

Check with your institution for specific strategies and policies for addressing resident wandering. If a person is missing, a search of the building, grounds and nearby streets and walkways should begin as soon as possible. Understanding why residents wander is an important part of keeping them safe. The individual’s previous home locations or places of special meaning should be searched, along with areas along the sides of roads. More effective searches mean less risk to the individual and fewer hours of worry.

Recent research focusing on wandering behavior at one institution showed that “people with Alzheimer’s [who] leave their own residence or nursing home and start to wander … are usually located (89 percent of all cases) within one mile (1.2 km) of the point last seen. If the person is not on the road itself (14 percent), he may be in a creek/drainage ditch (28 percent) or caught in briars/bushes (33 percent). The person is usually found wandering a short distance from a road. The majority of patients succumb to the environment (hypothermia, dehydration) and require evacuation (35 percent) or are deceased (19 percent).”

People with Alzheimer’s wander for a number of reasons. Sometimes, they attempt to go to a former home or a favorite place. A resident who has just moved to the nursing home may be searching for something or someone familiar, or looking for a bathroom, food or water but not be able to remember where these things are located. Some people need to explore their immediate environment periodically to reorient themselves. An individual may be trying to get away from too much noise or stimulation, too many people, or a noisy, cluttered or confusing environment. As the brain becomes more damaged by the disease, the individual with Alzheimer’s is more likely to feel overwhelmed, which can trigger wandering.

Sometimes wandering is associated with a former routine. If wandering occurs at a specific time of day, it may be related to the individual’s former business or family responsibilities. In such cases, it is useful to plan an activity at that time that will distract the individual from the tendency to wander. To reduce the risk of wandering, put away coats, boots, purses, etc., as these are visual reminders of going outdoors. Some residents are much less likely to go out without familiar items like coat, keys or a purse.

There is usually a trigger for wandering, which one can try to determine over time. In some cases, wandering fulfills a physical need for activity, is associated with stress, or is an attempt to drink, eat or use the bathroom. Anticipating needs and offering a glass of water, a snack or assistance to the bathroom may stem a wandering episode. Scheduling activities or exercise can help channel action into less wandering and more participation in other activities. Some institutions are able to provide a safe enclosed area where individuals can walk or explore safely. Creating a circular well-marked path or trail allows residents a secure route and an opportunity to stretch their legs.

It is useful to put signs with pictures on bathroom doors to signify where the toilet is, as residents may forget. Also put a no entry sign (with an appropriate image) to keep the individual from wandering from his/her room. A mirror, curtains over the door or a sign that says “STOP” may also signal a barrier to an individual with dementia. In many cases, individuals with dementia see obstacles where they don’t really exist. For example, placing a black mat or painting a black space outside the resident’s room may make it appear to be an “impassable space” to those with severe dementia.

Sundowning

Many difficult behaviors increase near the end of the day and last throughout the night. This tendency, called “sundowning,” is expressed in agitation, restlessness and disorientation, and is likely caused by increased fatigue and disruptions to internal factors that control when we wake and sleep. Encourage restful sleep by increasing daytime activity, especially movement or exercise, and in some cases, discouraging naps. Ingredients like caffeine and refined sugar can increase restlessness, so keep foods or drinks with these ingredients limited to early in the day. In some cases, a snack or light meal before bedtime encourages sleep.

Start quieting the resident’s schedule in the afternoon or evening, introducing structured activities like card or board games, reading aloud or listening to soothing music. Opening
curtains in the morning and closing them at night will reinforce what time of day it is and reduce disorientation. Keep lights on during the day and have a nightlight on at night in the bedroom and bathroom. Put away anything that might hurt the person if he/she bumps into it at night (going to the bathroom, for example). Making sure the individual is safe at night is critical. Medications that can help the individual sleep or tranquilize him or her to some extent exist, but may produce the undesired side effect of increased disorientation or lethargy the next day.

**Diet**

Individuals with dementia may forget to drink and eat, so reminders are important for proper nutrition and fluid intake. Ensuring proper nutrition is even more difficult if there are any barriers to comfortably eating or drinking, like tooth sensitivity or trouble swallowing. Additionally, some medications decrease appetite or make other foods taste or appear less appetizing. Assess the individual periodically for weight loss, note any dental or denture issues or problems passing food or liquids. Because individuals with dementia have decreased appetites, a larger number of smaller meals at regular intervals over the day can be a better strategy to ensure proper nutrition. Weight loss can also be countered with the addition of healthy high calorie snacks during the day.

Make mealtimes as enjoyable as possible and encourage the individual to feed him/herself without concern for “table manners” or correct use of eating implements, which may be difficult for a person with cognitive impairment. Finger food is often a good strategy. Cut the food into small bite-size pieces and space it to the individual’s tastes. Drinking from a glass can be facilitated with the use of a straw or children’s “sippy cup.” Provide adequate assistance to ensure the resident has eaten enough. Encourage chewing and swallowing by showing the motion yourself and gently touching the jaw to encourage chewing or stroking the throat to encourage swallowing.

**Hygiene**

Individuals with dementia may forget or be reluctant to do tasks related to personal care and grooming. Elements of proper hygiene such as brushing one’s teeth and hair, bathing and changing clothes will likely require reminders. Because these activities are so personal, having someone assist with them may symbolize a loss of control, triggering difficult behavior, or may be frightening to the resident. Being undressed and cleaned or bathed may feel humiliating to some people, as these activities have been done alone since childhood. These situations may be very stressful for both residents and caregivers, as well.

Try to emulate the bathing experience that the individual formerly carried out him/herself. Did he or she bathe in the morning or at night, by bath or shower? Did he/she shampoo hair everyday; what kind of soap, shampoo, or powder was used? Try to make it as close to the resident’s bathing routine as possible.

If bathing becomes a struggle, reduce its frequency; dry shampoo can be used to wash the hair if the individual is reluctant to get her/his hair wet. Hair washing can also be done as a separate procedure, in a sink, at a different time.

While bathing everyday is not necessary, most institutions require that the resident be bathed about twice a week, at minimum.

If showers or baths become very difficult, a towel bath may be a good alternative, especially if the individual is opposed to immersing him/herself in water. In this alternative, towels or washcloths are dampened with warm water and a no-rinse soap. Special bath blankets can be used to cover the bed, and a large towel is used to keep the resident covered while the dampened towel and washcloths are used to cleanse the body. (For further information, see “Bathing Without a Battle” listed in the bibliography). In cases where the individual is very weak or frail, a bed bath may be in order. In this process, the individual is washed incrementally; soaping a part of the person, rinsing with a container of water and towel drying.

As it is conventionally a private and personal activity, ensure modesty is protected by making sure curtains or doors are closed during bathing and undressing. Keep a towel covering the breasts, and lower parts of the person and lift the towel to wash these areas. Have towels and a robe ready when the resident gets out of the shower/bath. Make sure you have everything you’ll need for bathing before you begin, so you don’t have to leave the room to get towels or other supplies. Individuals with dementia should never be left alone in the bath or shower.

Elderly people may be more sensitive to heat and cold, so ensure that water and air temperatures are comfortable. Have the individual test the water temperature before stepping in to make sure it’s acceptable. Fear of falling in the bath or tub is very common, so help the individual feel as secure as possible, with all the assistive devices or help necessary. Use safety bars and bath mats to reduce the chance of slipping, and install bath and shower handrails or a shower seat. Hand-held showers can make bathing a much easier experience.

**Communication strategies for Alzheimer’s disease and other dementias**

**Getting ready to communicate**

Make sure the individual is prepared to understand you. Does he or she require a hearing aid, dentures or glasses? Has he/she just woken up from a nap or due for one? Trying to speak with someone who is drowsy makes communication more difficult.

Approach the individual from the front, as you may startle him/her if you’re not within their line of vision. Eye contact is an important element of nonverbal communication. It shows that you are ready to communicate. Try to get on the individual’s same level so you can look him or her in the eye. You should face the person as you speak, as some people with hearing loss or other issues may rely on lip reading more than hearing the words. Use the individual’s name to get his or her attention, and identify who you are.

**Timing**

Timing your communication is important. The resident must be receptive, awake and alert. He or she must be ready to focus and listen to what you are saying. The ability to communicate or understand is made more difficult when the resident is confused, sleepy, or medicated. Difficulty communicating may be greater later in the day, as the individual grows more fatigued. Some medications have side effects that make communication more difficult, like drowsiness or lethargy.

Give your complete attention to the resident. Do not attempt to communicate during other activities that require your or the resident’s full attention. Residents with severe dementia will need to focus on what you are saying to understand you. It is best not to ask them to focus on two activities at once. Save unnecessary conversation for safe times when transferring or completing an ADL.

Allow sufficient time for communication; everything needs to be slowed down for the resident with dementia. They are likely to communicate poorly, or without focus, and need additional time. Provide ample time and don’t appear rushed or distracted.

**Minimize distractions and noise**

Minimize external noise and distractions. This may require closing a curtain, shutting a door, or turning off a radio or TV (always ask first!). Reduce or avoid background noise that can be distracting or drown out what you are saying. The environment should be bright and quiet. Eliminate clutter, shadows, and sensory overload in the form of too many people, too much talking, or environmental distractions like lights and noises.

**Keep it short and simple**

Communicate simply. Use common words and short sentences. Avoid hospital lingo. Always refer to other people using their names (and a description, if necessary) rather than “him” or “her,” to provide a context for the listener. (Example: “Did your daughter, Susan, visit today?”)

Speak slowly in a low tone of voice. Higher pitched voices may be more difficult to hear, while louder voices can sound angry. If the individual does not seem to understand what you’re saying, repeat it more slowly using the same words. If there is still no recognition, rephrase what you are saying.

Slow down and use pauses when you speak. Individuals with dementia cannot take information in as quickly. Provide sufficient time for the patient to process information, respond, or ask questions.
Allow the resident to complete his/her own thoughts. In some cases, this means letting them struggle to find a word. Some people in this situation like to have a word supplied; others prefer to struggle. Don’t be too quick to guess what the person is trying to say unless the person doesn’t mind you trying to complete his/her thoughts. Find out what strategy is least frustrating for that individual. If the word is not forthcoming, suggest he/she write it, then try to read it out loud.

One step at a time
Discuss one topic, or one part of a topic, at a time. Avoid complicated information and do not provide too much information at once, as this can be confusing or overwhelming to a resident with severe dementia. Break ADLs and other projects into a series of short steps instead of one long process. Tell the resident each step, and let him/her complete it before you move on. Assist and remind as needed.

Develop simple routines and use a small number of key words in critical situations, such as making transfers, or completing other common tasks in a way that ensures resident safety. One strategy, for example, used when transferring an individual with cognitive impairment, is to use as few words as possible to complete this task: “stand;” “pivot” or “turn,” and “sit,” for example, identify what needs to be done at the appropriate time. Using too many words can confuse the resident.

Use behaviors to facilitate communication:
Show: Use pictures or symbols or show the item you’re talking about if possible. Show a urinal, for example, and use the word “urinate.” Also try writing, gestures, or pointing to items that help illustrate what you have to say. Visual clues are very helpful at getting the point across. See nonverbal communication, in this chapter.

Ask: Ask only one question at a time, and keep it as simple as possible. The best questions can be answered with a yes or no. Don’t give too many choices. “Would you like a banana or an apple with lunch?” is better than “What kind of fruit do you want with lunch?” The best option is to show both choices.

Repeat or rephrase: If repeating, say exactly the same thing, emphasizing key words. If after repetition the message still isn’t understood, try to find another way of saying the same thing. Repeat questions as needed; it may be necessary to repeat a great deal.

Listen: Good communication requires good listening skills. Don’t interrupt, and give the resident ample time to respond. It may take individuals with dementia up to 30 seconds or more to respond to a question. Be patient; everything takes more time with dementia.

Situations to avoid:
- Do not use long instructions, directions, lists, or complicated questions.
- Do not ask questions that rely on short-term memory. Instead, encourage discussion of things that happened long ago in the past, which may seem more vivid than recent memories. Asking what the resident had for breakfast may just be frustrating.
- Do not use medical terminology.
- Do not criticize, hurry, correct, argue or contradict. Individuals with dementia may be confused and prone to agitation. They may confuse reality with imagination, so do not try to argue or convince them they are wrong. Instead, focus on the feelings they are expressing. Respond with verbal and physical reassurance.
- Avoid rushing communication; be patient.
- Avoid crowding the individual. Give him/her “elbow room” and do not stand over him/her.

If you don’t understand:
- Let the person know you do not understand him/her. Do not pretend to understand what the person has said if you don’t. Nod yes only if you understand.
- Maintain eye contact and show that you’re listening and trying to understand.
- Ask questions such as “Does it have to do with …” and end the sentence with categories like “eating,” “sleeping,” “dressing,” etc., to get a clue of what the individual is trying to say.
- Use nonverbal communication, such as props, visual cues, charts, models, pictures or gestures to increase recognition of the message. Take the person to where the toilet is visible, for example, point to it and ask if he or she needs to use the toilet.
- Ask the person what might help them communicate (pictures, writing, etc.).
- Use family, friends, or familiar staff members to assist in cases of difficult communication; someone who knows the individual better may be able to interpret what is being said.
- Respond with verbal and physical reassurance. Use gentle touch to communicate and reassure when words don’t get through. Be aware that some people do not respond well to touch.

Using nonverbal communication
There are two main types of communication, verbal (spoken) and nonverbal (nonspoken). People with dementia often find that more words clutter up or confuse their reception of communication. That is why spoken communication should always be as simple as possible, using the fewest number of words.

Communication can also be nonspoken or nonverbal, which includes writing or communicating with signs or gestures (like a thumbs-up signal communicates good news). Nonverbal communication is sometimes better at communicating a message to people with cognitive impairments. You may want to act out an action or use hand gestures to ask someone to sit up or down. Do not gesture near the individual’s face or stand too close, however. Always keep a respectful distance.

Sometimes your body language is easier to interpret than spoken words, so watch gestures and the way you stand. Sometimes we communicate things we shouldn’t through the way we stand or talk – that we’re in a hurry, for example. While people with dementia have difficulty with spoken words, they are often very perceptive at reading nonverbal cues, like body language. Similarly, one can often interpret a lot by looking carefully at the resident, seeing signs of pain, for example, in the way a person walks or the look on his/her face.

Tone and posture
Even if you get frustrated, try to keep your voice calm and relaxed. If your words and the way you say them don’t match, it may be confusing to the resident. Remember that your nonverbal cues, including the tone of your voice, often send a clearer message than what you actually say. Smile and maintain a positive mood and frame of mind. Keep your tone pleasant, gentle, respectful and caring. Speak slowly, and be reassuring and positive. Use your expression and gentle touch to convey concern or care. Watch the resident’s tone and posture for signs of stress or pain. How are they holding their body? What is their expression? Do they appear to be in discomfort?

Visual cues
Visual cues are very useful nonspoken ways of communicating important information. Use written language or symbols, pictures, or objects to help communicate meaning. In making signs, use large, easy-to-read letters and focus lighting to emphasize the information. A bathroom sign hung over the bathroom door may be all that’s necessary to assist a resident who soils himself because he forgets where the bathroom is located.

Elderly individuals are also prone to visual disabilities with common visual problems, such as difficulty seeing in low light. They could have problems with glare and may have age-related macular degeneration leading to low vision. Use contrasting light and dark colors to make the sign as clear and easy to read as possible, using heavy block print and sharp images.

Pictogram grids are communication tools that show images, usually black and white, with graphic symbols against a background and text above that gives the meaning of the symbol. The combination of white and black gives optimum contrast to the eye and renders pictograms more user-friendly. Different kinds of pictograms exist for different functions. A similar device can be created by asking the resident to point at pictures that identify what he/she needs. A pictogram replaces written language for those people who are limited in their ability to speak, read and write.

Handling difficult situations and behavior
Problems communicating about ADLs can lead to frustration on the parts of both the CNA and the resident. The reason that resistance occurs with communication is to use as few words as possible to complete this task: “stand;” “pivot” or “turn,” and “sit,” for example, identify what needs to be done at the appropriate time. Using too many words can confuse the resident.
Try to be flexible. Rather than argue with the person, consider changing the environment or your own behavior to adjust and respond to the person’s needs. If the resident wants to sleep in a reclining chair rather than the bed, and there’s no good reason not to, accommodate the new behavior. Sometimes changing your response to the behavior is the best way to change the resident’s behavior, so try to accommodate it whenever possible if safety not an issue.

Because people with dementia have barriers to communication, they may do things we don’t understand, but there is typically a reason for the behavior. Difficult behavior is often triggered by something. Try to determine what triggered the behavior and what the individual is trying to communicate with the behavior. The trigger may be anything – a change in the environment that the resident finds disturbing, or the feeling that he/she is being rushed (because rushing is often a trigger of difficult behavior, you should plan plenty of time to get ready, get to appointments, etc.).

Do not try to control the person or the behavior, as this will increase their sense of loss of control. When things get difficult because the individual is upset or agitated, try the following:

- Distract and redirect: try to change the subject or shift to a new project. Always acknowledge the frustration or feelings before you redirect, however. For example, “I’m sorry you’re frustrated/sad/angry. Let’s try this again later. Right now let’s go for a walk/get a snack/etc.”
- Try different approaches to address difficult behaviors; what works one day may not work the next. You will need to be flexible in trying new things and developing new strategies. Breaking a project down into a series of simple steps, then explaining each step before you do it, as you go, often has a calming effect. Telling the resident what you are going to do gives the individual more sense of control. Always allow enough time.
- Consider the words or sentences you are using. Do you sound as if you are telling a child what to do (or what not to do)? Remember that you are with an adult, who may be trying to maintain some sense of control. When you say “You need to…” or “You can’t…” or “I want you to…” it is likely to escalate agitation or anger. Pay attention to the tone of your voice and/or body language. Remember that the dementia damages the person’s ability to be rational or logical. Contradicting or arguing with the person tends to make the situation worse. Don’t allow the difficulty to escalate.
- Appear as nonthreatening as possible by staying about three feet away from an angry or agitated person, smiling and keeping a pleasant expression, and using a calm tone of voice.
- Some difficult behaviors have medical reasons; see if it is a side effect of medication or can be helped with medication.

**Most important:**
- Keep your sense of humor and don’t take anything personally. Remember that personality changes are a part of dementia for many people. In most cases, it is the disease, not the person. Treat the resident with compassion and affection.
- The resident’s reasoning and judgment will decline over time. Avoid arguing or conflict, as the most likely outcome is increased anger and frustration for both of you.
- Recognize that you are human and have limitations. You will have good days and bad days. Self care and support from peers is important on those bad days.

**Other types of problems that affect communication**

There are many other kinds of conditions that make communication with residents/patients more difficult, especially when coupled with cognitive impairment. Other obstacles to clear communication include:

- Respiratory impairment.
- Speech pathology.
- Surgery.
- Problem in finding the correct words when speaking.
- Weak or absent voice.
- Auditory impairment.
- Laryngeal edema/infection.
- Deafness.
- Inattention to noises or voices.
- Confusion.
- Inability to understand or speak the language.
- Oral deformities.
- Pain.

There may be a number of issues at work that complicate the resident’s speaking, hearing or thinking. Communication can be made more difficult by the normal aging process, which can include sensory loss, memory loss and slower cognitive function. Additionally, as an individual ages, his/her voice may change, becoming harder to understand.

Problems articulating words can be traced to cognitive impairment. Other obstacles to clear communication include:

- Dysarthria
- Speech pathology
- Auditory impairment
- Laryngeal edema/infection
- Deafness
- Inattention to noises or voices
- Confusion
- Inability to understand or speak the language
- Oral deformities
- Pain

For those who wear hearing aids, ensure that the hearing aid is in the person’s ear, turned on, and has a good battery. If all is OK, and there are still problems, evaluate the individual’s hearing.

- Do not begin speaking until you are in front of the individual, facing him or her, and engage in eye contact.
- Do not smoke, chew gum or have candy or food in your mouth when you talk. It will make you more difficult to understand.
- Keep hands away from your face or covering your mouth.
- The hard of hearing are often less able to understand if fatigued or ill.
- Minimize background noise.
- Speak clearly without shouting.
- Write messages if necessary (the person must be able to read), use pictures.
- If not understood, try a different way to communicate the same thing.
- Communicate simply, with short sentences, statements, or questions.
- Use body language, gestures, etc, to help communicate.

**ENDNOTES**


**BIBLIOGRAPHY**

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CHAPTER 4
DOMESTIC VIOLENCE AWARENESS
(1 CONTACT HOUR)

Learning objectives
- List and define the five main categories of intimate partner violence.
- Explain why health care workers may use the term “survivor,” instead of “patient” or “victim,” to refer to the individual experiencing intimate partner violence.
- Identify negative health behaviors that are commonly associated with intimate partner violence.
- List risk factors for victimization and perpetration.

Domestic violence, also called intimate partner violence (IPV), is a serious, preventable public health problem affecting more than 32 million Americans (Tjaden and Thoennes 2000). The term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

The term “survivor” is often applied to those who have experienced intimate partner violence. Health care workers and advocates may use it instead of “patient” or “victim” because it is a more empowering term. If you or someone you know is the victim of intimate partner violence and needs help, contact your local battered women’s shelter or the National Domestic Violence Hotline at 800-799-SAFE (7233), 800-787-3224 TTY, or www.ndvh.org. These organizations can provide you with helpful information and advice.

IPV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering. Repeated abuse is also known as battering.

There are five main types of intimate partner violence (Saltzman et al. 2002):
- Physical violence
- Psychological/情感 abuse
- Economic abuse
- Stalking
- Sexual abuse

Physical violence is the intentional use of physical force with the potential for causing death, disability, injury or harm. Physical violence includes, but is not limited to scratching, pushing; shoving; throwing, grabbing, biting, choking, shaking, slapping; punching; burning; use of a weapon and use of restraints or one’s body, size or strength against another person.

Sexual violence is divided into three categories:
- Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed.
- Attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure.
- Abusive sexual contact.

Threats of physical or sexual violence use words, gestures, or weapons to communicate the intent to cause death, disability, injury or physical harm.

Psychological/情感 abuse involves trauma to the victim caused by acts, threats of acts or coercive tactics. Psychological/情感 abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence.

In addition, stalking is often included among the types of IPV. Stalking generally refers to repeated behavior that causes victims to feel a high level of fear (Tjaden and Thoennes 2000). IPV is a serious problem that is common in our society. Violence by an intimate partner is linked to both immediate and long-term health, social, and economic consequences. Factors at all levels—individual, relationship, community and societal—contribute to the perpetration of IPV.

Preventing IPV requires a clear understanding of those factors, coordinated resources and empowering and initiating change in individuals, families, and society.

Intimate partner violence: Fact sheet

Occurrence
Statistics about intimate partner violence (IPV) vary because of differences in how different data sources define IPV and collect data. For example, some definitions include stalking and psychological abuse, and others consider only physical and sexual violence. Data on IPV usually come from police, clinical settings, nongovernmental organizations and survey research.

Most IPV incidents are not reported to the police. About 20 percent of IPV rapes or sexual assaults, 25 percent of physical assaults, and 50 percent of stalkings directed toward women are reported. Even fewer IPV incidents against men are reported (Tjaden and Thoennes 2000a). Thus, it is believed that available data greatly underestimate the true magnitude of the problem. While not an exhaustive list, here are some statistics on the occurrence of IPV. In many cases, the severity of the IPV behaviors is unknown.

- Nearly 5.3 million incidents of IPV occur each year among U.S. women ages 18 and older, and 3.2 million occur among men.
- Most assaults are relatively minor and consist of pushing, grabbing, shoving, slapping and hitting (Tjaden and Thoennes 2000a).
- In the United States every year, about 1.5 million women and more than 800,000 men are raped or physically assaulted by an intimate partner. This translates into about 47 IPV assaults per 1,000 women and 32 assaults per 1,000 men (Tjaden and Thoennes 2000a).
- IPV results in nearly 2 million injuries and 1,300 deaths nationwide every year (CDC 2003). Estimates indicate more than 1 million women and 371,000 men are stalked by intimate partners each year (Tjaden and Thoennes 2000).
- IPV accounted for 20 percent of nonfatal violence against women in 2001 and 3 percent against men (Rennison 2003).
- From 1976 to 2002, about 11 percent of homicide victims were killed by an intimate partner (Fox and Zawitz 2004).
- In 2002, 76 percent of IPV homicide victims were female; 24 percent were male (Fox and Zawitz 2004).
- The number of intimate partner homicides decreased 14 percent overall for men and women in the span of about 20 years, with a 67 percent decrease for men (from 1,357 to 388) vs. 25 percent for women (from 1,600 to 1,202; Fox and Zawitz 2004).
- One study found that 44 percent of women murdered by their intimate partner had visited an emergency department within 2 years of the homicide. Of these women, 93 percent had at least one injury visit (Crandall et al. 2004).
- Previous literature suggests that women who have separated from their abusive partners often remain at risk of violence (Campbell et al. 2003; Fleury, Sullivan and Bybee 2000).
- Firearms were the major weapon type used in intimate partner homicides from 1981 to 1998 (Paulozzi et al. 2001).
- A national study found that 29 percent of women and 22 percent of men had experienced physical, sexual, or psychological IPV during their lifetime (Coker et al. 2002).
- Between 4 percent and 8 percent of pregnant women are abused at least once during the pregnancy (Gazmararian et al. 2000).

Consequences
In general, victims of repeated violence over time experience more serious consequences than victims of one-time incidents (Johnson and Leone 2005). The following list describes just some of the consequences of IPV.

Physical
At least 42 percent of women and 20 percent of men who were physically assaulted since age 18 sustained injuries during their most recent victimization. Most injuries were minor, such as scratches, bruises and welts (Tjaden and Thoennes 2000a).

More severe physical consequences of IPV may occur depending on severity and frequency of abuse (Campbell et al. 2002; Heise and Garcia-Moreno 2002; Plichta 2004; Tjaden and Thoennes 2000a). These include:
- Bruises.
- Knife wounds.
- Pelvic pain.
- Headaches.
- Back pain.
Children may become injured during IPV incidents between their parents. A large overlap exists between IPV and child maltreatment (Appel and Holden 1998). One study found that children of abused mothers were 57 times more likely to have been harmed because of IPV between their parents, compared with children of non-abused mothers (Parkinson et al. 2001).

**Psychological**

Physical violence is typically accompanied by emotional or psychological abuse (Tjaden and Thoennes 2000a). IPV – whether sexual, physical, or psychological – can lead to various psychological consequences for victims (Bergen 1996; Coker et al. 2002; Heise and Garcia-Moreno 2002; Roberts, Klein, and Fisher 2003):
- Depression.
- Antisocial behavior.
- Suicidal behavior in females.
- Anxiety.
- Low self-esteem.
- Inability to trust men.
- Fear of intimacy.

**Social**

Victims of IPV sometimes face the following social consequences (Heise and Garcia-Moreno 2002; Plichta 2004):
- Restricted access to services.
- Strained relationships with health providers and employers.
- Isolation from social networks.

**Health behaviors**

Women with a history of intimate partner violence are more likely to display behaviors that present further health risks (e.g., substance abuse, alcoholism, suicide attempts).

IPV is associated with a variety of negative health behaviors (Heise and Garcia-Moreno 2002; Plichta 2004; Roberts, Auinger, and Klein 2005; Silverman et al. 2001). Studies show that the more severe the violence, the stronger its relationship to negative health behaviors by victims.

- Engaging in high-risk sexual behavior:
  - Unprotected sex.
  - Decreased condom use.
  - Early sexual initiation.
  - Choosing unhealthy sexual partners.
  - Having multiple sex partners.
  - Trading sex for food, money, or other items.
- Using or abusing harmful substances:
  - Smoking cigarettes.
  - Drinking alcohol.
  - Driving after drinking alcohol.
  - Taking drugs.
- Unhealthy diet-related behaviors:
  - Fasting.
  - Vomiting.
  - Abusing diet pills.
  - Overeating.
  - Overuse of health services.

### Economic

Costs of IPV against women in 1995 exceeded an estimated $5.8 billion. These costs included nearly $4.1 billion in the direct costs of medical and mental health care and nearly $1.8 billion in the indirect costs of lost productivity (CDC 2003).

When updated to 2003 dollars, IPV costs exceeded $8.3 billion, which included $460 million for rape, $6.2 billion for physical assault, $461 million for stalking and $1.2 billion in the value of lost lives (Max et al. 2004).

Victims of severe IPV lose nearly 8 million days of paid work – the equivalent of more than 32,000 full-time jobs – and almost 5.6 million days of household productivity each year (CDC 2003).

Women who experience severe aggression by men (e.g., not being allowed to go to work or school, or having their lives or their children’s lives threatened) are more likely to have been unemployed in the past, have health problems and be receiving public assistance (Lloyd and Taluc 1999).

### Groups at risk

Certain groups are at greater risk for IPV victimization or perpetration.

- The National Crime Victimization Survey found that 85 percent of IPV victims were women (Rennison 2003).
- Prevalence of IPV varies among race. Among the ethnic groups most at risk are American Indian/Alaskan Native women and men, African-American women, and Hispanic women (Tjaden and Thoennes 2000b).
- Young women and those below the poverty line are disproportionately victims of IPV (Tjaden and Thoennes 2000b).
- Studies show that for low levels of physical violence, men and women self-report perpetrating physical IPV at about the same rate. However, a common criticism of these studies is that they are generally lacking information on the context of the violence (e.g., whether self-defense is the reason for the violence) (Archer 2000).

### Risk factors for victimization and perpetration

Some risk factors for IPV victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another; for example, childhood physical or sexual victimization is a risk factor for future IPV perpetration and victimization.

The public health approach aims to moderate and mediate those contributing factors that are preventable, and to identify protective factors which can reduce the risk of victimization and perpetration.

A combination of individual, relational, community and societal factors contribute to the risk of being a victim or perpetrator of IPV.

Understanding these multilevel factors can help identify various points of prevention intervention.

### Risk Factors for victimization

**Individual factors**

- Prior history of intimate partner violence.
- Being female.
- Young age.
- Heavy alcohol and drug use.
- High-risk sexual behavior.
- Witnessing or experiencing violence as a child.
- Being less educated.
- Unemployment.
- For men, having a different ethnicity from their partner’s.
- For women, having a greater education level than their partner’s.
- For women, being American Indian/Alaska Native or African American.
- For women, having a verbally abusive, jealous, or possessive partner.

### Relationship factors

- Couples with income, educational, or job status disparities.
- Dominance and control of the relationship by the male.

### Community factors

- Poverty and associated factors (e.g., overcrowding.)
- Low social capital—lack of institutions, relationships, and norms that shape the quality and quantity of a community’s social interactions.
- Weak community sanctions against IPV (e.g., police unwilling to intervene).

### Societal factors

- Traditional gender norms (e.g., women should stay at home and not enter workforce, should be submissive).

(Crandall et al. 2004; Heise and Garcia-Moreno 2002; Stith et al. 2004; Tjaden and Thoennes 2000a)

### Risk Factors for perpetration

**Individual factors**

- Low self-esteem.
- Low income.
- Low academic achievement.
- Involvement in aggressive or delinquent behavior as a youth.
- Heavy alcohol and drug use.
Societal factors
- Weak community sanctions against IPV (e.g., That shape the quality and quantity of a
- Economic stress.
- Emotional dependence and insecurity.
- Belief in strict gender roles (e.g., male dominance and aggression in relationships).
- Desire for power and control in relationships.

Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration).

Relationship factors
- Marital conflict – fights, tension, and other struggles.
- Marital instability – divorces and separations.
- Dominance and control of the relationship by the male.
- Economic stress.
- Unhealthy family relationships and interactions.

Community factors
- Poverty and associated factors (e.g., overcrowding).
- Low social capital—lack of institutions, relationships, and norms.
- That shape the quality and quantity of a community’s social interactions.
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence).

Societal factors
- Traditional gender norms, for example: women should stay at home, not enter the workforce, and/or should be submissive (Black et al. 1999; Heise and Garcia-Moreno 2002; Kantor and Jasinski 1998; Stith et al. 2004; Tjaden and Thoennes 2000a).

Sample domestic violence protocol and assessment form
The following protocol and assessment form can be adapted to fit your institution’s requirements.

Sample domestic violence protocol
Purpose:
A. Guide treatment of all injuries and illness.
B. Provide and communicate a safe environment for the patient.
C. Identify battered women through screening and through recognition of possible Indicators.
D. Offer supportive counseling, validation of her concerns and attention to safety issues after discharge.
E. Document the incident(s) correctly and take photos.
F. Provide referral information during the health care contact.

Philosophy:
ABC Hospital believes that all people are entitled to the right to live free from violence or threat of violence from current or former partners. Although 95 percent of domestic violence involves female victims and male abusers, sometimes men are abused by women, and domestic violence also occurs in gay and lesbian relationships. Due to the fact that the vast majority of domestic violence occurs toward women by male partners, the convention of using “she” to refer to the victim and “he” to refer to the abuser will be used in this policy and procedure.

Policy:
Because health care providers may be the first nonfamily members to whom an abused woman turns for help, the provider has an opportunity and responsibility to provide appropriate and sensitive interventions. ABC Hospital is committed to developing and implementing policies and procedures for identifying, treating, and referring victims of domestic abuse.

Legal consideration: State codes define domestic violence as a criminal offense and allows a person to seek relief through the legal system.

Reporting requirements: Some states do not have an explicit law requiring health care providers to report instances of domestic violence. Reporting domestic violence to law enforcement should be done only with the abused person’s knowledge; verbal consent should be obtained. Only the abused person can assess the danger and relative risk of reporting vs. nonreporting. All other reporting requirements such as gunshot wounds, stab wounds, second-degree burns, child abuse and elder abuse must be followed in accordance with state laws.

Definitions:
Domestic violence is an ongoing, debilitating experience of physical, psychological and/or sexual abuse involving force or threat of force from a current or former partner associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. A victim of domestic violence is anyone who has been injured or has been emotionally or sexually abused by a person with whom she has, or has had a primary relationship.

Procedure:
Health care worker role
1. Screen for domestic violence on all female patients over 16.
2. Conduct initial assessment in private (ask patient’s visitor/s to have a seat in the lobby before screening and inform that this is standard routine, or find a time when the patient is alone, such as in the bathroom).
3. Screen for domestic violence using simple direct questions. “Because domestic violence is so common in many people’s lives, I’ve begun to ask all my patients about it routinely. Are you in a relationship with a person who hurts or threatens you?” If you are suspicious of injuries that are present ask “Did someone cause these injuries? Who?” (Refer to end for review of screening questions).

4. If domestic violence is identified:
a. Send important message to the patient. (Avoid victim blaming). “You are not alone; you are not to blame; there is help available; you do not deserve to be treated this way.”
b. Let her know that the conversations will be confidential within the limits of reporting requirements which are injuries such as knife wounds, gunshot wounds or burns.
c. Assess immediate safety by asking these questions. “May I ask you some questions that will allow us to determine your level of safety?” Ask these questions in a thoughtful and caring manner:
   - Are you afraid to go home?
   - Are there weapons present?
   - Have there been threats of homicide or suicide?
   - Can you stay with family or friends?
   - Do you need access to a shelter?
   - Do you want police intervention?

5. If the patient verbalizes danger:
a. Ask the patient for her verbal consent to call a domestic violence victim advocate by saying, “I’d like to call and have an advocate come and meet with you. Would that be okay?” If she declines, then seek help from social services.
b. The advocacy agency or social services will do the safety assessment.
c. Notify the MD.
d. Notify security if immediate danger is present to patient or staff. The police department may need to be notified as the situation warrants.

6. If the patient is not in immediate danger, but positive for domestic violence:
a. Ask the patient for verbal consent to call a victim’s advocate by saying, “I’d like to call and have an advocate come and meet with you. Would that be okay?” The advocate will have the expertise to sort through a safety assessment and the patient’s desire to press charges or not. If the patient declines this, it will be up to the nurse or social services to help sort through the needs of the patient. (Discharge the patient with wallet cards and referral numbers for the advocate agency. Be careful to not document the numbers on the going home information, but on the wallet card).
b. Document objectively; include specifics of abuse; include quotes whenever possible; document circumstances of abuse and the abuser’s name.
c. When documenting in the record, ensure that the record is in an area where the abuser does not have access.
d. A determination needs to be made as to whether the patient will be pressing charges so; the police know what their role is.
7. Advise patient who denies domestic violence, but whom you suspect abuse:
   a. To confer with MD.
   b. To accept a resource wallet card even if patient has not admitted abuse but the RN is suspicious of injuries or complaints. Attempt to facilitate disclosure with questions such as: “Your injuries concern me. Injuries such as these are often caused by abuse. Could this be happening to you?”
   c. “If you are abused, please come back to the ED or contact an advocate.”
   d. Do not write any domestic violence referral on discharge instructions.

**Documentation**

Documentation should be done on the domestic violence assessment form, or domestic violence intervention screen in Meditech).
   a. Document any findings of abuse or probable abuse and warning to patient of risk of further violence. Use body map.
   b. Document patient’s comments regarding abuse. Use patient’s own words when possible.
   c. Document the name of the perpetrator of the domestic violence.
   d. Document Social Work or referral to an advocate and the reason for referral.
   e. Discharge instructions should not have domestic violence indicated. (Wallet card will have referral information.)
   f. Document “positive or negative” domestic violence and explanation.
   g. Offer to take photos of any injuries and bruising.
   h. Written consent must be obtained before proceeding with photographs.
   i. On discharge instruction sheet, do not indicate domestic violence, abuse, or advocate referral. (This instruction sheet could fall into the hands of the perpetrator.)

**Photos**

a. When injury lends itself to photographic documentation, physician or RN will assist with photos. Make sure an identifying characteristic or ID band appears in the photo and a ruler to indicate size of the injury.
   b. Instant photos are taken and placed in the medical record. Note the following on the bottom of the photo.
      1. Date.
      2. Location (e.g., BRH, BRH ED).
      3. Patient name.
      4. Medical record number.
      5. “Photo taken by” line.
      6. Photographer’s name.
      7. Part of body photographed.
   c. Consent must be signed before taking photos.

The ABC Hospital Domestic Violence Task Force is committed to ongoing care of the victim of domestic violence and to the training of the hospital staff and community. This is an interdepartmental/interagency task force with members from the Social Work Services Department, an advocate agency, a nurse from the emergency department and a physician. This group will come together to hold monthly meetings and discuss the objectives set out in the 10-state program and review the hospital’s ability to care for the victim of domestic violence.

ABC Hospital will train all new employees on use of the domestic violence protocol. Staff development officials will meet and collaborate with a victim’s advocate agency quarterly.

**Responsibilities**

Health care professionals should use “RADAR” to guide them in recognizing and treating victims of partner violence:

- Remember to ask routinely about violence.
- Ask questions. “At any time, has your partner hit, kicked or otherwise hurt or frightened you?” Interview patients in private at all times.
- Document findings. Information about suspected domestic violence in a patient’s chart can be used in court cases.

Assess patients’ safety. Is it safe to return home? Find out if there are any weapons; are children in danger? Is the violence escalating?

Review options. Let patient know where there is help. Tell them about shelters, support groups and legal advocates.

**Remember: Nurses have an obligation to tell their clients that:**
- No one deserves to be abused.
- One person cannot be the cause of another person’s violence.
- They are not alone.
- Pushing, shoving, and/or slapping are acts of crime.
- While conflict is inevitable, violence is a choice.
- The batterer is responsible and needs help.
- They are not bad.
- Substance abuse does not minimize the crime.
- Domestic violence is a crime.
References

CHAPTER 5
HIV PREVENTION STRATEGIES IN MEDICAL CARE SETTINGS
(2 CONTACT HOURS)

Learning objectives

- Name and distinguish between the ways HIV can and cannot be spread.
- List the precautions recommended by the CDC to prevent transmission of HIV to health care personnel in the workplace.
- List the factors affecting risk for transmission of HIV in general and among health care workers in particular.
- Identify three primary groups of people who require education on HIV.
- Identify population targets for HIV testing.
- Define and describe the Centers for Disease Control and Prevention’s new initiative.
- List four key strategies for the Centers for Disease Control and Prevention’s new initiative.

Preventing occupational HIV transmission to health care personnel [1]
The human immunodeficiency virus (HIV) is not spread easily. You can only get HIV if you get infected blood or sexual fluids into your system. You can’t get it from mosquito bites, coughing or sneezing, sharing household items or swimming in the same pool as someone with HIV.

Some people talk about “shared body fluids” being risky for HIV, but no documented cases of HIV have been caused by sweat, saliva or tears. However, even small amounts of blood in your mouth might transmit HIV during kissing or oral sex. Blood can come from flossing your teeth, or from sores caused by gum disease, or by eating very hot or sharp, pointed food.

To infect someone, the virus has to get past the body’s defenses. These include skin and saliva. If your skin is not broken or cut, it protects you against infection from blood or sexual fluids. Saliva contains chemicals that can help kill HIV in your mouth.

If HIV-infected blood or sexual fluid gets inside your body, you can get infected. This can happen through an open sore or wound, during sexual activity, or if you share equipment to inject drugs.

HIV can also be spread from a mother to her child during pregnancy or delivery. This is called “vertical transmission.” A baby can also be infected by drinking an infected woman’s breast milk. Adults exposed to breast milk of an HIV-infected woman may also be exposed to HIV.

Health care personnel and exposure [12]
An exposure that might place health care personnel at risk for HIV infection is defined as a percutaneous injury (e.g., a needle stick or cut with a sharp object) or contact of mucous membrane or nonintact skin (e.g., exposed skin that is chapped, abraded, or afflicted with dermatitis) with blood, tissue or other body fluids that are potentially infectious. In addition to blood and visibly bloody body fluids, semen and vaginal secretions also are considered potentially infectious. Although semen and vaginal secretions have been implicated in the sexual transmission of HIV, they have not been implicated in occupational transmission from patients to health care personnel.

The following fluids also are considered potentially infectious: cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid and amniotic fluid. The risk for transmission of HIV infection from these fluids is unknown; the potential risk to health care personnel from occupational exposures has not been assessed by epidemiologic studies in health care settings. Feces, nasal secretions, saliva, sputum, sweat, tears, urine and vomitus are not considered potentially infectious unless they are visibly bloody; the risk for transmission of HIV infection from these fluids and materials is low. Any direct contact (i.e., contact without barrier protection) to concentrated virus in a research laboratory or production facility requires clinical evaluation. For human bites, clinical evaluation must include the possibility that both the person bitten and the person who inflicted the bite were exposed to blood-borne pathogens. Transmission of HIV infection by this route has been reported rarely, but not after an occupational exposure.

Preventive strategies [7]
To prevent transmission of HIV to health care personnel in the workplace, the Centers for Disease Control and Prevention (CDC) offers the following recommendations. Health care personnel should assume that the blood and other body fluids from all patients are potentially infectious, so they should follow infection control precautions at all times.

These precautions include:

- The routine use of barriers (such as gloves and/or goggles) when anticipating contact with blood or body fluids.
- Washing hands and other skin surfaces immediately after contact with blood or body fluids.
- The careful handling and disposing of sharp instruments during and after use.

Safety devices have been developed to help prevent needle-stick injuries. If used properly, these types of devices may reduce the risk of exposure to HIV. Many percutaneous injuries are related to sharps disposal. Strategies for safer disposal, including safer design of disposal containers and placement of containers, are being developed.

Although the most important strategy for reducing the risk of occupational HIV transmission is to prevent occupational exposures, plans for postexposure management of health care personnel should be in place. CDC has issued guidelines for the management of health care personnel exposures to HIV and recommendations for postexposure prophylaxis (PEP); Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis (June 29, 2001).

Risk for occupational transmission of HIV [12]
The risks for occupational transmission of HIV vary with the type and severity of exposure. In prospective studies of health care personnel, the average risk for HIV transmission after a percutaneous exposure to HIV-infected blood has been estimated to be approximately 0.3 percent (95 percent confidence interval [CI] = 0.2 percent–0.5 percent) and after a mucous membrane exposure, approximately 0.09 percent (CI = 0.006 percent–0.5 percent). Although episodes of HIV transmission after nonintact skin exposure have been documented, the average risk for transmission by this route has not been precisely quantified but is estimated to be less than the risk for mucous membrane exposures. The risk for transmission after exposure to fluids or tissues other than HIV-infected blood also has not been quantified but is probably considerably lower than for blood exposures. Epidemiologic and laboratory studies suggest that multiple factors might affect the risk for HIV transmission after an occupational exposure.

In a retrospective case-control study of health care personnel who had percutaneous exposure to HIV, increased risk for HIV infection was associated with exposure to a larger quantity of blood from the source person as indicated by:

- A device (e.g., a needle) visibly contaminated with the patient’s blood.
- A procedure that involved a needle being placed directly in a vein or artery.
- A deep injury. The risk also was increased for exposure to blood from source persons with terminal illness, possibly reflecting either the higher titer of HIV in blood late in the course of acquired immunodeficiency syndrome (AIDS) or other factors (e.g., the presence of syncyti- inducing strains of HIV).

A laboratory study that demonstrated that more blood is transferred by deeper injuries and hollow-bore needles lends further support for the observed variation in risk related to blood quantity. The use of source-person viral load as a surrogate measure of viral titer for assessing transmission risk has not yet been established. Plasma viral load (e.g., HIV RNA) reflects only the level of cell-free virus in the peripheral blood; latently infected cells might transmit infection in the absence of viremia. Although a lower viral load (e.g., less than 1,500 RNA copies/ mL) or one that is below the limits of detection probably indicates a lower titer exposure, it does not rule out the possibility of transmission.

HIV prevention in medical care settings [7]
Despite significant advances in the treatment of HIV infection, the estimated number of annual new HIV infections in the United States has remained at 40,000 for nearly 10 years[16]. Historically, HIV prevention in this country has generally focused on persons who are not HIV-infected, to help them avoid becoming infected. However, further reduction of HIV transmission
will require new strategies, including an increased emphasis on preventing transmission by HIV-infected persons aware of their status [26,28]. This may be a highly cost-effective strategy in that prevention is targeted directly to potential sources of new infections.

After testing positive for HIV, many people reduce behaviors that may transmit HIV to others [2, 38]. However, recent studies suggest that such behavioral changes are not maintained by all HIV-infected persons and that some continue to engage in behaviors that place others at risk for HIV infection [5, 21].

Routine HIV prevention programs and support are needed to help HIV-infected persons reduce behavioral risks and maintain safer behavior in the years after the diagnosis of HIV infection. Studies have tested interventions in this population and have demonstrated significant reductions in risky sexual and drug-use behaviors. For example, in a study at public HIV clinics of HIV-infected persons who had multiple sex partners at baseline, the prevalence of unprotected anal and vaginal intercourse was reduced 38 percent after brief, ongoing prevention counseling from primary care providers [8, 35]. Successful risk-reduction interventions for HIV-infected persons have also been conducted in group settings [12]. Further, interventions for HIV-infected persons who inject illicit drugs have reduced illicit drug use and unsafe sex in this population [30, 36].

A number of studies have demonstrated the beneficial effect of substance abuse treatment, particularly methadone maintenance treatment, on HIV-risk behaviors among injection drug users (IDUs) [25]. Taken as a whole, the findings strongly suggest that a concerted, sustained effort to provide prevention counseling and appropriate referral to services can greatly benefit HIV-infected persons and help them maintain safer behaviors that prevent others from becoming infected with HIV. However, recent studies suggest the need for targeted health care personnel training on the importance of HIV transmission prevention counseling [23].

**HIV and AIDS in America: Today [22]**

HIV and AIDS affect all sectors of American society – men and women, young and old, black and white, gay and straight, rich and poor. The impact of AIDS has nevertheless been more serious among some groups than others. In the early years of the epidemic, the most commonly identified “vulnerable groups” in America were men who have sex with men, injecting drug users, hemophiliacs and Haitians.

Today, AIDS continues to infect thousands of gay and bisexual men and injecting drugs users every year, but it has also become a serious problem among heterosexual African Americans, and the Latino population is increasingly affected, too.

**Prevention [22]**

On a national scale, the main HIV prevention strategy in America is to introduce widespread HIV testing to identify HIV-positive people. The

Advancing HIV Prevention (AHP) initiative, for example, advocated voluntary testing in all health care facilities as well as improved partner notification services to ensure partners of HIV-positive people were made aware of the risk they were at. More recently, the U.S. has also implemented new testing guidelines that state that all adolescents and adults aged 15-64 should be routinely tested for HIV whenever they visit a health care facility [15].

Beyond AHP, the U.S. has no other national prevention strategy or prevention targets. Prevention initiatives that actively work to prevent people from becoming infected tend to be carried out on a state- or citywide level, either by local authorities or by HIV support organizations. Such prevention initiatives may concentrate on particular communities or groups of people, or they may be more general in their focus. Independent organizations play a particularly big role in preventing HIV among injecting drug users, as it is illegal for federal money (and occasionally state or city money) to be used for needle exchange programs.

One area where prevention efforts have been successful is in the U.S. in the prevention of mother-to-child transmission (PMTCT). Routine HIV testing for pregnant women in many states, and good treatment and care, means that diagnoses of HIV in babies have dropped dramatically since HIV was first discovered in the US.


In other areas, prevention efforts have had less of an effect, however, and while combination anti-retroviral treatment has helped to dramatically reduce the number of people developing and dying of AIDS in America overall, about 40,000 continue to be diagnosed with AIDS every year (see the graph). This suggests that HIV infection levels are not declining.

In September 2007, over 100 AIDS organizations joined together to call for the introduction of a national AIDS strategy that would set out a clear national prevention plan and bring an end to the 40,000 new infections that occur each year [32]. The campaign targeted the candidates for the 2008 presidential election, a number of whom had a particular interest in HIV and AIDS.

“The wealthiest nation in the world is failing its own people in responding to the AIDS epidemic at home. Our country must develop what it asks of other nations it supports in combating AIDS: a comprehensive national strategy to achieve improved and more equitable results,” said

Rebecca Haag, executive director of AIDS Action [33].

**AIDS and sex education [22]**

The level and type of sex and HIV/AIDS education received by school children and students tends to vary depending on state regulations and the type of school or college a child is attending. In some areas, sex education that incorporates information on HIV is comprehensive and compulsory. In others, it is not, and children may leave school knowing virtually nothing about HIV and AIDS.

In recent years, abstinence-only education, which was backed by former President George Bush and teaches children to wait until marriage before having sex, has become particularly popular. However, this form of sex education has proved controversial, as many say it is ineffective and does not adequately teach about sexually transmitted infections and other related issues [31]. Many AIDS and sexual health organizations therefore advocate a more comprehensive approach that includes information about condoms and general discussion of teenage sexual relationships.

AIDS education among adults is also used as a prevention tool, particularly in communities where HIV levels are high. Discussion of AIDS in the workplace or at community meetings and religious gatherings can provide essential information to adults whom might otherwise be unaware they are at risk.

**Education of the infected patient [3]**

When people talk about AIDS education, they usually have in mind education that is provided to people who are not yet infected with HIV – often young people – to help them stay uninfected. While this is clearly important, it is also vital that people who are already living with HIV receive AIDS education.

**Why educate HIV-positive people? [3]**

HIV-positive people need HIV/AIDS education to provide help and support for them, enabling them to understand and to cope with the knowledge that they are infected with HIV. Education for HIV-positive people should also help to prevent the onward transmission of HIV.

When receiving an HIV-positive test result, many people feel that they have been given a death sentence. HIV/AIDS education and counseling for HIV-positive people has several main goals:

- To help people to cope with the trauma of an HIV-positive test result.
- To inform HIV-positive people about the nature of HIV and AIDS.
- To help them to confront any discrimination they may face as a result of being infected with HIV.
- To enable them to lead full and healthy lives.
- To enable them, should they wish, to have an active sexual life without passing the infection on to anyone else.
- To ensure that the infection isn’t passed on by any other means – the sharing of injecting equipment, for example.
Most people who are HIV-positive have acquired the infection from another person, whether sexually or via injecting equipment. Just as people who are not HIV-positive must take responsibility for their own protection, so must people who are HIV-positive take responsibility for ensuring that they do not pass the virus on to anyone else.

**What do HIV-positive people need to know? [3]**

HIV does not discriminate. While some groups have been more affected than others, people across all sectors of society are affected by HIV. This means that some HIV-positive people will have little more in common than the fact that they are HIV-positive. Beyond their health care requirements, they will have very different needs and will need different types of support, services and education. A person who tests HIV-positive, for example, may need advice on how to cope with discrimination at work, while another may need support and help to stop injecting drugs, and yet another advice on how to get a mortgage.

People who are HIV-positive need to know the basic facts about their condition:
- They need to know the difference between HIV and AIDS, and to be informed about both. In spite of the HIV/AIDS education done in the past, misconceptions still exist. An HIV-positive test result can be very distressing, and many people feel that they have been given a death sentence. People in this situation need to know whether their HIV infection has progressed to AIDS and that being infected with HIV does not necessarily mean that a person has AIDS. It can take many years for people with HIV to develop AIDS.
- People need to know what happens next, what tests they will need to have, and what the results mean. Depending on these test results, patients can be told whether they need to take any medication.
- They need to know that they may have to change their behavior. Partaking in the same activities that caused them to become infected could infect another person in the same way. They could also put themselves at risk of becoming infected with additional sexually transmitted infections, which could increase the progression of their HIV infection towards an AIDS diagnosis.
- People also need to be informed about the type of lifestyle that could help to keep them healthy. They need to know that their body will require good nutrition, if possible, in order to fight infection. They need to know that smoking, drug and alcohol abuse can weaken the body’s immune system, making them more prone to opportunistic infections.
- Education needs to focus on how to insist on safer sex. Many HIV-positive people around the world, especially women, may not fully be in control of how they express themselves sexually.

People who are HIV-positive are informed are better equipped to decide whether they will let people know about their HIV status, and better equipped to challenge discrimination and stigmatization. HIV-positive people who are informed are better equipped with other HIV-positive people, too. There’s an attitude of “if we’re both HIV-positive, it doesn’t matter.” This isn’t the case, as there are different strains of HIV, some of which have become resistant to some of the drugs used to treat AIDS.

- They need to know about their rights in society and what to do in the event that they experience harassment or discrimination.
- They will also want to know what they can expect from the medical care available in their country, if they will be able to access AIDS medication, and if so, how to go about it. In some countries, the health service or medical insurance may provide medications; in other places, people may have to attempt to be accepted onto clinical trials as the only way of accessing medicines.

**Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health care [15]**

**Adults and adolescents**

CDC recommends that diagnostic HIV testing and opt-out HIV screening be part of routine clinical care in all health care settings while also preserving the patient’s option to decline HIV testing and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. The recommendations are intended for providers in all health care settings, including hospital EDs, urgent-care clinics, inpatient services, STD clinics or other venues offering clinical STD services, tuberculosis (TB) clinics, substance abuse treatment clinics, other public health clinics, community clinics, correctional health care facilities, and primary care settings. The guidelines address HIV testing in health care settings only; they do not modify existing guidelines concerning HIV counseling, testing and referral for persons at high risk for HIV who seek or receive HIV testing in nonclinical settings (e.g., community-based organizations, outreach settings, or mobile vans) [6].

**Screening for HIV infection**

- In all health care settings, screening for HIV infection should be performed routinely for all patients ages 13-64. Health care providers should initiate screening unless prevalence of undiagnosed HIV infection in their patients has been documented to be less than 0.1 percent. In the absence of existing data for HIV prevalence, health care providers should initiate voluntary HIV screening until they establish that the diagnostic yield is less than 1 per 1,000 patients screened, at which point such screening is no longer warranted.
- All patients initiating treatment for TB should be screened routinely for HIV infection [13].
- All patients seeking treatment for STDs, including all patients attending STD clinics, should be screened routinely for HIV during each visit for a new complaint, regardless of whether the patient is known or suspected to have specific behavior risks for HIV infection.

**Repeat screening**

- Health care providers should subsequently test all persons likely to be at high risk for HIV at least annually. Persons likely to be at high risk include injection-drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, and men who have sex with men or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.
- Health care providers should encourage patients and their prospective sex partners to be tested before initiating a new sexual relationship.
- Repeat screening of persons not likely to be at high risk for HIV should be performed on the basis of clinical judgment.
- Unless recent HIV test results are immediately available, any person whose blood or body fluid is the source of an occupational exposure for a health care provider should be informed of the incident and tested for HIV infection at the time the exposure occurs.

**Consent and pretest information**

- Screening should be voluntary and undertaken only with the patient’s knowledge and understanding that HIV testing is planned.
- Patients should be informed orally or in writing that HIV testing will be performed unless they decline (opt-out screening). Oral or written information should include an explanation of HIV infection and the meanings of positive and negative test results, and the patient should be offered an opportunity to ask questions and to decline testing. With such notification, consent for HIV screening should be incorporated into the patient’s general informed consent for medical care on the same basis as are other screening or diagnostic tests; a separate consent form for HIV testing is not recommended.
- Easily understood informational materials should be made available in the languages of the commonly encountered populations within the service area. The competence of interpreters and bilingual staff to provide language assistance to patients with limited English proficiency must be ensured.
- If a patient declines an HIV test, this decision should be documented in the medical record.

**Diagnostic testing for HIV infection**

- All patients with signs or symptoms consistent with HIV infection or an opportunistic illness characteristic of AIDS should be tested for HIV.
Clinicians should maintain a high level of suspicion for acute HIV infection in all patients who have a compatible clinical syndrome and who report recent high-risk behavior. When acute retroviral syndrome is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to diagnose acute HIV infection [37]. Patients or persons responsible for the patient’s care should be notified orally that testing is planned, advised of the indication for testing and the implications of positive and negative test results, and offered an opportunity to ask questions and to decline testing. With such notification, the patient’s general consent for medical care is considered sufficient for diagnostic HIV testing.

Recommendations for pregnant women
These guidelines reiterate the recommendation for universal HIV screening early in pregnancy but advise simplifying the screening process to maximize opportunities for women to learn their HIV status during pregnancy, preserving the woman’s option to decline HIV testing, and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. All women should receive HIV screening consistent with the recommendations for adults and adolescents. HIV screening should be a routine component of preconception care, maximizing opportunities for all women to know their HIV status before conception [14]. In addition, screening early in pregnancy enables HIV-infected women and their infants to benefit from appropriate and timely interventions (e.g., anti-retroviral medications [20], scheduled cesarean delivery [27], and avoidance of breastfeeding [40]). These recommendations are intended for clinicians who provide care to pregnant women and newborns and for health policy makers who have responsibility for these populations.

HIV screening for pregnant women and their infants [9]

Universal opt-out screening
- All pregnant women in the United States should be screened for HIV infection.
- Screening should occur after a woman is notified that HIV screening is recommended for all pregnant patients and that she will receive an HIV test as part of the routine panel of prenatal tests unless she declines (opt-out screening).
- HIV testing must be voluntary and free from coercion. No woman should be tested without her knowledge.
- Pregnant women should receive oral or written information that includes an explanation of HIV infection, a description of interventions that can reduce HIV transmission from mother to infant, and the meanings of positive and negative test results and should be offered an opportunity to ask questions and to decline testing.

No additional process or written documentation of informed consent beyond what is required for other routine prenatal tests should be required for HIV testing.
- If a patient declines an HIV test, this decision should be documented in the medical record.

Addressing reasons for declining testing
- Providers should discuss and address reasons for declining an HIV test (e.g., lack of perceived risk; fear of the disease; and concerns regarding partner violence or potential stigma or discrimination).
- Women who decline an HIV test because they have had a previous negative test result should be informed of the importance of retesting during each pregnancy.
- Logistical reasons for not testing (e.g., scheduling) should be resolved.
- Certain women who initially decline an HIV test might accept at a later date, especially if their concerns are discussed. Certain women will continue to decline testing, and their decisions should be respected and documented in the medical record.

Timing of HIV testing
- To promote informed and timely therapeutic decisions, health care providers should test women for HIV as early as possible during each pregnancy. Women who decline the test early in prenatal care should be encouraged to be tested at a subsequent visit.
- A second HIV test during the third trimester, preferably at less than 36 weeks of gestation, is cost-effective even in areas of low HIV prevalence and may be considered for all pregnant women. A second HIV test during the third trimester is recommended for women who meet one or more of the following criteria.
  - Women who receive health care in facilities in which prenatal screening identifies at least one HIV-infected pregnant woman per 1,000 women screened.
  - Women who are known to be at high risk for acquiring HIV (e.g., injection-drug users and their sex partners, women who exchange sex for money or drugs, women who are sex partners of HIV-infected persons, and women who have had a new or more than one sex partner during this pregnancy).
  - Women who have signs or symptoms consistent with acute HIV infection. When acute retroviral syndrome is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to diagnose acute HIV infection [37].

Rapid testing during labor
- Any woman with undocumented HIV status at the time of labor should be screened with a rapid HIV test unless she declines (opt-out screening).
- Reasons for declining a rapid test should be explored (see addressing reasons for declining testing).
- Immediate initiation of appropriate anti-retroviral prophylaxis [27] should be recommended to women on the basis of a reactive rapid test result without waiting for the result of a confirmatory test.

Postpartum/newborn testing
- When a woman’s HIV status is still unknown at the time of delivery, she should be screened immediately postpartum with a rapid HIV test unless she declines (opt-out screening).
- When the mother’s HIV status is unknown postpartum, rapid testing of the newborn as soon as possible after birth is recommended so anti-retroviral prophylaxis can be offered to HIV-exposed infants. Women should be informed that identifying HIV antibodies in the newborn indicates that the mother is infected.
- For infants whose HIV exposure status is unknown and who are in foster care, the person legally authorized to provide consent should be informed that rapid HIV testing is recommended for infants whose biologic mothers have not been tested.
- The benefits of neonatal anti-retroviral prophylaxis are best realized when it is initiated less than 12 hours after birth [39].

Confirmatory testing
- Whenever possible, uncertainties regarding laboratory test results indicating HIV infection status should be resolved before final decisions are made regarding reproductive options, anti-retroviral therapy, cesarean delivery, or other interventions.
- If the confirmatory test result is not available before delivery, immediate initiation of appropriate anti-retroviral prophylaxis [27] should be recommended to any pregnant patient whose HIV screening test result is reactive to reduce the risk for perinatal transmission.

Advancing HIV prevention [9]
In 2003, the Centers for Disease Control and Prevention’s new initiative, Advancing HIV Prevention: New Strategies for a Changing Epidemic, was aimed at reducing barriers to early diagnosis of HIV infection and, if positive, increasing access to quality medical care, treatment and ongoing prevention services. The initiative emphasizes the use of proven public health approaches to reduce the incidence and spread of disease. As with other sexually transmitted diseases (STDs) or any other public
The next decade promises new hope as three primary areas of HIV prevention are emphasized:

- Early detection of persons who are HIV-positive and referral to care services.
- Prevention interventions with persons living with HIV.
- Prevention with persons who are at high risk for HIV infection.

CDC, other federal agencies, and the HIV prevention community will continue their work to disseminate this document to a variety of health care providers.

Further decrease perinatal HIV transmission. CDC will promote recommendations and guidance for routine HIV testing of all pregnant women, and, as a safety net, for the routine screening of any infant whose mother was not screened. CDC will work with prevention partners, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Nurse-Midwives, to disseminate the recommendations and support their implementation.

CDC will monitor the implementation of these new activities through several systems, including new performance indicators for state and local surveillance of HIV infection among pregnant women.

Table from CDC [9]

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The initiative capitalizes on new rapid test technologies, interventions that bring persons unaware of their HIV status to HIV testing, and behavioral interventions that provide prevention skills to persons living with HIV, as indicated, part of routine medical care on the same voluntary basis as other diagnostic and screening tests.

2. Implement new models for diagnosing HIV infections outside medical settings. CDC will fund new demonstration projects using OraQuick®, a rapid HIV test recently approved by the U.S. Food and Drug Administration for use in clinical and non-clinical settings, to increase access to early diagnosis and referral for treatment and prevention services in high-HIV-prevalence settings, including correctional facilities.

3. Prevent new infections by working with persons diagnosed with HIV and their partners. CDC in collaboration with the Health Resources and Services Administration (HRSA), the National Institutes of Health, and the HIV Medical Care of the Infectious Diseases Society of America, has published the recommendations for incorporating HIV prevention into the medical care of persons with HIV infection. These groups will work to disseminate this document to a variety of health care providers.
Learning objectives
- Identify the prevalence of medication errors in the United States by the Institute of Medicines 1999 report.
- Identify the responsibilities of the nurse/CNA when a medical error occurs.
- Define the following terms:
  - Sentinel event.
  - Root-cause analysis.
  - Adverse event.
  - Medical error.
  - Near-miss.
  - Medication error.
- Distinguish the different types of medication errors.
- Distinguish the difference between a medication error and an adverse drug reaction.
- Identify ways to reduce medication errors.
- Identify the most common medical errors.
- List the steps patients can take to prevent and address adverse events and medical errors.
- Discuss methods to increase public awareness of medical errors and how to prevent them.

Introduction
The very critical issues of medical errors and patient safety have received a great deal of attention in recent years, spurred, in large part, by the Institute of Medicine (IOM), November 1999 publication report called To Err Is Human: Building a Safer Health Care System. The report estimated that between 44,000 and 98,000 Americans die each year not from the medical conditions they checked in with, but from preventable medical errors. A medical error, under the report’s definition, could mean a health-care provider chose an inappropriate method of care, such as giving a patient a certain asthma drug without knowing that he or she was allergic to it. Or it could mean the health provider chose the right course of care but carried it out incorrectly, such as intending to infuse a patient with diluted potassium chloride – a potassium supplement – but inadvertently giving the patient a concentrated, lethal overdose.

The Institute of Medicine (IOM) estimates that fully half of adverse reactions to medicines are the result of medical errors. Other adverse reactions – those that are unexpected and not preventable – are not considered errors. The statistics in the IOM report, which were based on two large studies, suggest that medical errors are the eighth-leading cause of death among Americans, with error-caused deaths each year in hospitals alone exceeding those from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).

But the numbers in the report don’t tell the whole story, its authors acknowledge. People in the hospital are just a small proportion of those at risk. Doctors’ offices, clinics, and outpatient surgical centers treat thousands of patients each day; retail pharmacies fill countless prescriptions; and nursing homes and other institutional settings serve vulnerable patient populations.

Despite the recent focus on the IOM statistics, experts assure that the health system in the United States is safe. But its safety record is a far cry from the enviable record of the similarly complex aviation industry, which is being held up as an example for the medical world. A major federal initiative was launched to reduce medical errors and improve patient safety in federally funded health care programs, and by example and partnership, in the private sector [10]. The literature provided introduces informative data related to some of the most important issues in patient safety and medical errors, and reviews the health care worker’s role in ensuring patient safety.

The danger of medical errors [9]
Two months after a double bypass heart operation that was supposed to save his life, comedian and former “Saturday Night Live” cast member Dana Carvey got some disheartening news: the cardiac surgeon had bypassed the wrong artery. It took another emergency operation to clear the blockage that was threatening to kill the 45-year-old funnyman and father of two young kids. Responding to a $7.5 million lawsuit Carvey brought against him, the surgeon said he’d made an honest mistake because Carvey’s artery was unusually situated in his heart. But Carvey didn’t see it that way: “It’s like removing the wrong kidney. It’s that big a mistake,” the entertainer told People magazine.

Based on a recent report on medical mistakes from the National Academy of Sciences’ Institute of Medicine, Carvey might fairly be characterized as one of the lucky survivors. In To Err Is Human: Building a Safer Health System, the IOM estimates that 44,000 to 98,000 Americans die each year not from the medical conditions they checked in with, but from preventable medical errors.

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Despite the recent focus on the IOM statistics, experts assure that the health system in the United States is safe. But its safety record is a far cry from the enviable record of the similarly complex aviation industry, which is being held up as an example for the medical world. A person would have to fly nonstop for 438 years before expecting to be involved in a deadly airplane crash, based on recent airline accident statistics. That, IOM says, places health-care at least a decade behind aviation in safeguarding consumers’ lives and health.

The report is a self-described “call to action” for the health care system. “Whether a person is sick or just trying to stay healthy, he or she should not have to worry about being harmed by the health system itself,” its authors say.

In response to IOM’s call, President Clinton proposed a plan to halve the number of medical errors over five years. “If we do the right things,” President Clinton said while announcing the White House plan, “we can dramatically reduce the times when the wrong drug is dispensed, a blood transfusion is mismatched, or a surgery goes awry.” Clinton’s plan included the creation of a new Center for Quality Improvement in Patient Safety, with a $20 million budget, and the installation of patient safety programs to reduce medical errors in each of the 6,000 hospitals participating in Medicare.

For its part, the Food and Drug Administration will take a “much-enhanced” role in error prevention, said Janet Woodcock, M.D., the head of FDA’s Center for Drug Evaluation and Research. “We’ll be taking a much harder look at medical products — beyond just whether they’re safe and effective, to how they’ll be used in the real world.”

Responsibilities [9]
As a member of the health care industry, one has a responsibility to be aware of the risk of medical error as well as learn strategies to minimize that potential risk. Remember that medical errors can occur at any point in treatment, even in preventive care, and do not always result in patient injury or death.

Health care personnel and institutions are held accountable for establishing and maintaining a safe health care environment for their patients. While personal responsibility is essential to reducing medical error and increasing patient safety, a root-cause analysis addresses the issue of personal fault within the existing health care framework. Understanding the context of medical errors is essential to minimizing their occurrence and providing strategies through the implementation of appropriate organizational and systemic changes.

The Joint Commission on Accreditation of Healthcare Organizations [JCAHO] requires health care organizations to establish internal processes to recognize sentinel events, conduct root-cause analyses, identify and document areas of risk, and implement a plan of risk-reduction measures to correct system failures. As defined per JCAHO in the sentinel event policy and procedures, updated July 2007, a sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Once a sentinel event is identified, a root-cause analysis should be completed within 45 calendar days. All personnel involved in the systems and processes under review must participate. JCAHO defines a root-cause analysis as a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root-cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease
the likelihood of such events in the future or determines, after analysis, where no such improvement opportunities exist. A thorough root-cause analysis should inquire into all associated aspects of the event and include the following points:

- What factor or factors relate most directly to the sentinel event, and what systems and processes are associated with it?
- What about the underlying systems and processes allowed the event, and how can they be made more foolproof?
- What other areas of risk exist and could potentially contribute to a similar event?
- What improvements, if any, in systems and processes could be implemented to reduce the likelihood of such an event in the future?
- Finally, individuals are assigned responsibility for implementing necessary improvements. Once in place, these changes should be evaluated to determine their degree of efficacy.

It is important to understand the terms “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

**Root-cause analysis**

Guidelines established by The Joint Commission on Accreditation of Health Care Organizations (JCAHO), a national organization dedicated to improving the quality of health care, are used to determine cause in the investigation of medical error, a process known as “root-cause analysis.”

![Framework for Identifying Errors](image)

Figure 1: Framework for Identifying Errors [10]

The IOM defines medical error as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.”[9].

Note that this definition does not consider whether an error is intended or accidental. Instead, it emphasizes how the failure may have occurred:

- An error of planning: The failure to determine the appropriate or necessary course of action (a diagnostic error, for example).
- An error of execution: The failure to carry out that appropriate or necessary course of action through, to the point of completion.

If a patient dies after undergoing a surgical procedure, for example, the death may be attributed to the patient’s pre-existing condition – the reason for surgery – or it may be attributed to some complication of the surgery, or another aspect of medical care. If it is determined that the surgical patient died from a post-operative infection caused by unhygienic surgical instruments, for example, the situation would be considered a preventable adverse event, or “sentinel event,” defined as a case in which patient injury cannot reasonably be attributed to the underlying medical condition of the patient.

**Sentinel events** [12]

Since the inception of its sentinel event policy in 1995, the JCAHO has compiled data from more than a thousand incidents. Reporting facilities associated sentinel events with root causes relating to:

- Inadequate safety or security of the physical environment.
- Inadequate assessment or incomplete reassessment of the patient.
- Inappropriate assignment of the patient.
- Incomplete examination of the patient.
- Infrequent or incomplete patient observations.
- Factors related to insufficient training or orientation of personnel, including inadequate staffing or competency reassessments.
- Factors related to the unavailability or miscommunication of information among health care personnel and other caregivers.

A study conducted by Medical Assurance Inc. (a company specializing in risk assessment and management) suggests the vast majority of adverse outcomes are not dependent on individual behavior or decision-making alone, but result from a cluster of risk factors [6].

Careful review and analysis of sentinel events and near-misses (situations in which medical error occurred but did not cause harm to the patient) suggests close scrutiny of sentinel events can be key to determining whether adverse events, such as patient injury or death, were caused by the patient’s diagnosed condition, a medical intervention, or inaction on the part of a health care provider. As such, “sentinel events” signal the need for immediate attention and investigation, in order to reduce occurrence of medical error.

**National patient safety goals**

In order to reduce preventable medical errors and improve patient safety, the joint commission began releasing a number of national patient safety goals (NPSGs) in 2003 and mandated that all accredited health care organizations implement these goals. However, these efforts are more than just goals. They are mandatory practice changes modeled after best-practices throughout the world. The goals, updated once a year, focus on a variety of safety challenges that our health care system faces on a daily basis and range from very simple to very complex [8].

**The joint commission 2008 national patient safety goals** [11]

**Patient identification**

Goal: Improve the accuracy of patient identification.
Health care-associated infections
Goal: Reduce the risk of health care-associated infections.
- Requirement: Comply with current World Health Organization (WHO) hand hygiene guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
  Applies to: ambulatory care, assisted living, behavioral health care, critical access hospital, disease-specific care, home care, hospital, lab, long-term care, office-based surgery.
- Requirement: Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.
  Applies to: ambulatory care, assisted living, behavioral health care, critical access hospital, disease-specific care, home care, hospital, lab, long-term care, office-based surgery.
- Requirement: A complete list of the patient’s medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility.
  Applies to: ambulatory care, assisted living, behavioral health care, critical-access hospital, disease-specific care, home care, hospital, long-term care, office-based surgery.

Reconcile medications
Goal: Accurately and completely reconcile medications across the continuum of care.
- Requirement: There is a process for comparing the patient’s current medications with those ordered for the patient while under the care of the organization.
  Applies to: ambulatory care, assisted living, behavioral health care, critical access hospital, disease-specific care, home care, hospital, long-term care, office-based surgery.
- Requirement: A complete list of the patient’s medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility.
  Applies to: ambulatory care, assisted living, behavioral health care, critical-access hospital, disease-specific care, home care, hospital, long-term care, office-based surgery.

Reduce falls
Goal: Reduce the risk of patient harm resulting from falls.
- Requirement: Implement a fall reduction program including an evaluation of the effectiveness of the program.
  Applies to: assisted living, critical access hospital, disease-specific care, home care, hospital, long-term care.

Influenza and pneumococcal disease
Goal: Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
- Requirement: Develop and implement a protocol for administration and documentation of the flu vaccine.
  Applies to: assisted living, disease-specific care, long-term care.
- Requirement: Develop and implement a protocol for administration and documentation of the pneumococcus vaccine.

Surgical fires
Goal: Reduce the risk of surgical fires.
- Requirement: Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels with enough time for patient preparation, and establish guidelines to minimize oxygen concentration under drapes.
  Applies to: ambulatory care, office-based surgery.

Implementation of NPSGs
Goal: Implementation of applicable national patient safety goals and associated requirements by components and practitioner sites.
- Requirement: Inform and encourage components and practitioner sites to implement the applicable National Patient Safety Goals and associated requirements.

Patient involvement
Goal: Encourage patients’ active involvement in their own care as a patient safety strategy.
- Requirement: Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.
  Applies to: ambulatory care, assisted living, behavioral health care, critical access hospital, disease-specific care, home care, hospital, lab, long-term care, office-based surgery.

Pressure ulcers
Goal: Prevent health care-associated pressure ulcers (decubitus ulcers).
- Requirement: Assess and periodically reassess each resident’s risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks.
  Applies to: long-term care.

Risk assessment
Goal: The organization identifies safety risks inherent in its patient population.
- Requirement: The organization identifies patients at risk for suicide.
  Applies to: behavioral health care, hospital (applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals).
- Requirement: The organization identifies risks associated with long-term oxygen therapy such as home fires.
  Applies to: home care.

Changes in patient condition
Goal: Improve recognition and response to changes in a patient’s condition.
- Requirement: The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient’s condition appears to be worsening.
  Applies to: critical access hospital, hospital.

Universal protocol for preventing wrong-site, wrong-person, wrong-procedure surgery
- Requirement: Use a pre-op verification process, such as a checklist, to confirm appropriate documents are available.
- Requirement: Implement a process to mark the surgical site and involve the patient in the process.
- Requirement: Prior to the start of any surgical or invasive procedure, conduct a final “time out” verification to confirm the correct patient, procedure, and site.

Common medical errors [5]
Preventable medical errors are most commonly related to operative and post-operative complications, surgical mistakes, issues of medication, and patient falls. Older patients are far more likely to be injured in these incidents, with individuals over the age of 65 experiencing medical error two to four times as often as patients under the age of 45. Many preventable errors occur in hospitals; with the likelihood of injury growing the longer the patient stays in the hospital and the greater their severity of illness.

Medication mistakes [9]
Even the seemingly simple process of giving a patient medicine – the right drug, in the right dose, to the right patient, at the right time – is, in reality, teeming with opportunities for error. The IOM estimates that preventable medication errors result in more than 7,000 deaths each year in hospitals alone and tens of thousands more in outpatient facilities. (See “Most-Made Mistakes,” in this chapter).

Name confusion is among the most common causes of drug-related errors, says Peter Honig, M.D., an FDA expert on drug risk-assessment. A recent example: the sound-alike names for the antiepileptic drug Lamictal and the antifungal drug Lamisil. The volume of dispensing errors involving these two drugs prompted the manufacturer of Lamictal, Glaxo Wellcome Inc., of Research Triangle Park, N.C., to launch a campaign warning pharmacists of the potential confusion. The possible consequences of prescribing the wrong drug are grave: Epileptic patients receiving the anti-fungal drug Lamisil by mistake could experience continuous seizures. Patients erroneously receiving the antiepileptic drug Lamictal might experience a serious rash, blood pressure changes, or other side effects.

Errors also have occurred in prescribing the arthritis drug Celebrex, the anticonvulsant Cerebyx, and the antidepressant Celexa. There have been well over 100 reports of confusion among the three drugs, none of which has resulted in serious harm to a patient.

In one case, a physician wrote a prescription for “Celexa 200 mg.” Since the antidepressant drug is available in only 20 and 40 milligram
doses, the doctor was called, and he corrected his prescription to the intended Celebrex 200 mg. In response to such reports, the co-marketers of Celebrex, G.D. Searle & Co., Chicago, Ill., and Pfizer Inc., New York, undertook an educational ad campaign to alert health professionals to the possible mix-ups.

Under FDA’s authority to regulate drug labeling, the agency’s new Office of Postmarketing Drug Risk Assessment evaluates medicines’ brand names in an attempt to avoid sound-alike and look-alike names. If FDA considers the name of a new medical product to be potentially confusing to health professionals, the agency works with the drug company to change the product’s name. FDA is developing new standards to prevent such name mix-ups, as well as to prevent confusion between similar-looking drug packaging.

Also, the agency is developing new label standards to highlight common interactions between drugs so that doctors are less likely to mistakenly prescribe dangerous combinations. And even after a drug is approved, FDA monitors its use to see if unexpected adverse events occur and whether any labeling changes are required to help avoid medication mishaps.

So where does FDA’s responsibility end and the health professionals’ judgment take over? “FDA must do everything within its authority to maximize the likelihood that approved products will be used correctly in the real world,” says Honig. But, he notes, “We don’t regulate the practice of medicine, such as the sloppy handwriting when prescribing a drug.”

The real-world practice of medicine occurs within an intricate system, says Woodcock. “It’s that complexity,” she says, “coupled with the limitations of humans that make avoiding mistakes a consuming task.”

**Policy initiatives related to medication errors [13]**
The U.S. FDA receives medication error reports on marketed human drugs (including prescription drugs, generic drugs, and over-the-counter drugs) and nonvaccine biological products and devices. The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as “any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.”

**Most-made mistakes [9]**
The American Hospital Association lists the following as some common types of medication errors:

- Incomplete patient information (not knowing about patients’ allergies, other medicines they are taking, previous diagnoses, and lab results, for example).
- Unavailable drug information (such as lack of up-to-date warnings).
- Miscommunication of drug orders, which can involve poor handwriting, confusion between drugs with similar names, misuse of zeroes and decimal points, confusion of metric and other dosing units, and inappropriate abbreviations.
- Lack of appropriate labeling as a drug is prepared and repackaged into smaller units.
- Environmental factors, such as lighting, heat, noise and interruptions that can distract health professionals from their medical tasks.

In 1992, the FDA began monitoring medication error reports that are forwarded to FDA from the United States Pharmacopeia (USP) and the Institute for Safe Medication Practices (ISMP). The agency also reviews MedWatch reports for possible medication errors. Currently, medication errors are reported to the FDA as manufacturer reports (adverse events resulting in serious injury and for which a medication error may be a component), direct contact reports (MedWatch), or reports from USP or ISMP.

The Division of Medication Errors and Technical Support include a medication error prevention program staffed with pharmacists and support personnel. Among their many duties, program staff review medication error reports sent to the USP-ISMP Medication Errors Reporting Program and MedWatch, evaluate causality and analyze the data to provide feedback to others at FDA.

**Campaign to eliminate use of error-prone abbreviations [7]**
The FDA and the Institute for Safe Medication Practices (ISMP) have launched a national education campaign to eliminate the use of ambiguous medical abbreviations that are frequently misinterpreted and lead to mistakes that result in patient harm. The campaign seeks to promote safe practices among those who communicate medical information.

As part of the campaign, the FDA recommends that health care professionals consider the ISMP’s list of error-prone abbreviations, symbols, and dose designations at http://www.ismp.org/tools/errorpronabbreviations.pdf whenever medical information is communicated. In addition, both the FDA and ISMP have provided a toolkit of resource materials available at www.ismp.org/tools/abbreviations.

**Human limitations [9]**
As its title – To Err Is Human – suggests, the IOM report supports moving away from the traditional culture of “naming, shaming and blaming” individual health providers who make mistakes. Instead, the institute believes that preventing future errors is best achieved by designing a safer overall system.

Woodcock supports that view. Most health-care practitioners are competent professionals who are vulnerable to error simply by virtue of being human, she says. The professionalism model – “If we train people enough, they won’t make a mistake, and we’ll punish them if they do” – has outlived its usefulness, according to Woodcock. “People have made mistakes and been drummed out of their professions. They were the ones unfortunate enough to administer the lethal dose, but the systems were not in place to adequately support them in preventing such an error.”

Some medical centers have begun using computer programs and other system supports to curtail medical mishaps by double-checking the care decisions doctors and nurses make. Even simple computer systems that use electronic prescriptions in place of handwritten ones have in some cases already paid off with substantial error reductions. (See “Lessons Learned,” below.)

But systems, too, can fail, cautions Raymond L. Woosley, M.D., a professor and chairman of pharmacology at Georgetown University Medical Center. Woosley’s example: “It’s true that if you have a prescription drug with an electronic bar code on it – the right code – it can help prevent errors. But if the wrong code is on there, you may have even more errors. There will always be mistakes, though they will be different mistakes as the systems change. You’ve got to be ready to handle them.”

Despite technological advances, preventing mistakes will always depend on the vigilance of health professionals, Woosley says. Otherwise, human carelessness can render useless the very systems designed to avert mistakes. Even among pharmacies with a computer program to highlight dangerous drug interactions, according to a study published in the Journal of the American Medical Association, one-third of pharmacists nevertheless continued to fill prescriptions for a known killer combination: the prescription antihistamine Seldane (terfenadine) with the antibiotic erythromycin. (Seldane has since been removed from the market.)

“The pharmacists would get the computer warnings and zip right on by them,” Woosley says. “Or they would turn off the program entirely.” Why turn off the computer program? Because, Woosley explains, it was slowing down the pharmacists when they wanted to print labels.

Health professionals “are trained to memorize everything and are rewarded for it,” says the pharmacology professor. “The medical student who says, ‘I don’t know; I’ve got to look it up,’ is likely to fail an exam, yet that’s the one who is less likely to make an error.” Woosley hopes medical students will be taught to accept their limitations and admit their mistakes. Under the current system, however, some people call that goal pie-in-the-sky.
still ends up having to pay the patient a huge settlement. It’s that culture – the feeling they’re going to lose no matter what they do – that keeps physicians closed among themselves.”

Historically, people have looked for someone to blame when medical accidents happen, according to FDA’s Woodcock. For victims and their relatives, she says, there may be some satisfaction in that. But from the perspective of fixing the problem, the secrecy that results keeps the medical community from learning what happened and how to correct the problem.

Most experts agree that mandating medical error reporting, in itself, will not surmount the hesitancy of doctors. More than 20 states currently have mandatory reporting systems, yet state officials say that underreporting persists.

FDA, too, faces the problem of “tremendous underreporting,” according to Susan Gardner, Ph.D., deputy director of the Office of Surveillance and Biometrics in the agency’s Center for Devices and Radiological Health.

Hospitals, nursing homes, and other facilities that use medical devices are required to report to FDA all deaths caused or possibly caused by devices. “Guess what? They don’t report,” says Gardner, whose office gets only about 4,000 reports a year from the 40,000 to 50,000 facilities covered by the reporting requirement.

Gardner thinks that simply assuring facilities of confidentiality of reports could go far to increase compliance with the reporting requirement. “If you give incentives to report, they’ll report. In many cases, that might simply mean good feedback so they can improve their systems.” A published list of previously reported device problems in FDA’s database, Gardner says, would enable facilities to benchmark their own experiences. Newsletters could discuss important medical device issues. And strategies could be suggested to avoid potential pitfalls in using a medical device.

With devices, more than with drugs, it can be difficult to determine if an adverse event was a preventable error or an unexpected reaction, Gardner says. Devices sometimes require specific knowledge and training to use the product correctly.

It’s the interface between the device and the user, referred to as “human factors,” that can complicate an investigation into why something went wrong. The problem usually isn’t that the device itself broke, Gardner says, but rather that it wasn’t intuitively user-friendly, or the user didn’t have instructions on hand or didn’t know about a change in the way the device was to be used in a certain setting.

In the agency’s Center for Biologics Evaluation and Research, the lack of reporting is characterized by consumer safety officer Sharon O’Callaghan as one of the biggest problems where medical errors are concerned. She says that while manufacturers of biological products, such as blood components and vaccines, must report to FDA certain errors that occur during manufacturing, companies are not sufficiently aware of reporting requirements.

For biological products, manufacturing errors can lead to mistakes in treatment that are potentially serious and even deadly. In blood banks, for example, a blood product that is mislabeled can present a serious threat to a patient if the wrong type of blood is transfused.

“Things happen that we might not hear about,” O’Callaghan says. “We want to increase reporting so we can assess what’s happening in the industry.” To increase reporting of manufacturing glitches, the agency has proposed a rule that would increase the number of facilities that must report errors and other adverse events.

Clinton’s proposal to reduce medical errors contained a nationwide, state-based system of reporting medical errors that would include mandatory reporting of mistakes that result in death or serious injury and voluntary reporting of other medical mistakes, including so-called “close calls” or “near-misses.” Clinton also expressed support for legislation that protects provider and patient confidentiality, while safeguarding the legal remedies of those whose health is harmed.

To improve is human [9]

Woodcock encourages consumers to help prevent errors by being vigilant about their health care – understanding their treatment, keeping organized records of what doctors they see and what medications they take, and asking questions when things don’t seem right. For example, “If your pills look different than they have in the past, they might be the right medication, and they might not. But raise the issue.”

Honig calls consumer education the “secret weapon” in the war against medical errors. “It’s unfortunate that people research buying a car better than they research health care decisions. They’re willing to tolerate more uncertainty with their health care than their mode of transportation.” He encourages patients to feel comfortable asking more questions about their medical care.

With everyone from pharmaceutical manufacturers to consumers playing a role in improving the safety of the health system, Woodcock believes that the already “very safe” medical system in the United States will become even safer. “There are fixes,” she says. “We know that from other industries.”

The spotlight on the health system’s problems might be just what the system needed to transform itself, says Woodcock. After all, as the IOM report notes, “It may be part of human nature to err, but it is also part of human nature to create solutions, find better alternatives, and meet the challenges ahead.”

Department of Veterans Affairs [9]

The VA health-care system is held up in the Institute of Medicine’s report on medical errors as a shining success story. The VA has the largest health-care system in the country, by one estimate serving more than 3 million veterans a year at its 172 hospitals and its 1,000-plus outpatient clinics, nursing homes, counseling centers, and other health programs.

The VA counted almost 3,000 errors – some 700 deaths among them – within its health network between June 1997 and December 1998. Among the major steps the VA has taken to improve its safety record is a new bar-coding system to prevent and track medical errors. Generally, the bar-coding system works this way: ID strips are worn by nurses and patients and attached to medications. Before giving a patient a drug, a nurse scans all three ID strips into a computer, which verifies that the drug is being given correctly and will not cause drug interactions. If the program identifies a potential problem, it flashes a warning. Otherwise, it just keeps a record of the activity.

In a test of the bar-coding technology at two VA hospitals in Kansas, the medication error rate dropped 70 percent over a five-year period.

Other changes at VA facilities include:
- Storing concentrated potassium chloride and other such hazardous medications away from patient care areas.
- Encouraging cooperation and a focus on correcting the system rather than placing blame on individuals unless they perform negligently or incompetently.

Dana-Farber Cancer Institute [9]

In November 1994, two women got poisonous doses of chemotherapy while being treated for recurrent breast cancer at the prestigious Dana-Farber Cancer Institute in Boston. Boston Globe medical reporter Betsy Lehman, age 39 at the time, died as a result of the error, and the second patient, Maureen Bateman, suffered permanent heart damage and died from cancer several months after the mistake.

Instead of prescribing the daily dose of the powerful anticancer drug cyclophosphamide to be given on each of four days, as planned, the doctor ordered the drug’s combined four-day dose so that the total was given to the patients each day.

Since the fatal miscommunication, Dana-Farber has updated its systems to avoid errors. For one thing, the institute has installed a $1.7 million computer system to take over many tasks. Doctors don’t hand-write prescriptions anymore, but instead fill out an electronic form with the patient’s personal information, as well as the name of the drug, the dose, and the number of days for which the medicine is to be given. The information goes into the institute’s computer system, which compares the information with upper dose limits for the drug and other pre-programmed guidelines. If the doctor seems to have made a mistake, the computer signals the error.

Secondly, a nurse checks the information in the computer before ordering the drug from
the pharmacy. The pharmacist conducts yet another computerized review for potential drug interactions with other drugs, foods, or the patient’s allergies.

After being prepared at the pharmacy, the drug goes next to the nurses’ station, where two nurses check the drug’s label and the patient’s wristband to make sure the right person gets the drug.

Additionally, the cancer center began a system of nonpunitive error reporting to encourage open discussion of medical mistakes. The change effectively brought about what the institute has described as a “dramatic increase” in error reporting.

**Medical error linked to nurses [4]**
About a year after the IOM released it report on medical errors, the Chicago Tribune reported that nursing mistakes alone were responsible for thousands of injuries and deaths. Specifically, the investigation stated that poorly trained and overworked nurses were responsible for the deaths of 1,700 patients and 9,548 injuries between 1995 and 2000. Among its findings, the investigation alleged nurses delayed vital care, overdosed patients and performed medical procedures without appropriate training.

The Tribune study, which analyzed 3 million state and federal computer records, strongly suggested that patient safety is being sacrificed at the expense of short-staffed nursing care, concluding that cuts in hospital staffing had forced nurses to work too many hours and rely too heavily on under-trained nurses. Both the American Nurses Association, which said it tried to warn consumers about the risks of inadequate care through mandatory overtime, and a spokesman for the Agency for Healthcare Research and Quality, which noted a “correlation between nurse staffing ratios and adverse events that occur in hospitals,” agreed that hospitals are sacrificing patient safety for the bottom line. Another contributing factor to the nursing shortage is the aging workforce, with increasing numbers of retiring nurses each year.

**Disclosing medical error [9]**
Even today, according to the dean of the Emory School of Nursing, hospital personnel may still feel conditioned to hide inadequate care. More and more, hospitals like Massachusetts General Hospital (MGH), in Boston, are practicing a policy of full disclosure of medical errors to patients and their families. MGH’s policy was forged by Jeanette Ives Erickson, chief nurse and senior vice-president of patient care at the hospital. Years ago, she states, there was a “don’t ask, don’t tell mentality” regarding mistakes. Now, instead of “blaming and shaming” health care personnel, she focuses on the factors that caused or contributed to the error.

Hiding mistakes does not prevent them from happening again, but learning how to disclose medical errors to patients and families is something that is just beginning to be taught now to hospital personnel. Health care providers need training to learn how to effectively respond to error, including how to deal with their own feelings, when they are the source of error. While Ives Erickson notes that some of a family’s anger may dissipate with an apology, most hospital personnel naturally fear retribution from coworkers and patients and potentially charged, emotional confrontations.

Aaron Lazare, who wrote “On Apology,” a guide to the immediate aftermath of an adverse event, suggests specific types of effective communication make disclosure easier. He suggests the following critical steps:

- Report the facts of the incident only, not how or why the event occurred.
- Make the disclosure quickly; information should be disclosed as soon as it becomes available.
- Discuss recommendations for further care.
- Discuss the event’s implications for prognosis.

The following fact sheet outlines important steps for health care personnel to prevent and address adverse events:

**Fact sheet**

30 safe practices for better health care [2]

One reason adverse events and medical errors occur is that evidence-based information on what works to prevent them, or reduce the harm they cause, is not available.

The National Quality Forum, with support from the Agency for Health care Research and Quality (AHRQ), has identified 30 safe practices that evidence shows can work to reduce or prevent adverse events and medical errors.

**Background**
The goal in the United States is to deliver safe, high-quality health care to patients in all clinical settings. Despite the best intentions, however, a high rate of largely preventable adverse events and medical errors occur that cause harm to patients. Adverse events and medical errors can occur in any health care setting in any community in this country.

The 30 safe practices that follow have been endorsed by the membership of the National Quality Forum, which includes representatives of 260 of the nation’s leading health care provider, purchaser and consumer organizations. These organizations strongly urge that these 30 safe practices be universally adopted by all applicable health care settings to reduce the risk of harm to patients.

**Creating a culture of safety**

1. Create a health care culture of safety. There is a need to promote a culture that overtly encourages and supports the reporting of any situation or circumstance that threatens, or potentially threatens, the safety of patients or caregivers and that views the occurrence of errors and adverse events as opportunities to make the health care system better.

2. For designated high-risk, elective surgical procedures or other specified care, patients should be clearly informed of the likely reduced risk of an adverse outcome at treatment facilities that have demonstrated superior outcomes and should be referred to such facilities in accordance with the patient’s stated preference.

3. Specify an explicit protocol to be used to ensure an adequate level of nursing based on the institution’s usual patient mix and the experience and training of its nursing staff.

4. All patients in general intensive care units (both adult and pediatric) should be managed by physicians having specific training and certification in critical care medicine (“critical care certified”).

5. Pharmacists should actively participate in the medication-use process, including, at a minimum, being available for consultation with prescribers on medication ordering, interpretation and review of medication orders, preparation of medications, dispensing of medications, and administration and monitoring of medications.

**Facilitating information transfer and clear communication**

6. Verbal orders should be recorded whenever possible and immediately read back to the prescriber; that is, a health care provider receiving a verbal order should read or repeat back the information that the prescriber conveys in order to verify the accuracy of what was heard.

7. Use only standardized abbreviations and dose designations.

8. Patient care summaries or other similar records should not be prepared from memory.

9. Ensure that care information, especially changes in orders and new diagnostic information, is transmitted in a timely and clearly understandable form to all of the patient’s current health care providers who need that information.

10. Ask each patient or legal surrogate to recount what he or she has been told during the informed consent discussion.

**In specific settings or processes of care**

11. Ensure that written documentation of the patient’s preference for life-sustaining treatments is prominently displayed in his or her chart.

12. Implement a computerized prescriber-order entry system.

13. Implement a standardized protocol to prevent the mislabeling of radiographs.

14. Implement standardized protocols to prevent the occurrence of wrong-site or wrong-patient procedures.
Medical errors can occur anywhere in the health care system:
- Hospitals.
- Clinics.
- Outpatient surgery centers.
- Doctors’ offices.
- Nursing homes.
- Pharmacies.
- Patients’ homes.

Errors can involve:
- Medicines.
- Surgery.
- Diagnosis.
- Equipment.
- Lab reports.

They can happen during even the most routine tasks, such as when a hospital patient on a salt-free diet is given a high-salt meal.

Most errors result from problems created by today’s complex health care system. But errors also happen when doctors and their patients have problems communicating. For example, a recent study supported by the Agency for Healthcare Research and Quality (AHRQ) found that doctors often do not do enough to help their patients make informed decisions. Uninvolved and uninformed patients are less likely to accept the doctor’s choice of treatment and less likely to do what they need to do to make the treatment work.

**What can you do? Be involved in your health care**

1. The single most important way you can help to prevent errors is to be an active member of your health care team. That means taking part in every decision about your health care. Research shows that patients who are more involved with their care tend to get better results. Some specific tips, based on the latest scientific evidence about what works best, follow.

2. Make sure that all of your doctors know about everything you are taking. This includes prescription and over-the-counter medicines, and dietary supplements such as vitamins and herbs.

3. Make sure your doctor knows about any allergies and adverse reactions you have had to medicines. This can help you avoid getting a medicine that can harm you.

4. When your doctor writes you a prescription, make sure you can read it.

   If you can’t read your doctor’s handwriting, your pharmacist might not be able to either.

5. Ask for information about your medicines in terms you can understand — both when your medicines are prescribed and when you receive them.

6. When you pick up your medicine from the pharmacy, ask: Is this the medicine that my doctor prescribed?

   A study by the Massachusetts College of Pharmacy and Allied Health Sciences found that 88 percent of medicine errors involved the wrong drug or the wrong dose.

7. If you have any questions about the directions on your medicine labels, ask.

   Medicine labels can be hard to understand. For example, ask if “four doses daily” means taking a dose every six hours around the clock or just during regular waking hours.

8. Ask your pharmacist for the best device to measure your liquid medicine. Also, ask questions if you’re not sure how to use it.

   Research shows that many people do not understand the right way to measure liquid medicines. For example, many use household teaspoons, which often do not hold a true teaspoon of liquid. Special devices, like marked syringes, help people to measure the right dose. Being told how to use the devices helps even more.

9. Ask for written information about the side effects your medicine could cause.

   If you know what might happen, you will be better prepared if it does — or, if something unexpected happens instead. That way, you can report the problem right away and get help before it gets worse. A study found that written information about medicines can help patients recognize problem side effects and then give that information to their doctor or pharmacist.

**Hospital stays**

10. If you have a choice, choose a hospital at which many patients have the procedure or surgery you need.

   Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.

11. If you are in a hospital, consider asking all health care workers who have direct contact with you whether they have washed their hands.

   Hand-washing is an important way to prevent the spread of infections in hospitals. Yet, it is not done regularly or thoroughly enough. A recent study found that when patients checked whether
health care workers washed their hands, the workers washed their hands more often and used more soap.

12. When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will use at home. This includes learning about your medicines and finding out when you can get back to your regular activities. Research shows that at discharge time, doctors think their patients understand more than they really do about what they should or should not do when they return home.

Surgery

13. If you are having surgery, make sure that you, your doctor and your surgeon all agree and are clear on exactly what will be done. Doing surgery at the wrong site (for example, operating on the left knee instead of the right) is rare. But even once is too often. The good news is that wrong-site surgery is 100 percent preventable. The American Academy of Orthopaedic Surgeons urges its members to sign their initials directly on the site to be operated on before the surgery.

Other steps you can take

14. Speak up if you have questions or concerns. You have a right to question anyone who is involved with your care.

15. Make sure that someone, such as your personal doctor, is in charge of your care. This is especially important if you have many health problems or are in a hospital.

16. Make sure that all health professionals involved in your care have important health information about you. Do not assume that everyone knows everything they need to.

17. Ask a family member or friend to be there with you and to be your advocate (someone who can help get things done and speak up for you if you can’t). Even if you think you don’t need help now, you might need it later.

18. Know that “more” is not always better. It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.

19. If you have a test, don’t assume that no news is good news. Ask about the results.

20. Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.

Works Cited

CHAPTER 7
RESIDENT RIGHTS
(2 CONTACT HOURS)

Learning objectives
List nursing home responsibilities associated with the following residents’ rights:

- Dignity, respect and a comfortable living environment.
- Quality of care and treatment without discrimination.
- Freedom of choice to make their own, independent decisions.
- The safeguard of their property and money.
- Privacy in communications.
- To participate in organizations and activities of their choice.
- An easy-to-use and responsive complaint procedure.
- To exercise all rights without fear of reprisals.

Introduction
State and federal regulations require nursing homes to have written policies covering the rights of residents. The nursing home’s staff must implement these policies and explain them to residents.

Any person requiring nursing home care should be able to enter any nursing home and receive appropriate care, be treated with courtesy and enjoy continued civil and legal rights. This chapter describes residents’ rights and the responsibilities you and nursing homes have for ensuring those rights.

The basic right of any nursing home resident is to be treated with dignity and respect. All other rights support this basic premise. Your state department of health and family services is committed to ensuring that every nursing home resident’s rights are protected and supported. It is important that residents and their representatives communicate regularly with nursing home staff to ensure a meaningful, respectful and helpful environment.

Dignity and respect
Resident rights
Residents have the right to:

- Be treated with dignity, respect and consideration at all times.
- Privacy in the treatment and care of their personal needs.
- Choose activities, schedules and health care consistent with their interests and plan of care.
- Communicate with and have access to people and services inside and outside the facility.
- Be consulted when the facility sets policies about their rights and responsibilities and about aspects of their life in the facility.
- Staff assistance in interpretation of their rights.

Nursing home responsibility
The nursing home must:

- Ensure that the residents are treated as individuals and encourage them to participate in programs and services of their choice.
- Provide residents with safe, clean and comfortable rooms and surroundings.
- Protect residents from any kind of harsh and abusive treatment.
- Provide residents privacy in communicating and associating with people of their choice.

Admission
Resident rights
Residents have the right to:

- Nondiscrimination in admissions.
- Equal access to quality care.
- Apply for Medicare or Medicaid benefits.
- The absence of a guarantee of payment from another person or source other than themselves for admission or continued stay.

Nursing home responsibility
The nursing home must:

- Provide the resident with access to quality care by exercising identical policies and practices covering the provision of all required services, regardless of their source of payment.
- Obey all pertinent state and local laws that prohibit discrimination against individuals entitled to Medicaid benefits, and give explicit advice to residents concerning their right to nondiscriminatory treatment in admissions (State regulations prohibit discrimination against individuals entitled to Medicaid benefits).
- Fully inform residents and their designated representatives both verbally and in writing (in a language that they understand) of their rights and all facility rules and regulations governing their conduct and their responsibilities during their stay. This information must be given to them prior to or upon admission and during their stay. Residents must acknowledge receipt of this information in writing. The facility must also post a summary of this information.

The nursing home must not:

- Require a third-party guarantee of payment as a condition of admission, expedited admission or continued stay in the facility.
- Charge, solicit, accept or receive (in addition to any amount otherwise required to be paid by third-party payers) any gift, money donation or other consideration as a precondition of admission, expedited admission, special room assignment or continued stay in the facility, beyond the amount needed for prepayment of basic services for up to three months.
- Require the residents to waive their rights to Medicare or Medicaid.
- Require verbal or written assurance that residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

The nursing home may:

- Require a relative or other designated representative to sign a contract to provide facility payment from the resident’s income or resources, without their representative incurring personal financial liability.
- Charge the resident, if eligible for Medicaid, only for those items and services they requested and received that are not specified at the time of admission as included in the nursing home’s basic services.
- Solicit, accept or receive a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident, provided that the contribution is not a condition of admission, expedited admission, special room assignment or continued stay in the facility.

Life at the facility
Residents rights
Residents may always exercise their rights as citizens or residents of the United States, including their right to:

- Vote, with arrangements made by the facility.
- Action for damages or other relief for deprivations or infringements of their right to adequate and proper treatment and care.
- Exercise their civil and religious liberties, including the right to independent personal decisions and knowledge of available choices.
- Be free from verbal, sexual, mental or physical abuse, corporal punishment and involuntary seclusion, and free from chemical and physical restraints except those restraints authorized in accordance with nursing home minimum standards; this includes but is not limited to doctor’s orders, specified time periods, close monitoring, periodic re-evaluation of need, conferring with a family member or designated representative and documentation in the record.
- Meet with and participate in activities of social, religious and community groups at their discretion.

Resident council
Residents have the right to participate in the established resident council at the facility.

Access to information
Residents have the right to:

- Examine the results of the most recent federal or state survey of the facility including any statement of deficiencies, any plan of correction in effect with respect to the facility and any enforcement actions taken by the state department of health. Results must be made available for examination in a place readily accessible to residents.
- Receive information from agencies acting as residents’ advocates and be given the opportunity to contact these agencies.
- Request, or have a designated representative request and be provided information concerning their specific assignment to a resident classification category for purposes of linking reimbursement to the intensity of their care.
- Inspect, upon verbal or written notice, within 24 hours renders pertaining to the resident, and with two working days’ notice, purchase
and receive photocopies of such records. The cost of reproduction may not exceed 75 cents per page.

**Grievances**

Residents have the right to:

- Voice grievances without discrimination or reprisal.
- Prompt resolution of their grievances, including those with respect to the behavior of other residents.
- Recommend changes in policies and services to facility staff and/or outside representatives, free of interference, coercion, discrimination, restraint or reprisal from the facility.

**Privacy**

Residents have the right to:

- Locked storage space upon request in their room.
- Share a room with their spouse, relative or partner when the spouse, relative or partner lives in the same facility and both consent to the arrangement.
- Be assured of privacy for visits when a spouse, relative or partner resides outside the facility.
- Retain, store securely and use personal possessions, including furnishings, and appropriate clothing, as space permits, provided the rights or health and safety of other residents are not infringed.

**Food/nutrition**

Residents have the right to:

- Receive special food or food products, upon request, when as a matter of religious belief they wish to observe special dietary laws.

**Work/services**

Residents have the right to:

- Perform services only when:
  - Residents can safely perform the services.
  - The facility documents the need or desire for work in the resident’s plan of care.
  - The plan specifies the nature of the services performed and whether the services are voluntary or paid (Compensation for the paid services must be at or above prevailing rates and residents must agree to the work arrangement described in their plan of care).
- Refuse to perform services for the facility.

**Nursing home responsibility**

The nursing home must:

- Furnish residents with a written description of their legal rights including:
  - A description of how the facility protects their personal funds.
  - A statement telling residents that they may file a complaint with the facility or the state department of health concerning resident abuse, neglect, mistreatment and misappropriation of resident property in the facility. (This statement must include the name, address and telephone number of the office established by the state department of health, state office for the aging, or other appropriate organization to receive complaints).
- Record and periodically update the address and telephone number of resident’s designated representative or interested family member.
- Provide immediate access to the resident by:
  - Any representative of the U.S. Secretary of Health and Human Services.
  - Any representative of the state department of health.
  - The resident’s own doctor.
  - Ombudsmen who are duly certified and designated by the state office for the aging.
- Representatives of a commission on quality of care and advocacy for persons with disabilities (which protects and advocates for developmentally disabled individuals and mentally ill individuals).
- Other individuals who are visiting, with the resident’s consent, subject to reasonable restrictions and their right to deny or withdraw consent at any time.
- Provide reasonable access to the resident by an entity or individual that provides health, social, legal or other services, subject to the resident’s right to deny or withdraw consent at any time.
- Encourage the resident’s voluntary choice of activities and assist them in the participation of all social activities in which they wish to engage by:
  - Transporting residents to and from in-house activities as needed.
  - Encouraging residents to participate in and help maintain their involvement in community, religious and/or social activities including the organization of trips outside the facility.
  - Posting a copy of the monthly activities schedule and providing residents with a copy upon request.
- Advise veterans and the spouses of veterans in writing of the contact numbers for their state’s division of veterans affairs, the nearest veterans service agency and the nearest accredited veterans service officer.

**Resident council**

The nursing home must:

- Encourage residents to participate in the facility’s resident council and encourage them to take part in decision-making processes and make recommendations that could improve the quality of life in the facility.
- Ensure that residents receive notices of resident council meetings and that they are given assistance in transport to and from meetings, if such assistance is needed.
- Describe and promote the function and organization of the resident council to maximize their participation.
- After consultation with the resident council, assign to the council a staff person who is acceptable to the members of the resident council.
- Ensure that members of the governing body make themselves available to hold meetings with representatives of the resident council at least three times a year to discuss matters contained in a jointly developed agenda.
- Ensure that the quality assessment and assurance committee provides consultation on at least a quarterly basis with the resident council to seek recommendations on quality improvements.

**Family council**

- When a family council exists, inform families of the existence of the council upon admission and at least quarterly. The notice should include the dates, times and place of the family council meetings and a person to contact regarding involvement in the council.

**Access to information**

The nursing home must:

- Promptly notify the resident when there is:
  - A change in the resident’s room assignment. This requires prior notice unless the resident requested or agreed to the change, the resident’s medical condition requires a more immediate change, an emergency situation develops or there is a need to alter the resident’s treatment significantly. Then, the resident must be immediately informed, their doctor consulted and their designated representative or an interested family member notified.
  - A change in roommate assignment (This must be acceptable, where possible, to all affected residents).
  - A change in resident rights under federal or state law or regulations as specified in the official compilation of codes, rules and regulations of the state.

Inform the resident of the facility’s visiting hour policies, which are to be in compliance with the state department of health mandates for residential health care facilities (at least 10 hours within a 24-hour period, including at least two meal periods) and which must be posted.

**Grievances**

- Inform the resident upon admission about the complaint and recommendation procedure.
- Ensure that a method is in place to respond to residents’ complaints or grievances and recommendations.

**Privacy**

- Arrange for the resident to share a room with their spouse, relative or partner if they do not reside in the facility.
- Provide the resident space for storage and placement of personal possessions as follows:
  - Possessions may include some furnishings if such meet government fire safety and health code regulations.
  - If sufficient storage space is not available in the resident’s room, possessions may be stored in other areas of the facility (if such space is available) at the option of...
the nursing home, or the home will help the resident find other space.

- Provide a lockable drawer and/or locked storage area (upon the resident’s request) in the resident’s room or within their immediate area. Staff should help the resident store their possessions.

**Food/nutrition**

The nursing home must:

- Provide special food or food products prepared in accordance with orthodox religious requirements when, as a matter of religious belief, the resident wishes to observe special dietary laws.
- Offer substitute menu items at the resident’s request.
- Provide assistance with eating and special eating equipment or assistive devices and utensils if needed.

**Work/services**

The nursing home must:

- Accept the resident’s request to perform services, when work is available, under the following conditions:
  - The resident must make the request known to the facility staff, nursing staff or doctor.
  - The resident’s need or desire for work must be documented in their plan of care, along with the nature of the services to be performed, whether they are deemed able to safely perform the work described, whether they will be compensated for their services, and whether they have signed the work arrangement described in their plan of care, showing their agreement with it.
  - The resident must be compensated for the work at or above the prevailing rate for like services.

**Clinical care and treatment**

**Resident rights**

Residents have the right to:

- Adequate and appropriate medical care, including nursing, rehabilitation therapies, social work, dental and other professional services for which the resident has been assessed to show need for.
- Be fully informed by a doctor in a language or a form that the resident can understand (using an interpreter when necessary) of their total health status, including but not limited to their medical condition including diagnosis, prognosis and treatment plan.
- Ask questions about their medical condition and have the questions answered.
- Refuse to participate in experimental research.
- A second opinion if the resident disagrees with the diagnosis or treatment being provided; the resident or their designated representative may call in a consultant (the resident may have to pay for this visit).
- Appoint someone the resident trusts, such as a family member or close friend, to be their health care agent to decide about treatment if they lose the ability to decide for themselves.
- Provide advance directives, such as a living will or other verbal or written instructions, about important health care decisions, like the withdrawal of life-sustaining treatment.
- Refuse medication and treatment and be discharged from the facility should they so choose, after being fully informed and understanding the probable consequences of such actions.
- Choose a personal attending doctor from among those who agree to abide by all applicable federal and state regulations and who are permitted to practice in the facility.
- Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident’s well-being.
- Participate in planning the resident’s care and treatment or changes in the resident’s care and treatment.
- Self-administer drugs only if the facility’s interdisciplinary medical team has determined that this practice is safe.

**Nursing home responsibility**

The nursing home must:

- Use chemical and physical restraints only if necessary for medical reasons and ordered by the resident’s doctor and, except in an emergency situation, obtain the resident’s consent or the consent of their designated representative who has legal authority to give such consent.
- Inform the resident of the name, office address, telephone number and specialty of the doctor responsible for their personal care.
- Inform the resident prior to admission that their doctor or dentist must be affiliated with the facility in order to practice there.
- Promptly respond to requests by the resident’s personal attending doctors or dentists to be approved to attend to the resident.
- Inform the resident (except in a medical emergency) immediately and consult their physician and designated representative or an interested family member when there is:
  - An accident involving the resident that results in injury.
  - A significant improvement in the resident’s physical, mental or psychosocial status, in accordance with generally accepted standards of care and services.
  - A need to alter treatment significantly.
  - A decision to transfer or discharge the resident from the facility
- Discharge the resident from the facility, should the resident so choose, after fully informing the resident of the probable consequences of such action.
- Provide the resident with information, a health care proxy form and assistance to decide about advance directives and designation of a health care agent.
- Provide the resident with all information they may need to give informed consent for a “Do Not Resuscitate” order and comply with the state provisions regarding orders not to resuscitate.
- Provide the resident with CPR if they wish.
- Furnish to the resident, upon their request, a copy of state department of health brochures on “Do Not Resuscitate” orders.

**Privacy and confidentiality**

Resident rights

Residents have the right to:

- Privacy and confidentiality of their personal and clinical records which reflect accommodations, medical treatment, written and telephone communications, personal care, associations and communications with people of their choice, visits and meetings of family and resident groups.
- Private meeting space for the resident and their family.
- Approve or refuse the release of personal and clinical records to any individual outside the facility except when they are transferred to another health care facility or when record release is required by law or health insurance company contract.
- Privacy in written communications, including the right to send and receive unopened mail promptly.
- Access to stationery, postage and writing implements (at the resident’s own expense).
- Regular access to the use of a telephone where calls can be made without being overheard and which is wheelchair accessible and usable by residents who are visually and hearing impaired.

**Nursing home responsibility**

The nursing home must:

- Ensure that the resident has privacy in accommodations, medical treatment, personal care, visits and meetings of family, friends and resident groups.
- Ensure that the resident’s mail is delivered unopened and that it is sent out unopened.
- Provide the resident, upon their request, with stationery, postage and writing materials (to be paid for by the resident) and assist the resident in reading or writing mail if they so request.
- Provide the resident, upon their request, with access to a telephone (and assist them in its use) that is private and, if necessary, wheelchair accessible and equipped for the hearing impaired or the visually impaired.
- Instruct all staff and assure that all staff adheres to its instructions to fully honor and maintain the resident’s right to approve or refuse to approve release of their personal and clinical records to any outside individual.
- Instruct all staff involved in the resident’s care to maintain their personal and clinical record in the strictest privacy. Staff must restrict discussion of residents’ medical, mental and psychosocial problems to appropriate forums only, for example, at facility interdisciplinary care team conferences or unit conferences. Staff must
not discuss or otherwise divulge residents’ medical, mental and psychosocial problems with any other residents, even though discussion may be initiated by the other resident.

Finances
Resident rights
Residents have the right to:
- At the time of admission, a written copy and explanation of the facility’s basic services.
- Manage their own financial affairs or, in writing, authorize the facility to manage personal finances in accordance with specific requirements, such as those governing resident interest-bearing accounts.
- Refuse to deposit their personal funds with the facility.
- Request their complete financial record and have the facility provide it to them within one business day.
- Request an assessment that will determine nonexempt resources of the resident and their spouse at the time of admission, and will give the spouse, if he or she is living in the community, an equitable share of resources which cannot be used to pay for the resident’s care as they spend down to Medicaid eligibility levels.

Nursing home responsibility
The nursing home must:
- Provide the following information to the resident if they are entitled to Medicaid benefits:
  - A list of the items and services included in nursing home services and for which the resident may not be charged (see glossary for included services).
  - A list of any other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those items and services (the facility must inform the resident when changes are made in these lists).
- Inform the resident verbally and in writing before the time of admission and periodically when changes occur during their stay, of services available in the facility and of the charges for those services, including any charges for services not covered by sources of third-party payment or by the facility’s basic daily rate.
- Prominently display written information in the facility and provide verbal and written information to residents and potential residents about:
  - How to apply for and use Medicare and Medicaid benefits.
  - How to receive refunds for previous payments covered by such benefits.
- Not require the resident to deposit personal funds with the facility.
- Refund promptly any amount or proportion of repayment in excess of the amount used for services in the event the resident leaves the facility prior to the end of the prepayment period for reasons beyond their control.
- Deposit the resident’s funds in excess of $50 in an interest-bearing account separate from any of the facility’s operating accounts.
- Upon request, provide an assessment that will determine nonexempt resources of the resident and their spouse at the time of admission, and will give the spouse, if he or she is living in the community, an equitable share of resources that cannot be used to pay for the resident’s care as they spend down to Medicaid eligibility levels.
- Upon request, inform the resident or their designated representative about funds held in account through quarterly statements.
- Make available to the resident or their designated representative their individual financial record within one business day of a request.
- Upon the resident’s death, convey within 30 days their personal funds deposited with the facility and a final accounting of those funds to the individual or probate jurisdiction administering the resident’s estate.
- If the resident is a private-pay resident, give the resident a 30-day notice for any change in rate and, if they request, provide documentation explaining any additional charges.

Transfer and discharge
Resident rights
Resident have the right to:
- Transfer to another room in the facility if they wish.
- Be given 30 days notice before transfer or discharge, except in cases where the resident is at risk of harming themselves or others, in which case the resident could be discharged earlier.
- File an appeal to the state department of health in response to an involuntary transfer or discharge, for which a hearing can be held under the auspices of the department.
- Examine their own medical records.
- Remain in the facility pending the appeal determination.
- A post-transfer hearing within 30 days of transfer if the resident did not request a hearing prior to transfer; if the resident wins the appeal, he or she will return to the first available bed in the facility.
- Retain the bed if they have been involuntarily transferred until after the appeal decision is reached.
- Information such as the name, address and telephone number of the state department of health, long-term care ombudsman and any commission on quality of care and advocacy for persons with disabilities.

Nursing home responsibility
The nursing home may transfer or discharge the resident:
- Only after the interdisciplinary care team, in consultation with the resident, determines:
  - That the transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met after reasonable attempts at accommodation at the facility.
  - That the transfer or discharge is appropriate because the resident’s health has improved sufficiently to the point where he or she no longer needs the services provided by the facility.
  - The resident’s health or safety or the health or safety of other individuals in the facility would otherwise be endangered and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem.
- When the resident has failed to pay for a stay at the facility after having received reasonable and appropriate notice from the facility or to have paid under Medicare, Medicaid or third-party insurance. For failure to pay, such transfer or discharge is permissible only if:
  - A charge is not in dispute.
  - No appeal of a denial of benefits is pending.
  - Funds for payment are available, but the resident refuses to cooperate with the facility in obtaining them.
- When it discontinues operation and has received approval of its plan of closure from the state department of health or other approved agency.

The nursing home must:
- Inform the resident and his or her designated representative, verbally and in writing, about bed reservation and readmission regulations at the time of the resident’s admission to the facility and again at the time of a transfer for any reason and/or for therapeutic leave.
- Readmit the resident, if they have been in residence at least 30 days, as soon as the first bed becomes available in a semi-private room if they were hospitalized, transferred or discharged on therapeutic leave without being given a bed hold when they require the services provided by the facility and are eligible for Medicaid.
- Complete in the resident’s clinical records the reasons for the move.
- Before transferring or discharging the resident, notify them and a family member or designated representative both verbally and in writing (in a language and manner they understand) of the transfer or discharge and the reasons for it.
- Include in its written notice of transfer or discharge to the resident the following:
  - A statement about the resident’s right to appeal to the state department of health, including the telephone number for the department that can initiate an appeal.
  - The name, address and telephone number of the state long-term care ombudsman.
  - If the resident is mentally ill or developmentally disabled, the mailing address and telephone number of any commission on quality of care and advocacy for persons with disabilities, the agency that can advocate for them.
Provide its notice of transfer or discharge to the resident at least 30 days prior to the expected date of transfer or discharge or provide its notice to them as soon as practicable before transfer or discharge when:
- The health or safety of individuals in the facility would be endangered.
- The resident’s health improves sufficiently to allow a more immediate transfer or discharge.
- An immediate transfer or discharge is required by the resident’s urgent medical needs.

The transfer or discharge is made in compliance with the resident’s request.

Provide sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the facility, including an opportunity for the resident to participate in deciding where to go.

Provide information to assist the resident in appealing a transfer or discharge by:
- Seeing to it that the resident contacts the appropriate state agency.
- Calling upon the resident’s doctor and the facility staff to help in examining and reviewing medical records.
- Working with the state department of health to make certain that the appeals determination is held and that the resident is present if he or she desires.

**Required postings**

Nursing homes must post the following information in the facility, in a location easily accessible to residents and the public:

- Summary of residents’ rights and all rules and regulations governing resident conduct and responsibilities.
- Information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.
- Information about advance directives or written instructions concerning important health care decisions, health care proxy and designation of a health care agent.
- A schedule of the facility’s current monthly activities.
- The facility’s visiting hours.
- The date and time the facility will assess residents to determine the intensity of their needs.
- The date and time the state department of health auditors will visit the facility to audit the patient review instrument.
- A statement that each resident has the right to know to which reimbursement category he or she has been assigned by the facility.
- The person to contact in the facility for more information about resident assessment categories and reimbursement.
- A nondiscrimination regulatory poster (must be displayed in the admissions office).
- Ensure that residents, employees or other person(s) may file complaints with or provide information to any long-term care patient ombudsman.

The home shall make available for examination the results of the most recent survey of the facility conducted by federal or state surveyors including any statement of deficiencies, any plan of correction in effect with respect to the facility and any enforcement actions taken by the department of health. They shall be made available in a place readily accessible to residents and designated representatives without staffing assistance.

For further information about your responsibilities or residents’ rights, contact your state department of health and family services.

**Glossary**

**Advance directives** – A verbal or written instruction plan in advance of incapacitating illness or injury that ensures that the resident’s wishes about treatment will be followed for a short or long period of time. This includes, but is not limited to, a health care proxy, an order not to resuscitate recorded in the resident’s medical record and a living will.

**Baseline services** – Those services included in the daily rate. At the time of admission, a written copy of the following basic services must be made available to all residents:
- The daily, weekly or monthly rate.
- Board, including therapeutic or modified diets, as prescribed by a doctor.
- Lodging – A clean, healthful, sheltered environment, properly outfitted.
- Dietary services.
- 24-hour-per-day nursing care.
- Pharmacy services.
- Diagnostic services.
- The use of all equipment, medical supplies and modalities used in the care of nursing home residents, including but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, etc.
- Fresh bed linen, as required, changed at least once a week.
- Advanced directives to resuscitate recorded in the resident’s medical record and a living will.
- The resident’s health improves sufficiently to allow a more immediate transfer or discharge.
- An immediate transfer or discharge is required by the resident’s urgent medical needs.
- The transfer or discharge is made in compliance with the resident’s request.

**Services** – Those services included in the daily rate. At the time of admission, a written copy of the following basic services must be made available to all residents:
- The daily, weekly or monthly rate.
- Board, including therapeutic or modified diets, as prescribed by a doctor.
- Lodging – A clean, healthful, sheltered environment, properly outfitted.
- Dietary services.
- 24-hour-per-day nursing care.
- Pharmacy services.
- Diagnostic services.
- The use of all equipment, medical supplies and modalities used in the care of nursing home residents, including but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, etc.
- Fresh bed linen, as required, changed at least once a week.
- Advanced directives to resuscitate recorded in the resident’s medical record and a living will.

**Special services** – These services may be offered in addition to those considered standard:

**Adult day health care (ADHC)** – ADHC programs provide the health care services and activities provided to a group of persons, who are not residents of a residential health care facility, but are functionally impaired and not homebound. Require supervision, monitoring, preventive, diagnostic, therapeutic, rehabilitative or palliative care or services, but do not require continuous 24-hour-a-day inpatient care and services to maintain their health status and enable them to remain in the community.

Each approved adult day health care session must operate for a minimum of five hours duration, not including time spent in transportation. It must also provide, at a minimum, nutritional services in the form of at least one meal and necessary supplemental nourishment, planned activities, ongoing assessment of each registrant’s health status in order to provide coordinated care planning, case management and other health care services as determined by the registrant’s needs.

**Adult day health care – AIDS** – An adult day health care program may be approved as a provider of specialized services for registrants with AIDS (acquired immune deficiency syndrome), and other human immunodeficiency virus (HIV) related illness. The program shall provide comprehensive and coordinated health services and the operator must provide or make arrangements for case management services; substance abuse services, if appropriate; mental health services; HIV prevention and counseling services; pastoral counseling; TB screening and ongoing follow up, and specialized medical services including gynecology, as needed.
AIDS – The facility shall provide comprehensive and coordinated health services, and the operator must provide or make arrangements for: case management services; substance abuse services, if appropriate; mental health services; HIV prevention and counseling services; pastoral counseling; TB screening and on-going follow up; and specialized medical services including gynecology, as needed.

Behavioral intervention services – This program must include a discrete unit with a planned combination of services with staffing, equipment and physical facilities designed to serve individuals whose severe behavior cannot be managed in a less restrictive setting. The program shall provide goal-directed, comprehensive and interdisciplinary services directed at attaining or maintaining the individual at the highest practicable level of physical, affective, behavioral and cognitive functioning.

Clinical laboratory service – Clinical laboratory means a facility for the microbiological, immunological, chemical, hematological, biophysical, cytological, pathological, genetic or other examination of materials derived from the human body, for the purpose of obtaining information for the diagnosis, prevention or treatment of disease, or the assessment of a health condition, or for identification purposes. Such examinations shall include procedures to determine, measure, or otherwise describe the presence or absence of various substances, components or organisms in the human body.

Coma services – A resident admitted for coma management shall be a person who has suffered a traumatic brain injury with structural nondegenerative brain damage, and is in a coma. The resident may be completely unresponsive to any stimuli or may exhibit a generalized response by reacting inconsistently and non-purposefully to stimuli in a nonspecific manner.

Dementia programs – Dementia programs seek to improve the quality and treatment of patients with dementia. Architectural designs and interior finishes are required to implement special programs for residents with dementia. Staff is trained to manage behavior and promote effective care of dementia patients by arranging the environment in ways that produce positive outcomes for patients. Special activities are offered to the residents with the goal of maintaining and promoting autonomy and decision-making on the part of dementia patients.

Diagnostic radiology – When this service is provided, the operator shall ensure that: the radiographic procedures requiring the use of contrast media or fluoroscopic interpretation and control are performed with the active participation of a qualified specialist in diagnostic radiology or a physician qualified in a medical specialty related to the radiographic procedure.

Hospice – Hospice shall mean a coordinated program of home and inpatient care that treats the terminally ill patient and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous hospice administration. The program provides palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness, and during dying and bereavement.

A resident of a nursing home who becomes terminally ill may receive hospice services. In order to establish eligibility for hospice care, the patient’s physician and the hospice medical director must certify that the patient is terminally ill, the patient or authorized representative must elect the hospice benefit in writing, and a hospice plan of care must be established. Terminal illness is defined as a medical life expectancy of six months or less if the illness runs its normal course.

Limited transfusion services – Limited transfusion service means a facility, which transfuses blood and may temporarily store blood and distribute it within its own organization, but relies on a blood bank holding a permit in blood services-transfusion to perform laboratory tests.

Outpatient Services

Occupational therapy – This consists of instructing patients in prescribed academic subjects to prevent mental de-conditioning, improving patients’ mental and physical conditions and aiding in the attainment of knowledge and skills that will further residents’ progress toward vocational objectives.

Physical therapy – Physical therapy employs therapeutic exercises and massage and utilizing effective properties of heat, light, cold water and electricity for diagnosis and rehabilitation of patients with neuromuscular, orthopedic and other impairments. Such services are provided in a coordinated and integrated program under the direction and prescription of a physician or a registered physical therapist. Additional activities include, but are not limited to, the following: the provision of clinical and consultative services; the direction of patients in the use, function and care of braces, artificial limbs and other devices; prescribing therapeutic exercises; counseling patients and their relatives; organizing and conducting medically prescribed physical therapy programs; applying diagnostic muscle tests; administering whirlpool and compact baths; changing linen on physical therapy department beds and treatment tables; assisting patients in changing clothes and other personal needs and participating in discharge coordination.

Speech pathology – Rehabilitation services shall be made available, only at the direction of a physician, to eligible persons as medically needed and as an integral part of a comprehensive medical care program. Such services include not only service to the patient, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient.

Pediatric – The facility provides extensive age-specific nursing, medical, psychological and counseling support services to children with diverse and complex medical, emotional and social problems in a program recognized and approved by the department to provide these services.

Respite care services (short term) – Scheduled short-term nursing home care provided on a temporary basis to an individual who needs this level of care, but who is normally cared for in the community. The goal of scheduled short-term care is to provide relief for the caregiver(s) while providing nursing home care for the individual. Schedules for scheduled short-term care are generally pre-arranged and shall be limited to one or more periods of from one to 30 days and shall not exceed 42 days in any one year except in extraordinary circumstances, such as sudden illness of the primary caregiver or temporary unfitness of the individual’s principal residence.

Traumatic brain-injured (TBI) – A planned combination of specialized services provided in a nursing home unit for head-injured residents, where the unit consists of at least 20 beds. The head-injury program shall be designed specifically to serve medically stable, traumatically brain-injured individuals with an expected length of stay from three to 12 months. The program shall provide goal-oriented, comprehensive, interdisciplinary and coordinated services directed at restoring the individual to the optimal level of physical, cognitive and behavioral functioning. The population served shall consist primarily of individuals with traumatically acquired, nondegenerative, structural brain damage resulting in residual deficits and disability. The program shall not admit or retain individuals who are determined to be a danger to self or others.

A resident admitted for long-term rehabilitation shall be a person who has suffered a traumatic brain injury with structural non-degenerative brain damage, is medically stable, is not in a persistent vegetative state, demonstrates potential for physical, behavioral and cognitive rehabilitation and may evidence moderate to severe behavior abnormalities. The resident must be capable of exhibiting at least localized responses by reacting specifically but inconsistently to stimuli; education and counseling services are available and offered to the residents and families.

Ventilator dependent – This program is intended to serve long-term ventilator-dependent residents. Services shall be
directed at restoring each resident to his or her optimal level of functioning and assisting each resident to achieve maximum independence from mechanical ventilation.

Residents shall be assessed as to their ability to be weaned from their ventilatory dependence. Those residents who are assessed as potentially able to be weaned from dependence on support with mechanical ventilation or whose daily use of ventilator support may be reduced shall receive an active program of therapy and other supportive services designed for that resident to reduce or eliminate his or her need for use of a ventilator.

Residents shall be assessed as to their ability to be discharged to home or to a homelike setting with or without supportive services. When such potential is identified, the facility shall initiate an active program of therapy and other supportive services designed to assist the resident in the transition to the new setting. Facility discharge planning staff shall arrange for any home modifications, equipment or assistance expected to be required of the resident in the new setting.

**Designated representative** – The individual or individuals designated to receive information and to assist and/or act on behalf of a particular resident to the extent permitted by state law. This is not the same as a health care agent. The designation occurs by a court of law if sought by the resident if he or she has the capacity to make such a designation; or by family members and other parties who have an interest in the well-being of the resident. The name of the designated representative must be noted in the resident’s clinical record at the facility.

The designated representative:
- Receives any written and verbal information required to be provided to the resident if the resident lacks the capacity to understand or make use of the information, and receives any information required to be provided to both the resident and the designated representative.
- Participates (to the extent authorized by state law) in decisions and choices regarding the care, treatment and well-being of the resident if such resident lacks the capacity to make decisions and choices.

**Governing body** – The policymaking body of the facility, the board of directors or trustees of the facility or the proprietor or proprietors of a nursing home.

**Health care agent** – Someone appointed by the resident whom he or she trusts to decide about treatment if the resident becomes unable to decide for himself or herself. The resident has the right to appoint someone by filling out a form called a health care proxy. These forms should be available at the facility.

**Health care proxy** – A document that delegates the authority to another individual known as a health care agent to make health care decisions on behalf of the resident when that resident is incapacitated.

**Quality assessment and assurance committee** – A committee consisting of at least the facility administrator (or designee), director of nursing, a doctor designated by the facility, at least one member of the governing body (not affiliated with the nursing home in an employment or contractual capacity) and at least three other facility staff members, meeting at least quarterly to oversee the effectiveness of monitoring, assessing and problem-solving activities for purposes of initiating quality improvements designed to advance the quality of life, care and services in the facility. The committee meets quarterly with the resident council to seek recommendations or quality improvements.

**Resident** – An individual who has been admitted to and who resides in a nursing home (facility) and is entitled to receive care, treatment and services required by state law.

**Resident care unit (or nursing unit)** – A designated area that includes a group of resident rooms and adequate supporting rooms, areas, facilities, services and personnel providing nursing care and management of residents that is planned, organized, operated and maintained to function as a unit so as to encourage the efficient delivery of resident services and effective observation of and communication with facility residents.

**Resident council** – The organization created by residents of a nursing home and recognized by the facility as the group that represents the interests of its members.

**Sponsor** – The agency or people, other than the resident, responsible in whole or in part for the financial support of the resident, including the costs of care in the facility.

ENDNOTES
1. Adapted from Your Rights as a Nursing Home Resident And Nursing Home Responsibilities April 2007 http://www.nyhealth.gov/facilities/nursing/rights/docs/your_rights_as_a_nursing_home_resident.pdf
CHAPTER 8  
GERIATRIC ASSESSMENT  
(12 CONTACT HOURS)

Learning objectives
- Discuss demographics related to the geriatric population.
- Perform a “first glance” assessment.
- Review the importance of providing culturally appropriate care.
- Assess the nutritional status of the geriatric patient.
- Offer the geriatric patient practical suggestions for maintaining a healthy diet.
- Describe the physiological responses of the elderly adult’s body to medications.
- Explain how to facilitate safe management of medication regimens in the older adult.
- Initiate sexual assessment of the geriatric patient.
- Assess the sleep patterns of the older adult.
- Identify strategies for pain assessment in the older adult.
- Identify pain reduction measures for the older adult.
- Assess mental health in the elderly adult.
- Recognize signs and symptoms of elder abuse.
- Describe changes in vision, hearing and sensation that affect the aging adult.
- Describe normal age-related changes in the integumentary system.
- Identify common health problems related to the integumentary system in the older adult.
- Assess the aging adult for potential problems related to cardiovascular functioning.
- Identify lung disorders commonly found in older patients.
- Identify important aspects of assessment of the endocrine system.
- Explain the ways age influences hematologic function.
- Recognize common health problems of the nervous system in the older adult.
- Review age-related issues of the genitourinary system.
- Assess the musculoskeletal system of the geriatric patient.
- Recognize age-related immune system deficiencies related to the aging process.

Introduction
The needs of persons over the age of 65 will continue to place significant demands on the health care system for the foreseeable future. In 2009, it was estimated that nearly 13 percent of the population of the United States was over the age of 65. The number of adults living into late adulthood is increasing dramatically. It is predicted that by 2050, the number of people over the age of 60 in developed countries will reach 416 million. According to the World Health Organization, the fastest-growing segment of this population is persons 80 years of age and older. Older adults often have one or more chronic illnesses or conditions, such as urinary incontinence, dementia, cardiovascular disease and diabetes mellitus. In fact, nearly 80 percent of older adults have one or more chronic health problems. Although older adults make up the majority of those who use health care services, most are able to live independently in the community. This means, however, that nurses must be quite knowledgeable in the delivery of geriatric services in both inpatient and outpatient settings, including such services as preventive care, risk identification, patient education and promotion of maximum health and wellness.

The health care demands of a dramatically aging population require a workforce of nurses skilled in geriatrics. As a result, there has been a significant increase in the amount and depth of gerontological nursing content in baccalaureate schools of nursing during the past 15 years. There is a corresponding need for continuing education on gerontological nursing for licensed professionals and nursing assistants. Nurses play a critical role in helping older adults to effectively manage health problems, create and maintain safe and healthy living environments, and live lives of dignity and quality. One of the most important ways nurses can do this is to perform a thorough assessment of their geriatric patients. Such assessments require that nurses be astute observers and excellent communicators. A good assessment begins with the nurse’s first glimpse of the patient.

Assessment at first glance
Assessment begins with your first glimpse of the patient. So many things can be observed in these first few moments. Start with the patient’s appearance. How is the patient dressed? Is the clothing appropriate for the time of year and the weather? Are clothes neat and clean? Do they fit properly? Is the patient clean? Do you smell any unusual odors such as urine, which may indicate incontinence problems, or sweat, which may indicate lack of hygiene? Are the patient’s hands and fingernails clean? Is there any evidence of unusual bruising or injury such as lacerations, scars or burn marks?

At first glance, what is the patient’s mobility status? Is he ambulating independently or does he require assistance? Does the patient use any assistive devices such as a cane or a walker? Observe the quality of his gait. Is balance maintained without difficulty? Are movements of all extremities without tremors?

How does the patient respond to the nurse’s initial greeting? Is the response appropriate? Does the patient speak clearly and distinctly? Are his facial features symmetrical? If not, what abnormalities are present? (For example, is one side of the face drooping or is one eyelid drooping?) Is the patient oriented to person, place and time? Does he maintain eye contact (if culturally appropriate)? Is he able to respond to simple questions such as “How are you feeling today?”

Does the patient wear glasses? Does he seem able to see his surroundings without difficulty? Can the patient hear what you are saying, assuming you are speaking clearly and distinctly and in a normal tone of voice? Does the patient wear hearing aids?

Is the patient alone or is he accompanied by a family member or friend? Observe the interaction between the patient and whoever accompanies him. Does the patient seem comfortable with this companion? Do they interact appropriately? Does the patient give any indication that he is intimidated by his companion?

What, briefly, is the patient’s health history? For example, is there a history of heart attack, stroke, diabetes, other conditions? What medications is the patient taking?

What is the patient’s cultural and ethnic background? Is English his first language? If not, how well is the patient able to communicate in English? Will an interpreter need to be present during the assessment to facilitate communication?

Remember that you need to adapt your communication to the specific needs of the geriatric patient. Never assume that because a patient is elderly that he will be unable or unwilling to participate actively in his health care regimen. Communicate directly with the patient whenever possible. Don’t bypass him or belittle him by talking to family or friends instead. Make sure that, if needed, he has his glasses on and hearing aids in place. And always let him know exactly what you are doing during assessment.

Ask patients how they would like to be addressed. Ask if they may call them by their first names or if they would prefer to be addressed as Mr., Mrs., Ms. Never, ever “talk down” to an elderly patient by calling him or her “sweetie,” “dar,” or other such names. They are not infants or children and should be treated with respect. Introduce yourself by giving your full name and your title/role. For example, “My name is Andrea Burns. I am a registered nurse, and I will be taking care of you today.”

The “first glance” of the patient can provide a great deal of information about the patient’s physical, mental and emotional state. Use this first glance as a foundation for the detailed assessment of the geriatric patient.

Cultural considerations
Cultural considerations must be incorporated into geriatric physical assessment. Failure to provide culturally appropriate and competent care can lead to lack of patient compliance, frustration and even hostility. Patients need and expect that their cultural perspectives will be respected.

The shift in minority demographics in the United States has changed significantly in the past 10 years. According to the United States Census Bureau, the 2000 census indicated that the white, non-Hispanic majority was 69.1 percent. In 2008, this percentage had decreased to 65.6 percent.

In May 2007, Census Bureau data suggested that one in three U. S. residents is a minority. In fact,
it is predicted that by 2020, people of color will be the majority population.9

Cultural sensitivity encompasses many issues. Culture is complex and is made up of thoughts, values, beliefs and traditions of racial, ethnic, religious or social groups.9 Culture influences moral beliefs, traditions, communication, gender and familial roles, expressions of emotion, family interactions, diet, dress and beliefs about health and wellness. The large number of different cultures that exist in the U.S. make it impossible for all health care providers to have an intimate knowledge of all of them. Here are some suggestions to encompass cultural appropriateness into the assessment process:

- Identify the various cultural populations for which you are most likely to provide health care services.
- Familiarize yourself with appropriate cultural responses for these populations. For example, in Middle Eastern cultures, sexual segregation is often very important, and same-sex caregivers should be assigned whenever possible.
- Investigate the availability of interpreters to facilitate communication if the patient has difficulty communicating in English.
- Develop written patient education materials in the most common languages (in addition to English) that are spoken by your patient populations.
- Remember to be sensitive to dietary practices that are important to cultural and religious viewpoints.
- Remember that expression of emotions may vary from culture. Some cultures are vocal and overt about expressing fear or pain, while others are stoic. All expressions should be respected.
- Identify cultural and religious viewpoints concerning death and dying, life-prolonging interventions (such as feeding tubes), treatment of the body after death and funeral practices.9
- Consult appropriate resources to gather information about cultural perspectives. One such resource is www.ggalanti.com. This site offers respectful cultural profiles of various populations, resources, articles and related links. When using Web sites, make sure that they treat all cultures with respect. Be wary of and avoid sources that criticize or make jokes about cultures or religious practices.

The age of a person or the generation he was born into also influences the way health care services are perceived. For example, the “traditional” generation, also known as the “veterans,” are those adults born between 1922 and 1946 and represent the oldest members who access health care in this country. As a rule, these people are more formal in their approach to life and often preferred to be addressed as Mr., Mrs. or other formal titles. They generally have a strong work ethic and a rigid view of hierarchy and respect for authority. This may make it difficult for them to ask questions or participate actively in their health care plans because they often view health care providers as authority figures.13

It is important to encourage questions and facilitate active communication between older adults and health care professionals. When possible, a reliable family member or friend should accompany the older adult to facilitate communication when needed.

Nutritional assessment
Nutritional assessment is much more than an evaluation of the intake of nutrients and the body’s ability to effectively use nutrients. It starts with the mouth and oral cavity and includes the patient’s ability to taste and smell, the body composition of the older adult, alcohol use, access to food and socioeconomic factors that influence nutritional status.

Assessment of the mouth and oral cavity Important questions to ask
The ability to eat depends, in part, on a person’s teeth. Observe your patient’s teeth. Are they his own or does he wear dentures? Are dentures, including partial dentures, clean, and do they fit well? Are his teeth clean? Is there any evidence of chipped, broken or missing teeth and/or dentures? Additional important information that should be obtained about a patient’s dental habits includes:

- How does he take care of his teeth/dentures? Is he physically and mentally capable of taking care of his teeth and mouth? Teeth should be brushed and flossed at least twice a day. A soft-bristled toothbrush should be used to properly clean teeth and to avoid damaging gums.9
- How often does he visit a dentist? The geriatric patient should see a dentist at least annually, with the ideal time frame of every six months. These visits should also include a screening for oral cancers such as cancer of the tongue at each visit.
- Does the patient use alcohol and/or tobacco products? Explain to the patient that avoiding these products decreases the risk for oral or lung cancers.9
- Does the patient have bad breath? What does it smell like? Bad breath (halitosis) may indicate poor oral hygiene or certain disease processes. For example, a fruity smelling breath suggests hyperglycemia.
- Does the patient report any problems with the oral cavity, such as painful teeth or gums, bleeding gums, dry mouth, changes in the sense of taste, or problems chewing or swallowing?
- Does the patient complain of having a dry mouth? This is the most common oral problem in the elderly adult and can be due to mouth breathing, dehydration, oxygen therapy, various diseases, side effects of medication, and head and neck radiation treatments.

Assessment Tip: A frequent complication of dry mouth is the fungal infection oral candidiasis, more commonly known as thrush.

Inspection
Inspect the patient’s lips, teeth, tongue, gums, soft and hard palate, buccal mucosa and the back of the throat. Look for any signs of cracks, bleeding, lesions, ulcers, swelling, induration or broken or decayed teeth. If the patient wears dentures, observe how they fit, whether they are clean, and whether there is any evidence of breakage.

Look for signs of leukoplakia, which is a white or gray patch that may develop on the tongue, on the floor of the mouth or on the buccal mucosa. Leukoplakia is most commonly found in elderly patients and is due to irritation from teeth or dentures that rub against the inside of the cheeks or gums or chronic irritation from use of tobacco products. Leukoplakia is usually painless and is generally biopsied to rule out oral cancers.12

When inspecting the mouth and oral cavity, remain alert to signs and symptoms of oral cancer. These include:

- A lump or thickening of the lip or in the patient’s mouth.
- A sore in the mouth or on the lip that does not heal.
- White or red patches on the gums, tongue or buccal mucosa.
- Patient complains that there is always a feeling of something “stuck” in the throat.
- Swelling of the jaw or mouth that changes the way dentures fit.
- Pain in the ear or when chewing or swallowing.
- Changes in the patient’s voice.

Assessment Tip: When inspecting the mouth and oral cavity, make sure that extra light is available to allow good visualization of the tongue, buccal mucosa, lips, teeth and gums.

It is important to be aware of risk factors for the development of oral problems. Diseases or other factors that cause oral problems will affect the patient’s ability to consume food and maintain a state of proper nutrition. Issues and factors that increase the risk for oral problems include:49

- Diseases such as cancer, HIV and AIDS, diabetes mellitus, stroke, dementia, renal failure and viruses such as herpes simplex.
- Deficiencies of vitamins including B6, B12, folic acid, C, K, A, and niacin.
- Changes that accompany aging, such as thinning teeth enamel, lines and cracks in teeth, thinner and smoother mucosa that loses elasticity, and a decrease production of saliva.

Assessment Tip: After inspecting the mouth and oral cavity, palpate the lymph nodes in the neck. Lymph nodes should be small, smooth, round and painless. Tenderness may indicate infection. Enlarged, fixed, hard lymph nodes require further evaluation as these signs may indicate a serious problem, such as malignancy. At the same time, observe the neck for any lesions, moles or bulging areas.

Another important risk factor for oral problems (and corresponding nutritional problems) is lack of money. Elderly adults living on a fixed and/or inadequate income may not have the money...
to schedule regular dental visits, or purchase dentures and oral hygiene products. Persons with financial problems should be referred to local dental practices that offer services at reduced rates. They should also be helped to identify stores where dental supplies may be purchased at minimal costs (such as dollar stores).

Transportation may also be an issue. Find out whether patients have access to public transportation or whether they have family members or friends who are able to help them get to dental visits and purchase oral hygiene supplies. Remember that assessment of the oral cavity and mouth involves much more than physical assessment techniques. Finances, mental acuity, transportation and family/friend assistance play important parts in good dental hygiene.

### Taste assessment

After about the age of 70, adults begin to experience a reduced sense of taste, which is called hypoguesia. The ability to perceive the tastes of salt and sweet are most affected. Taste buds are located on the tongue, epiglottis, larynx and the first third of the esophagus. In addition to the normal changes of aging, many factors contribute to a diminished sense of taste. These include poor dental hygiene, broken teeth or dentures, and dry mouth. There are also quite a few medications that adversely affect taste. These include:

- Antibiotics.
- Antidepressants.
- Antibiotics.
- Antihypertensives.
- Anti-cancer drugs.
- Antihistamines.
- Decongestants.
- Muscle relaxants.
- Cholesterol-lowering drugs.
- Drugs used to treat Parkinson’s disease.

### Assessment Tip: Not every drug in the preceding classifications necessarily alters taste. Be sure to determine which medications patients are taking and check to see whether these drugs have an impact on the sense of taste.

Sometimes the sense of taste can be affected by the environment in which a patient eats. Elderly adults who live alone may not be as interested in preparing meals or in eating them compared to the days when they prepared meals for a family and ate food with others. Encourage adults to eat in a comfortable, relaxed setting as much as possible and to take the time to enjoy a meal. Help patients to select foods that are easy to prepare, nutritious, and that they like.

### Assessing the sense of smell

Problems with the sense of smell (olfactory) are quite common (even more common than problems with taste) in older adults. In fact, about half of adults over the age of 60 experience alterations in their sense of smell. The medical term for reduced sense of smell is hyposmia. A lack of sense of smell can be dangerous. The inability to smell smoke, gas or spoiled food can actually lead to illness or death. If severe enough, hyposmia can reduce appetite to the point that the older adult becomes malnourished.

There are a number of factors that contribute to hyposmia. These include age-related changes, such as reduction in the number of sensory cells, injury to the olfactory mucosa and alterations to the structure of the upper airway hypothalamus and olfactory tract. Other factors include nasal congestion, smoking and drug use. Sometimes nurses and physicians simply assume that a decreased sense of smell is due to a person’s age. But it could also be the result of damage to the olfactory nerve (cranial nerve I). It is important to assess the function of this nerve by first checking to be sure that both nostrils are patent and unobstructed. Then ask the patient to close his eyes. Occlude one nostril and place a familiar, strong-smelling substance (such as coffee, peppermint or orange peel) under his nose and ask him to identify it. Do the same thing with the other nostril. The patient should be able to identify each smell correctly. If olfactory nerve damage is suggested, the patient will need further evaluation.

### Assessment tip: Be sure that you use scents with which the patient is familiar. He can’t identify a scent if he has never smelled it before.

### Body composition changes in the older adult

There are a number of changes in body composition in the older adult that can have an impact on nutrition and overall health. One such change is the loss of lean muscle mass that occurs with aging. The loss is due to a reduction in physical activity, hormone production and alterations in nutrition. If caloric intake continues at the rate consumed at a younger adult, the older adult will gain weight in the form of fat, not muscle.

Loss of muscle mass is associated with a reduction in strength and endurance and an increased risk for falls. Research indicates that even a 10 percent loss of muscle mass is linked to increased mortality in older adults.

Other body changes that directly or indirectly influence body composition include:

- **Loss of bone mineral density**, which increases the risk for osteoporosis in both men and women. Loss of bone density increases the risk of fractures as well as the risk of falls.
- **Decrease in both the size and number of gastric glands and mucous membranes**, and reduction in gastric acid production, can lead to atrophic gastritis (irritation of the stomach due to atrophy). The decrease in gastric acid production results in a decrease in the acidity of the stomach. Since iron and vitamin B12 need an acid environment for proper absorption, this lack of acidity can inhibit the absorption of both of these substances.
- **Peristalsis in the intestines slows** as the adult ages. If this is compounded by a lack of fluid and fiber intake, lack of exercise or chronic illnesses, constipation can, and often does, occur.
- **Aging diminishes the thirst drive**. Because of this, the fluid intake of older adults is often inadequate. Compounded by the aging kidney’s inability to efficiently concentrate urine, this lack of fluid intake often leads to dehydration in geriatric patients. If older patients experience vomiting and/or diarrhea, excessive sweating, or excessive urination due to diuretic therapy, they must be carefully monitored for signs and symptoms of dehydration. Such symptoms include dry skin, poor skin turgor, dark-colored urine, headache, dizziness, dry mucous membranes, increased heart rate and respirations, and confusion.

### Older adults often experience vision changes that compromise the sense of sight.

These include cataracts, macular degeneration and generalized deterioration of vision. Such changes can make it difficult, and unpleasant, for them to shop, prepare food and, at times, eat. Reduced vision may make it necessary for someone to transport elderly people to the grocery store, help them to purchase food and even prepare it. The nurse may need to put the older adult in touch with services such as Meals on Wheels and community groups that assist elders in these activities. Many public transportation companies offer elder services at reduced rates. Older patients need assistance to access community services that will help them with transportation, shopping and meal preparation/delivery.

### Assessment tip: Older adults are often afraid of being incontinent of urine. Because of this fear, they may limit their fluid intake, which further increases the risk for dehydration.

### Socioeconomic impact on nutrition

It is important that socioeconomic factors be included as part of the nutritional assessment of the geriatric patient. These have been mentioned briefly in the preceding sections, but deserve additional emphasis.

Nutritional intake is closely linked to socialization. Where we eat, how we eat, and with whom we eat can have as much of an impact as what we eat. When assessing the social aspects of nutrition, consider the following issues:

- **With whom does the older adult eat?** If he eats with others, is it in a home setting or long-term care setting such as assisted living? If he eats with others, is the atmosphere congenial? For example, if the older adult is living with an adult child, is he made to feel welcome and a part of the family’s social interactions? If he eats in a long-term setting, in what type of environment are meals served? Is the environment conducive to enjoying a meal?
- **If the older adult lives at home, does he have easy access to a grocery store?** Does he drive or does he depend on others to transport him? Is he aware of public transportation options for transportation and
how to access them? If needed, is he aware of options such as Meals on Wheels and other similar community services?

- **If the older adult does have access to a grocery store, is he physically capable of shopping and carrying bags of groceries or does he need help?** If he needs help, who is available to help him? Does he have the visual acuity to read and understand food product labels and prices? Does he have the mental acuity to make appropriate food choices?

Another important aspect of nutritional assessment is the financial impact of food purchase:

- **Does the older adult have enough money to purchase healthy foods?** If not, he may purchase whatever “fits” within his budget, even if such foods are not recommended for his state of health. For example, does he purchase microwave dinners that are high in salt because they are cheap and easy to prepare, even though he is on a limited salt diet?

- **Does the elderly adult need help managing his money?** He may have adequate financial resources but is unable to live within his budget due to uncertainty over prices or decreasing mental acuity. Does he have anyone to help him manage his money? What family or community resources are available to assist him with money management?

If there is not enough money to purchase food, the older adult needs to be referred to agencies that may be able to help or to make referrals. Possible sources are veterans associations, area agencies on aging, church groups and government assistance agencies.

**Assessment tip:** Always include socioeconomic evaluation as part of physical assessment. These areas influence every aspect of health. Also note that women are twice as likely as men to live in poverty.9

**Nutritional requirements**

Nutritional requirements for older adults correlate with the physical changes that accompany aging. There are generally decreased caloric needs due to decreased physical activity. However, the need for vitamins and minerals does not decrease. In fact, based on food intake, there may actually be a need for vitamin supplements.

The U.S. Department of Agriculture (USDA) Food Pyramid is a tool often used by health care professionals and others to plan balanced diets. Nutrition faculty in the Department of Family, Youth, and Community Sciences, IFAS, University of Florida in Gainesville, Florida, have adapted the USDA’s MyPyramid in a handout titled “MyPyramid for Older Adults.”15

This tool is based on an 1,800-calorie diet and should be adapted to the individual needs of each elderly patient. It encourages older adults to choose foods high in fiber to avoid constipation, to drink plenty of fluids to maintain hydration, reduce salt intake, and use fish, nuts and liquid oils instead of saturated fats. Practical suggestions to remain active include going for walks, working in a garden, taking an exercise class at a community center or gym, and playing with pets.15 These suggestions may be helpful when working with older patients and teaching them about nutritional requirements. Additional examples (based on an 1,800-calorie diet) of good dietary habits include the following.15 Note that these suggestions should be adapted to the unique needs and health status of each patient.

- **Eat 6 ounces of grains per day, such as whole-grain cereals, whole grain breads, rice or pasta. Choose cereals fortified with vitamin B12.**
- **Eat 2½ cups of vegetables, especially dark-green and orange vegetables, and dried beans and peas.**
- **Eat 1½ cups of fruit per day.**
- **Drink 3 cups of milk or other calcium-rich foods daily, such as low fat milk or yogurt or low fat cheeses.**
- **Eat 5 ounces of lean meat, beans and other sources of protein, such as low-fat meats and poultry, and include fish, eggs, beans and nuts as protein sources. Bake, broil or grill foods rather than fry them.**

There are some vitamin requirements specific to the needs of older adults. These include:

- **Vitamin D** is important to maintain bone mineralization and to facilitate proper use of calcium in the body. Inadequate amounts of vitamin D have been linked to increased risk for falls in the elderly. If adults have limited exposure to the sun (e.g. those who reside in long-term care facilities without much time outside), they may be at increased risk for vitamin D deficiency. Good food sources of vitamin D include liver, milk fortified with vitamin D, fish such as salmon, and milk and juices fortified with vitamin D. If vitamin D deficiency is not corrected by diet, older adults may be prescribed vitamin D supplements by a physician.

- **Calcium** intake is important to help maintain or slow loss of bone mineral density. Older adults should have three servings of calcium-rich foods every day.3,15

- **Intake of the B vitamins** is very important. Vitamin B6 is necessary to the metabolism of protein and fat, and vitamin B12 is required for the process of cell division and central nervous system functioning. Older adults should be monitored if taking vitamin B supplements. Excess of vitamin B6 can result in toxic side effects leading to sensory neuropathy.9

**Assessment tip:** Older adults should not simply add vitamins to their diet. Any additions of vitamins, minerals or other supplements should be under the supervision of health care professionals. Fat-soluble vitamins, such as D, E, K and A are stored in the body and not excreted the way water-soluble vitamins are. Taking large amounts of fat-soluble vitamins could lead to toxic levels and adverse effects.9

Alcohol ingestion can have an impact on nutrition, especially for deficiencies of thiamin, riboflavin, foliate and vitamin B6 because alcohol can inhibit nutrient absorption, irritate the stomach and affect metabolism.9 In cases of significant alcohol use, alcohol may actually be ingested in place of or in preference to food, thus further compounding its negative effects.

In summary, nutritional assessment is critical to identifying problems and correcting them in the older adult. The nurse must evaluate nutritional status carefully, taking into consideration not only the types and quantities of food being ingested, but the social and economic factors that influence nutrition as well.

**Pharmacology assessment and the geriatric patient**

Mrs. Burns is 80 years old. Her physician prescribed Benicar, 20 mg daily, for hypertension. During a routine checkup, her blood pressure was still significantly elevated. When questioned, Mrs. Burns admitted that she only takes the Benicar four times a week instead of daily. She says she does this to save money and to “make the pills last longer.”

Mr. Lord is 70 years old, and has had epilepsy for many years and takes Dilantin to control his condition. He recently had a seizure, the first he has had in many years. During a thorough evaluation, it was discovered that Mr. Lord recently began to take ginseng, an herbal supplement, to “increase my energy. My daughter takes it and says it really helps her. I know it can’t hurt me because it’s ‘natural’ and not really medicine,” he said. What neither Mr. Lord nor his daughter realized is that ginseng and Dilantin interact, and that ginseng reduces the effectiveness of Dilantin.14,16

The preceding scenarios illustrate two common problems with medication adherence among the elderly. Financial concerns may cause an older adult to take less of his medication than prescribed in an attempt to, as Mrs. Burns says, “make the pills last longer.” Sometimes it may be difficult to make trips to the pharmacy, especially if the elder’s physical or mental health makes driving impossible. Seeking and obtaining transportation may be a problem.

Another issue that is impacting medication compliance with increasing frequency is that of adding herbs or other supplements to medication regimens without the knowledge or consent of health care providers. Many people believe that non-prescription agents such as aspirin, herbal supplements, vitamins and minerals are harmless and can be taken without medical supervision. They do not realize that these agents can interact with prescription drugs and cause adverse effects. They also fail to realize that these agents may be harmful by themselves as well.

When conducting a pharmacologic assessment of the older adult, start by determining what prescription medications they are taking.
Reconcile the list of medications, making sure you have the most current information. Find out how much the patient and, if appropriate, a family member knows about the patient’s medication regimen. Important questions to ask include:

- **What are the names of the medications you are taking?**
- **When do you take your medications?**
  Do you take your medications with food or something to drink? What kinds of food and drinks do you take with your medication?
- **What kinds of side effects may occur when you take your medicine?**
  If side effects take place, what do you do about them?
- **Do you have insurance that covers some of the cost of your medicine?**
  Do you ever have trouble affording the cost of your medicine?

You also need to find out about other medicines your patient is taking. You need to ask if he takes any medicine that the doctor has not prescribed, such as aspirin, allergy tablets, cold medication and so on. Explain that non-prescription drugs and prescription drugs can interact and cause harmful side effects. Emphasize that he should not take other medicines without his physician’s approval.

It is very important to ask if the patient is taking any herbal preparations, vitamins, minerals or dietary supplements (including weight-loss products or nutritional supplements). These agents can cause harmful interactions with each other, alone, and with prescription and non-prescription drugs.

**Assessment tip:** Provide simply written instructions about what medications the patient is taking, their actions, when and how to take them, common side effects and what to do if side effects occur. If necessary, a family member or friend should be involved to help the patient adhere to his medication regimen.

After determining what medications (including non-prescription, vitamins, herbs, minerals and so on) the patient takes, if he knows how and why to take them and the possibility of side effects, consider the physiological alterations in the body of the older adult that impact on medication effectiveness.

The body’s ability to metabolize drugs and use them most effectively decreases with age. Here are some aging body changes that influence the effectiveness of medication in the geriatric patient.9,14

- **Body water content:** As the body ages, there is as much as a 15 percent decrease in water content and an increase in body fat. The extra fat means that the effects of fat-soluble drugs may be increased, and the reduction in water content means that water-soluble drugs exist in more concentrated amounts.
- **Liver functioning:** Hepatic (liver) blood flow, liver mass and liver metabolic activity may decrease with age. It is important that liver functioning be assessed if the patient is taking drugs that are metabolized by the liver or if taking drugs that have the potential to damage the liver.
- **Renal functioning:** Renal function also decreases with age, but this decrease varies considerably among older adults. Since the kidneys excrete most drugs, it is important to be aware of kidney functioning and remain alert to possible build-up of potentially toxic levels of drugs.
- **Gastric functioning:** Aging causes a decrease in gastric motility and gastrointestinal absorption surface. These factors may cause a decrease in or delayed absorption of acidic drugs.
- **Vision changes:** Age-related reduction in visual acuity may make it difficult for older adults to read drug labels, thereby increasing the risk for taking the wrong medication.

**Assessment tip:** Be sure to include socioeconomic factors when assessing pharmacology factors in elderly adults.

**Sexual Assessment**

**Mr. Grimes, a 78-year-old retired construction supervisor, arrives at his physician’s office for a routine checkup. His blood pressure is unusually high, despite the fact that he was prescribed anti-hypertensives several months ago. When questioned, Mr. Grimes says he “only takes my blood pressure pills a couple times a week.” When asked why, he explains, “Since I’ve been taking those things, I can’t satisfy my wife. When I don’t take them too often, things are better.” Medication side effects can include sexual dysfunction. Such side effects must be discussed with patients at the time of prescription.**

Sexuality and sexual functioning are life-long issues for all persons. Health care professionals sometimes forget or disbelieve that these issues are important to geriatric patients. Research shows that interest in sex and sexuality continues throughout the life span.1 Therefore, it is important that sexual assessment be part of the physical assessment of older adults.

First, be aware of changes in the reproductive tract that occur with aging. In men, sperm production and testosterone levels decrease. The time needed to become aroused and to ejaculate increases, and the refractory period lengthens. The firmness and force of ejaculation decreases.9 Oral medications for erectile dysfunction, such as sildenafil (Viagra) and tadalafl (Cialis) are often able to compensate for normal age-related changes in the sexual functioning in men.11

In women, as estrogen levels decrease, the thickness, elasticity and lubrication of vaginal tissues decreases.8 These changes may cause intercourse to become painful. Women may avoid sexual intercourse due to such pain. The use of vaginal lubricants can help alleviate dryness and reduce discomfort.11

Glandular tissue in the breasts decreases, and there is an increase in the amount of time it takes for arousal to occur.8 The vagina shortens, labia atrophy and the cervix may descend into the vagina, which causes discomfort. Orgasms may become less intense and less gratifying. Additionally, post-menopausal women generally return to pre-arousal state more quickly than younger women.11

In addition to normal age-related changes, cardiovascular disease, depression and diabetes have been associated with sexual dysfunction and/or a decrease in libido.12 Persons with these conditions should receive sexual counseling as necessary.

Nurses must also be aware of medications that may cause sexual dysfunction. These include certain types of antihypertensives, selective serotonin reuptake inhibitors (SSRIs) used to treat depression, and beta blockers.13 When performing a pharmacologic as well as a sexual assessment, be sure to explain the potential for these types of side effects.

Sexual assessment requires that a nurse asks patients questions that are highly personal and intimate in nature. If a nurse is uncomfortable with such an assessment, she/he will most likely transmit this discomfort to the patient. The more confident and comfortable the nurse is with sexual assessment, the more at ease will be the patient.11 The nurse must maintain an objective, non-judgmental attitude and conduct the assessment in a quiet, private area.

One framework that may be used when conducting a sexual assessment is the PLISSIT model.11 (To view an online video of a nurse demonstrating the use of the PLISSIT model visit [http://links.lww.com/A277].)

The first step in the model is P: To seek permission to begin the sexual assessment. Asking for permission helps to preserve the patient’s dignity and to allow him some control over the assessment process. You might begin by asking the patient, “Mr. Grimes, would it be all right if I asked you some questions about your sexual health?”11 After permission is obtained, you could proceed by asking, “What kinds of changes have you noticed in your sexual health since you began taking your heart medication?” Make the questions pertinent to your patient’s situation. If appropriate, you might ask the patient if he would like his sexual partner to take part in the discussion. Respect his response, whether it is “yes” or “no.”

The next step is to provide limited information (LI).13 For example, if specific medications are linked to the patient’s sexual difficulties, information about medication side effects could be provided. Other types of limited information might include discussing normal age-related changes in the reproductive system or the effects of certain diseases on sexual functioning.

Next, offer specific suggestions (SS).11 This means that you will offer specific suggestions tailored to your patient’s situation. For example, if sexual dysfunction is related to painful intercourse due to vaginal dryness, you could
The stages of sleep can be described as stage.

Stages one through four comprise the period of non-REM sleep and last from 90 to 120 minutes. Each stage lasts from five to 15 minutes. REM sleep is characterized by rapid respiration, increased heart rate and blood pressure, increased brain activity, rapid eye movements and temporary paralysis of limbs. REM sleep is also referred to as dream sleep because dreaming takes place during this stage. It is believed that REM sleep is necessary for psychological restoration, learning, memory and concentration during the day. This stage occurs in cycles about every 90 to 120 minutes following the first four stages. The percentage of time spent in REM sleep is greatest during infancy and early childhood and decreases during adolescence and young adulthood with greater increases occurring in old age.

**Sleep assessment in the older adult**

A common mistaken belief is that the need for sleep decreases with age. In fact, the elderly adult needs about the same amount of sleep as he did as a young person and in middle age. The majority of older adults need between six and 10 hours of sleep each night. Research shows that less than four or more than eight hours of sleep is associated with mortality rates that are higher than those of persons sleeping eight hours.

When asking the older adult about his sleep patterns, try to avoid “yes” and “no” questions, because these usually do not elicit enough helpful information. For example, if you ask, “Do you have trouble sleeping?” many older adults will simply say “no.” Here are some suggestions for phrasing questions when assessing sleep patterns.

- **“What time do you usually go to bed?”**
- **“What time do you usually get up?”**

These questions will give you an idea whether the patient goes to bed and gets up at about the same time each day. A regular bedtime and awakening time is associated with better sleep patterns. Asking the patient “How many pillows do you sleep with?” is better than asking the patient “Do you need a lot of pillows to sleep?”

- **“How many times do you wake up during the night?”**
- **“What causes you to wake up?”**

This is better than asking the patient whether he sleeps through the night. It requires the older adult to think about his answer. He may assume it’s normal to wake up frequently during the night. If he does, this may indicate a health problem.

- **“How many times do you wake up to go to the bathroom during the night?”**

The answer to this question can indicate various problems, such as incontinence, enlarged prostate in men or anxiety.

- **“What kinds of things help you to sleep at night?”**
- **“What kinds of things prevent you from sleeping at night?”**

The answers to these questions may provide you with clues to specific physical or mental health problems. For example, a patient may tell you that some nights he wakes up gasping for air or coughing, indicating a possible cardiovascular or nervous system problem.

- **“How many naps do you take during the day?”**
- **“How long do you nap?”**

Frequent naps or lengthy naps can disrupt a person’s nighttime sleep patterns.

The preceding questions are a good baseline for questioning older patients about their sleep. Become familiar with some of the more common sleep problems and how they impact the elderly patient’s ability to obtain a good night’s sleep. It is estimated that about 5 million older adults in the United States have a serious sleep disorder.

Some of the more common problems include the following issues:

- **Anxiety and depression.** These issues can interfere with a person’s ability to fall asleep and/or stay asleep.
- **Substance abuse.** Abuse of alcohol, prescription drugs and/or illegal drugs can profoundly disrupt a person’s sleep patterns.
- **Excessive intake of caffeine.** Excessive intake of caffeine, especially in the evening, can prevent a person from falling asleep or staying asleep.
- **Pain.** Older adults may deal with chronic pain issues. Pain may be due to arthritis, cancer, nervous system disorders, and so on. Elderly patients who are in physical discomfort take longer to fall asleep, stay asleep or find a comfortable sleeping position.
- **Cardiovascular disease and respiratory disease.** These types of diseases may cause orthopnea and shortness of breath. Asking the patient “How many pillows do you sleep on at night?” gives you an indication that he needs to sit up or be propped up to sleep without having difficulty breathing.
- **Dementia.** Older persons with dementia experience more sleep problems than other older persons. Sleep is often fragmented, and nighttime wandering may occur.
- **Urinary issues.** Frequency, nocturia and urgency commonly occur in older adults and increase with age. Older men may experience benign prostatic hypertrophy, which prevents the bladder from emptying completely and often causes the sensation of constantly feeling the urge to void. These issues are compounded by the decreased bladder capacity of the elderly.
- **Sleep apnea.** Sleep apnea is an intermittent, temporary pause in breathing during sleep. This can occur many times throughout the night and lasts about 10 seconds each time it occurs. These interruptions in breathing can lead to hypoxia. Research shows that older adults who suffer from these kinds of hypoxic episodes are more likely to experience sudden death, stroke, angina and exacerbating hypertension.

Patients and their sleep partners should be questioned about the occurrence of the signs and symptoms of sleep apnea, which include heavy, loud snoring; choking, coughing or struggling to breathe while sleeping; extreme sleepiness during the day, headaches in the morning and trouble concentrating.

- **Medications.** A number of medications can interfere with sleep patterns. When providing
pharmacology patient education as well as assessing sleep and rest, be sure to familiarize yourself with medications that may disturb a patient’s sleep. Some drugs commonly associated with sleep interference include decongestants, antihistamines, beta-blockers and beta-agonists.8,14

**Assessment tip:** Some antidepressants, such as Elavil and Sinequan, can have sedating effects and should be taken in the evening. But antidepressants such as Zoloft and Paxil have stimulating effects and should be taken in the morning.8

**Pain assessment**

Pain assessment should be part of the assessment of all geriatric patients. Older adults often live with chronic illnesses and disorders that cause varying degrees of pain. They may also experience more acute types of pain that follow trauma or surgery.

Research shows that about 25 percent-50 percent of older adults who live in the community suffer from some type of pain. That percentage increases to 45 percent-80 percent for older adults who live in long-term care facilities. Research also indicates that older adults are often undertreated for both acute and chronic pain, and some live with untreated pain every day of their lives.9

Why is pain undertreated? Some reasons include:2,9

- Some health care professionals may be unaware of the prevalence of pain in the older population or may think that some degree of pain is “normal” in the geriatric population.
- Failure of older adults to report pain. They may believe that pain is a “normal” part of the aging process and that nothing can be done to alleviate it. Some older adults may believe that taking pain medication is a sign of weakness or are afraid of becoming dependent on pain relief medications.
- It is difficult to assess pain in patients who have difficulty communicating, such as those persons suffering from various forms of dementia or following a disorder that affects communication, such as stroke.

**Assessment tip:** Some older adults may not believe that they have pain, but may admit to discomfort or other unpleasant sensations. When assessing for pain, do not only ask a patient, “Do you have any pain?” Also ask whether they have any discomfort, aching or soreness.

Pain may be either chronic or acute. Acute pain is due to surgery, medical procedures, injury or trauma. It is often self-limiting with appropriate treatment of the underlying cause. However, some acute pain may become chronic. For example, a back injury may initially cause acute pain, but damage may be severe enough to cause lingering effects.

Chronic pain is “ongoing” pain that is treated but not self-limiting. It may be related to disease processes such as cancer, neurological disorders, degenerative diseases, arthritis, osteoporosis and vascular disease. Older adults (or any adult for that matter) who suffer from chronic pain need a thorough pain treatment plan that not only addresses pain relief but the social and emotional consequences of living with such pain as well.

**Assessment tip:** Persons living with chronic pain should also be assessed for depression. Chronic pain can limit mobility, social interaction, interfere with performance of activities of daily living and interfere with sleep and rest.8

There are a number of pain assessment techniques in use. Some require the use of numeric pain rating scales while others rely on pictures that illustrate various degrees of pain. Important issues for the nurse to address when conducting a pain assessment include the following:

- Ask the patient to describe the pain, aching, or soreness he is experiencing. For example is the pain sharp or dull? Is it constant or intermittent? Is it burning or “squeezing”? Does it cause any lack of sensation? Does it cause tingling, numbness, or “pins and needles” feelings? Does the pain stay in one spot or does it radiate?
- When does the pain occur? Is it worse at specific times during the day or at night? If so, what is the patient doing or what is happening in his environment when the pain becomes worse?
- What makes the pain better or less uncomfortable?
- What makes the pain feel worse?
- Are there any other symptoms that occur with the pain, such as nausea or vomiting?
- Does the patient take any medications for his pain? What are they and how often does he take them? How well do these medications work to control your pain? Be sure to ask about ALL medications including prescription, over-the-counter, herbal preparations, minerals, vitamins and other supplements. Remember that some patients don’t consider items such as herbal preparations, minerals, vitamins and over-the-counter drugs as “medicine.” Are the medications causing any side effects?
- Does the patient do anything specific to relieve his pain (in addition to medication)? Some patients may drink alcohol or take other drugs (including illegal drugs) to relieve pain. Others may use remedies such as warm milk to induce sleep, relaxation tapes, meditation or prayer. How successful are these interventions?
- What does pain mean to the patient from a cultural and/or religious viewpoint? For example, some patients may believe that pain is punishment for misdeeds. Some cultures value stoicism when confronting pain while others are quite emotionally vocal about expressing pain. Remember to remain objective and respectful of a patient’s cultural and religious beliefs about pain and how it is dealt with.

Many patients may be able to participate in completing pain assessment scales. A numeric pain rating scale generally consists of a scale of 0-10 with 0 indicating no pain and 10 indicating the worst possible pain. The degree of pain worsens as the numbers increase.9 This type of scale requires that the patient be able to understand your explanation of the scale, correlate his pain to a numeric value, and communicate this correlation to you.

A verbal descriptor scale is one that requires the patient to describe his pain from “no pain,” to “mild,” “moderate,” “severe,” or “as bad as the pain could be.”9 This requires that the patient be able to understand the descriptive terms used and be able to correlate the terms with his pain, and describe his pain using the given terms without the benefit of visual cues.

A pictorial scale such as the Faces Pain Scale requires that the patient select a visual depiction of pain. For example, the patient is asked to look at a number of different faces that range from a face with an expression of calm or contentment to faces that look increasingly uncomfortable. The patient chooses the face with the expression that best “fits” his current pain experience.9 This scale does not require the patient to express himself using specific descriptive terms or to understand specific descriptive terms.

**Assessment tip:** A family member, friend or reliable caretaker should be involved in the pain assessment if patients are unable or reluctant to communicate their pain experience.

But what about patients who are unable to understand verbal or visual communications, such as the patient suffering from dementia? Researchers are working to develop valid and reliable pain assessment tools for use with patients suffering from dementia. One such tool is the Pain Assessment in Advanced Dementia (PAINAD) scale, which relies on direct observation of five behavioral indicators of pain.2

An overview of the five behaviors used to assess pain includes:2

- **Breathing** (does not include mechanical ventilation): Ranges from a score of 0 for normal breathing, a score of 1 for occasional labored breathing or short periods of hyperventilation, to a maximum score of 2 for noisy, labored breathing and prolonged periods of hyperventilation.
- **Negative vocalization:** Ranges from a score of 0 for none, a score of 1 for occasional moaning or groaning, to a maximum score of 2 for loud moaning or groaning, crying, or calling out.
- **Facial expressions:** Ranges from a score of 0 for no expression or an expression of calm or smiling, a score of 1 for frowning or expressions of sadness, to a maximum score of 2 for facial grimacing, frowning, scowling, etc.
- **Body language:** Ranges from a score of 0 for a relaxed body posture, a score of 1 for tenseness, fidgeting, or, if ambulatory, distressed pacing, to a maximum score of 2 for rigid body posture, clenched fists, pushing
or striking out, and/or pulling knees up towards chest.

- **Consolability:** Ranges from a score of 0 for needing no consolation, a score of 1 to the need for reassurance by touch or tone of voice, to a maximum score of 2 for being inconsolable.

Scores for each category are totaled with scores ranging from a minimum total of 0 to a maximum total of 10. The higher the total number, the more severe the pain. The Harford Institute for Geriatric Nursing Web site offers a detailed explanation of the scale and may be accessed at www.ConsultGeriRn.org. Specific information about the use of the scale may also be found in the publications of the American Medical Directors Association.¹⁸

A comprehensive pain management treatment plan is important for anyone dealing with pain. A number of complementary and alternative therapies are being used with increasing frequency. These include acupuncture, herbal supplements, massage therapy, chiropractic care, Yoga, meditation, relaxation therapy, biofeedback, and, in some cases where not prohibited, exercise. Any and all complementary and alternative therapies should be initiated and maintained only under the supervision of the patient’s primary health care provider.

Most patients dealing with pain participate in some type of medication regimen. Be aware of and help the patient and family prepare for and deal with some common side effects of analgesics.

- Some analgesics, particularly opioid analgesics, slow the intestinal tract and can lead to constipation. Stool softeners, adequate fluid intake, and fruit and vegetable intake should help to alleviate the problem of constipation.⁹,¹⁴
- Nausea and vomiting are also fairly common side effects, and an antiemetic may be prescribed for these types of adverse occurrences. Some analgesics cause drowsiness and sedation, and patients should be cautioned against activities that require alertness. In severe pain, morphine may be administered, and pruritis is often associated with its administration. Antihistamines are effective in combating pruritis, but may also cause sedation as a side effect.⁹,¹⁴
- When assessing mental health, be sure to evaluate the patient for mental health and cognition.

**Assessing mental health**

Mental health and well-being is as important to the older adult as it is to any other population. Unfortunately, some mental health issues, such as depression and anxiety, may be overlooked in elderly adults. The signs and symptoms of these and other mental health problems may be mistakenly attributed to the aging process or dementia, and as a result, a thorough assessment is not done. In fact, only about half of older adults with mental health problems actually receive appropriate mental health services.¹⁹

**Assessment tip:** When assessing mental health, be sure to evaluate the patient for mental disturbances related to medication side effects. Sometimes adverse occurrences are related to alterations in mental status.

Some health care professionals may hold the mistaken belief that older adults suffer from mental health problems more than younger adults. Actually, older adults demonstrate fewer diagnosable psychiatric disorders than younger persons with the exception of cognitive problems such as Alzheimer’s disease, which show age-related increases.⁹ Some experts bemoan the fact that many health care professionals are more concerned about a broken bone than a “broken spirit.”¹⁷

The geriatric population can experience a number of mental health problems, just as younger persons do. Although some problems may develop in old age, others may have begun earlier in life (e.g. depression, obsessive-compulsive disorder). Let’s look at the normal aging changes that influence mental health and cognition and review some mental health and cognition problems and how they can be identified in the older adult.

**Normal age-related changes in mental health and cognition**

An older adult’s mental health and cognition stay comparatively stable. The alterations that do take place are usually not dramatic enough to cause major problems with activities of daily living. Serious changes and abrupt loss of cognition usually indicate a physical or mental disorder such as Alzheimer’s disease or stroke.⁹ Some normal age-related changes in mental health and cognition include the following:⁹

- The speed with which information is processed decreases with age. This means that older adults take a longer time to learn new information and require that information be repeated.
- The ability to deal with multiple tasks slows.
- The capability with which the older adult can maintain attention and ignore unimportant information decreases with age.
- The use of language is maintained, but word finding and naming ability decreases with age.
- The ability to use abstract thought and demonstrate mental flexibility are associated with some decline as a person ages.
- The ability to acquire practical experience and wisdom continues until the end of life.

**Grief and bereavement**

Geriatric patients generally must deal with the loss of loved ones, including spouses, siblings, parents and others. Grief is considered to be a normal response to such losses within a two-year period. Grief that lasts longer than two years is considered to be pathological. However, the length of grief varies with cultural norms. The American Psychological Association’s standard of care concerning grief in the older adult encourages the health care professional not to focus on time, but on the way grief is presented. Profound depression, extensive guilt, overwhelming senses of loss, preoccupation with death, difficulty performing activities of daily living and social incapacitation indicate pathological grief and require medical intervention.⁹

**Depression**

While the prevalence of major depression declines with age, symptoms of depression increase. Eight to 20 percent of older adults living in the community and up to 37 percent in primary care settings experience depressive symptoms.¹⁹ Depressive symptoms are often associated with chronic illness and pain.⁹

Older adults suffering from depression often report numerous somatic complaints, including chronic pain. They may not consider themselves depressed and focus on physical rather than mental symptoms.⁹

**Assessment tip:** Older people may feel that it is a sign of weakness to report feelings of depression. They may believe it is more “acceptable” to have a physical illness, thus the focus on physical complaints. Your first clue to depression in older adults may be the reporting of somatic complaints.

A number of tools for the assessment of geriatric depression are available. One such tool is the Geriatric Depression Scale, which consists of 30 questions (a shortened 15-question version may
also be used) that can be answered with “yes” or “no.” Examples of questions include:

- Are you basically satisfied with your life?
- Do you feel full of energy?
- Do you feel happy most of the time?
- Do you think that most people are better off than you are?

Criteria for major depression as noted in the Diagnostic and Statistical Manual of Mental Disorders–IV–TR\(^9\) include:

- Depressed mood or loss of interest or feelings of loss of pleasure.
- Symptoms must last for at least two consecutive weeks and indicate a change from previous mood and functioning.
- At least five of the following: depressed mood, changes in sleep patterns, reduced feelings of interest or pleasure, feelings of guilt or worthlessness, loss of energy or fatigue, inability to concentrate, changes in weight or appetite, psychomotor agitation or retardation, and suicidal thoughts.

The incidence of depression is twice as high in older women than in older men. Some of the possible reasons for this difference is that older women are more likely to experience loneliness, financial problems and a reduction in independence cause by functional disabilities.\(^9\)

**Assessment tip:** Depression is a major risk factor for suicide. Adults age 65 and older have the highest suicide rates of all age groups. Suicide is highest among Caucasians, followed by Asians, Hispanics and non-Hispanic blacks. Older adults suffering from alcoholism have a greater risk for suicide as well. Nurses must not only assess for depression but for suicidal ideation!\(^9\)

When evaluating elderly patients for depression, be sure to check on the potential for depressive side effects of certain medications. Medications that can cause depression include:

- Antihypertensives, such as reserpine.
- Hormonal replacement therapy, including estrogen and progesterone.
- Cardiac agents, such as digitalis.
- Analgesics, such as codeine.
- Anti-anxiety agents, including diazepam.

**Dementia**

Dementia is a syndrome that leads to a decline in multiple cognitive abilities. The presenting signs and symptoms range from mild cognitive impairment to complete incapacitation.

Dementia is both chronic and terminal, because the syndrome progresses to causing the patient to become completely dependent in all aspects of activities of daily living. There is no consistent course, and the rapidity with which the disease will progress cannot be predicted.\(^9\)

According to the Diagnostic and Statistical Manual of Psychiatric Disorders – Text Revision (4th edition)\(^9\), the diagnostic criteria must include both a decline in memory and at least one of the following:

- The ability to understand spoken or written language and to generate understandable speech.
- The ability to recognize or identify objects (assuming such ability is not impaired by other disease processes).
- The ability to perform motor activities (assuming such activities are not impaired by other disease processes).
- The ability to think abstractly, make appropriate judgments, and plan and execute complex tasks.
- The decline in cognitive ability must be of a severity to interfere with normal activities of daily living.

There are a number of types of dementia, with the most common being Alzheimer’s disease (AD). It is responsible for about 50 percent to 70 percent of cases and has a subtle onset. The exact etiology of AD is unknown, but researchers believe that genetic and environmental components may play a role in its development.\(^9\)

There are three stages of dementia: mild, moderate, and severe. Six aspects of cognition are evaluated to determine staging. These six aspects are memory, orientation, judgment and problem solving, community affairs, home and hobbies, and personal care. Diagnosis is based on assessment of these aspects because there is not a definitive diagnostic study or studies that can confirm diagnosis.\(^9\)

Treatment is aimed at slowing the progression of the dementia and improving cognitive function. Medications such as Namenda and Exelon are currently used to treat cognitive impairment. Alternative therapies, such as ingestion of ginkgo biloba and various vitamins and minerals, are under investigation.\(^9\)

**Assessing for elder abuse**

Mrs. Dash is an 80-year-old female who lives with her daughter, son-in-law and three grandchildren. She was recently hospitalized for a total hip replacement and infection of the surgical wound. After discharge, she returned to her daughter’s home. A visiting nurse arrives this morning to assess Mrs. Dash’s wound and perform a dressing change. Mrs. Dash lives in a self-contained apartment attached to the main house via a short hallway. Her daughter provides Mrs. Dash with housecleaning services and brings her meals three times a day. Mrs. Dash’s apartment is spotlessly clean. Mrs. Dash is dressed in a clean housedress, and is wearing make-up and jewelry. She does not make eye contact with the visiting nurse and has a sad expression on her face. Her daughter is present and interacts with the visiting nurse, asking if her mother is “healing.” She does not interact with Mrs. Dash. One of the grandchildren stops in to ask for a ride to a sports event. The grandchild does not interact with Mrs. Dash, but rolls her eyes and mutters something about “that old woman is more trouble than it’s worth.” Mrs. Dash’s daughter prepares to leave and casually says, “So long, Mom,” and leaves without looking back. Mrs. Dash looks at the visiting nurse and says sadly, “They take care of me, but no one really cares about me. There is no love. They don’t like me.” Mrs. Dash is suffering from emotional neglect, sometimes characterized as a form of elder abuse.

When nurses hear the term “elder abuse,” they often picture an older adult who is bruised, in poor physical condition and may be dressed in dirty clothing. But there are many forms of abuse, not all of them readily apparent. Elder abuse can take place in any setting: the patient’s home, an acute-care hospital or long-term care facility. It occurs among all socioeconomic groups. As nurses, we must be aware of the various types of abuse and how to protect the elderly adult from the effects of abuse.

**Physical abuse**

Physical abuse is defined as the use of physical force to intentionally inflict physical injury or pain. Actions such as hitting, pushing or shaking are forms of physical abuse.\(^7\)

Signs of physical abuse include bruising, fractures, abrasions, lacerations and cuts. But it can be difficult to distinguish accidental injury from physical abuse. The elderly adult’s skin contains only small amounts of subcutaneous fat, and blood vessels are thin and fragile.\(^9\) This makes the older person susceptible to accidental bruising, which can be difficult to distinguish from physical abuse. However, research shows that 90 percent of accidental bruising occurs on the extremities. Accidental bruises rarely, if ever, occur on the neck, ears, genitals, butts or soles of the feet.\(^22\)

Low bone density and the existence of osteoporosis place the elderly at high risk for fractures. To date, no particular pattern of abuse fractures has been identified.\(^22\) The location, frequency and health history of the older adult with fractures must be evaluated to identify suspected abuse.

When evaluating abrasions, lacerations and cuts, it is important to describe them accurately. Many nurses refer to any wound as a laceration. When documenting these kinds of trauma, it is important to be accurate.\(^22\)

- **Abrasion:** A scraping injury that can occur if the elder is pulled or dragged across a surface (e.g. a carpet) that abrades the skin.\(^22\)
- **Laceration:** Full-thickness splitting open of the skin with ragged edges that occurs when the individual is traumatized by blunt force.\(^22\)
- **Cut:** An incision made by a sharp object that has smooth, clean edges.\(^22\)

**Sexual abuse**

Sexual abuse is defined as any type of nonconsensual sexual intimacy.\(^9\) Examples include rape, molestation, sexual harassment, unwanted touching, sodomy, coerced nudity and nonconsensual explicit sexual photography. Signs and symptoms of sexual abuse include:

- Bruises around the genital area and/or breasts.
- Unexplained vaginal or anal bleeding.
- Unexplained occurrence of venereal disease.
or genital infections.
- Torn, stained or bloody undergarments.
- Elder’s verbal report of sexual abuse.

**Emotional or psychological abuse**

Emotional or psychological abuse is defined as infliction of distress, anguish or sadness via verbal and/or non-verbal acts. Examples of elder emotional or psychological abuse include yelling, threatening, swearing, name calling, insults, intimidation and humiliation. Other forms of emotional abuse include isolating the older adult from family and friends, preventing him from pursuing his regular social activities (e.g. attending church, visiting a senior citizen’s center), isolating him from others in the home, and/or giving the older adult the “silent treatment” and not providing any affection. Signs and symptoms of emotional or psychological abuse include sadness, emotional upset or agitation, withdrawal and verbal reporting of emotional abusive behaviors.

**Neglect**

Neglect is defined as the failure to fulfill or refusal to fulfill obligations to an elder such as safety, shelter, affection, food, water, clothing, hygiene, medicine or comfort. Neglect may be on the part of a spouse, family member, friend or caregiver. Additionally, the elderly adult may also initiate self-neglect, which occurs when the elder himself disregards such needs as hygiene, food, safety and so on, because of mental or physical impairments or because he chooses not to take care of himself. Signs and symptoms of neglect include malnutrition, dehydration, poor personal hygiene, untreated health problems, unsanitary or unsafe living conditions, history of being left alone or choosing to be alone, and reports of being neglected.

**Abandonment**

Abandonment is the desertion of an elderly person by someone who is responsible for providing care to the elder or who has physical custody of the elder. In such cases, the elder is simply deserted or abandoned at a hospital (e.g. emergency department), long-term care facility, shopping center or other public location. In addition to being abandoned, the elderly adult may also exhibit signs and symptoms of other types of abuse.

**Financial or material abuse**

Financial or material abuse is defined as illegal or improper use of an older adult’s money, property or other assets. The person committing this abuse does so for personal or monetary gain or benefit. Examples of this type of abuse include unexplained disappearance of personal items, unusual withdrawals of money from savings or checking accounts, or changes in property ownership. As a result of financial losses, elders may not be able to pay bills or buy food and medicine.

**Risk factors for elder abuse**

Elder abuse can occur within all socioeconomic, cultural and intellectual groups. However, research shows that certain characteristics surface most commonly among abuse victims. These include:
- **Sex**: Women are more likely to be victims of elder abuse than men.
- **Age**: Victims of elder abuse are likely to be more than 75 years of age.
- **History of violence**: Victims of elder abuse are more likely to be prior victims of abuse, such as child abuse or spousal or intimate partner abuse. If the elder abuse victim was himself an abuser (e.g. abused his children), he is more likely to be a victim of elder abuse committed by those he abused in the past.
- **Functional status**: Elders whose physical and/or mental status is impaired are more likely to be abused.
- **Poor social network**: Elders who have fewer than three significant others are more likely to suffer abuse.
- **Economic status**: Elders who are poor are more likely to be abused.
- **Education**: Older adults who have less than an eighth-grade education are more likely to be abused.
- **Minorities**: Members of minority groups have statistically higher rates of elder abuse.

**Characteristics of abusers**

Some common characteristics of abusers include the following:
- **Sex**: Abusers are more likely to be men.
- **Substance abuse**: Abusers are more likely to have a history of substance abuse, including alcohol abuse.
- **Mental health**: Abusers are more likely to suffer from mental illness.
- **Family status**: Elders are more likely to be abused by members of their own families.
- **Social network**: Abusers have a poor social network and are more likely to be dependent on the elder for financial or shelter or other needs.
- **Caregiver stress**: Caregivers who are overwhelmed by the burden of caring for the older adult may end up abusing the person for whom they are caring.
- **Cycle of family violence**: Caregivers may have been abused by the elder they are now abusing.

**Screening for elder abuse**

Evaluate signs and symptoms that may indicate abuse. Monitor those who provide care for elderly adults. Do they show signs and symptoms of stress and difficulty coping? Is there a history of abuse in the elder or caregiver’s family?

There are a number of elder assessment screening tools available for use. The Hartford Institute for Geriatric Nursing recommends the Elder Assessment Instrument (EAI) as a screening tool in the clinical setting. This is a 40-item tool used to determine whether the elderly patient needs to be referred for suspected elder abuse. Elders are often reluctant to report abuse. They may be afraid of retaliation by the abuser. They may believe that they have done something to deserve the abuse or feel guilty about being an abuser themselves at some point in their lives. Abused elders may also be reluctant to report abuse if they are dependent on the abuser for care, shelter or financial help.

**Assessment tip**: The elder and the suspected abuser should be interviewed separately. This may reveal inconsistencies in reported histories or explanations of signs and symptoms of abuse. If the suspected abuser refuses to allow separate interviews, the suspicion of abuse increases.

Nurses must be aware of local elder abuse/ mistreatment reporting laws. Many states have mandatory reporting laws, and health care professionals must report suspected cases of elder abuse. Know your organization’s policies and procedures regarding the reporting of elder abuse, and familiarize yourself with contact information for local departments on aging and adult protective services. For state reporting numbers, visit the National Center on Elder Abuse Web site at www.nceaa.aao.gov or call the Eldercare Locator at 1-800-677-1116.

**Assessment tip**: You don’t need to prove that abuse is occurring. You do need to report your suspicions. The experts in abuse will follow up to investigate your suspicions.

**Overview of assessment of body systems**

Basic physical assessment techniques, such as inspection, palpation and percussion, are similar for all age groups. This overview of the assessment of body systems focuses on those issues that are particular to the geriatric population.

**Vision**

The first step in assessing the vision of an older adult is observation. Elderly persons who have stained clothing, poorly combed hair or excessive or poorly applied makeup may have vision impairment. A Snellen chart may be used to assess visual acuity, or you may ask the patient to read from a newspaper or other printed material with various size prints.

**Assessment tip**: Be sure that the patient is wearing his glasses or contact lens when assessing vision. Assess vision with and without corrective lenses. It is estimated that 92 percent of persons over 70 wear glasses, 18 percent also use a magnifying glass for close work, and 14 percent of persons 70-74 have difficulty seeing even with corrective lenses. Thirty-two percent of persons over 85 have trouble seeing even with corrective lenses.

There are a number of normal age-related changes pertaining to the appearance of the eye and vision. These include the following issues:
- The eyebrows gray and thin, as do the eyelashes. Skin around the eye wrinkles as subcutaneous tissue atrophies. Orbital fat decreases, giving the eyes a sunken appearance, and eyelids sag.
- The eye becomes less sensitive to feelings of pain and discomfort. This can cause the...
patient to be unaware of infections or injuries to the eye.

- The lenses thicken and harden, which reduces accommodation and brings a decrease in near-vision (presbyopia). The lens begins to appear “yellowish” and rather opaque. Visual acuity starts to decrease starting about the age of 50. This decrease becomes more rapid after the age of 70.

- The eye begins to lose its ability to adapt to changing degrees of light. Thus, as the adult ages, he needs more light to see objects in shadow or in dim light.

- The eye’s ability to adapt to a darkened room decreases with age. It takes more time for the eye to accommodate to darkness.

- The elderly’s pupils become sluggish as the pupils decrease in size and become less responsive with age.

**Assessment tip:** As always, include medication evaluation as part of your assessment. Some drugs, such as Tamoxifen and thiazide diuretics, can interfere with vision.4,9

There are several visual problems that are commonly seen in the older adult. Nurses must be aware of these problems and their signs and symptoms so that appropriate referrals may be made.

- **Cataracts:** Cataracts are the most common causes of correctable vision loss.22 A cataract is an opacity of the lens that develops gradually without pain. It decreases the amount of light able to reach the retina, thus inhibiting vision. The patient experiences painless, gradual blurring and loss of vision; may see halos around objects; and have difficulty distinguishing colors. The pupil of the eye appears hazy. Cataracts are the leading cause of blindness in the world. Surgery is the treatment of choice, and prognosis is usually good. Risk factors include increased age, diabetes, eye trauma, long-term use of corticosteroid medications, smoking and alcohol use, and Caucasian race.4,9,24

- **Glaucoma:** This is a group of disorders characterized by an increase in intraocular pressure (IOP) that can damage the optic nerve. Untreated glaucoma can lead to peripheral vision loss and blindness. Its onset can be slow and insidious (chronic open-angle glaucoma) or abrupt (angle-closure glaucoma), which is a medical emergency. Treatment includes medications and/or laser therapy. Risk factors include IOP; being older than 60 years of age; a family history of the disease; personal history of hypertension, diabetes, myopia, or migraines; and African-American ancestry.4,9,24

- **Age-related macular degeneration (ARMD):** ARMD is the leading cause of blindness in persons over the age of 65. It is the atrophy of the macular region of the retina. The dry form of ARMD is characterized by retinal pigment degeneration and is slow and progressive and associated with a mild vision loss. The wet form involves the leakage of blood or serum from blood vessels beneath the retina. It is not as common as the dry form but is responsible for the majority of severe vision loss associated with ARMD. The primary symptom is a change in central vision, such as distortion of straight lines or bland areas that appear in the center of printed pages. There is no treatment for the dry form, but the wet form may be treated with laser treatments or injections.4,9,24

- **Diabetic retinopathy:** This is a microvascular disease of the eye associated with diabetes. The ocular microvascular system is damaged, and transport of oxygen and nutrients to the eye is inhibited. Patients experience a gradual vision loss. Treatment consists of laser therapy.9

**Hearing**

Hearing loss is quite common in the elderly patient. It is estimated that more than 30 percent of older persons between 65 and 74 have some degree of hearing loss. This percentage increases to 66 percent in persons over 75. In addition to age, risk factors for hearing loss include smoking, history of middle ear infections, tumors, the buildup of ear wax and long-term exposure to loud noises.9

Normal aging changes that influence hearing include:

- The skin of the external ear wrinkles and sags.
- Cerumen is drier and harder and tends to accumulate in the ear more than in younger adults.
- Loss of nerves and sensory organs associated with hearing.

**Assessment tip:** When assessing hearing, be sure to assess for the presence of excessive ear wax, which may hinder hearing.

Hearing is assessed in the same ways as with other adult age groups. The use of a tuning fork and covering one ear and whispering two-syllable words toward the uncovered ear are two of the ways to assess hearing.

**Assessment tip:** As with all assessment evaluations, be sure to review the patient’s medications to determine whether any of them may affect hearing.

Tinnitus is a common problem in older adults. It is a ringing sound in the ear and can happen with or without accompanying hearing loss. The problem may be self-limiting or chronic. Tricyclic antidepressants may be prescribed as part of the treatment as well as relaxation techniques, biofeedback and counseling to deal with the discomfort.9

**Touch**

The sense of touch or physical sensation decreases with age. This is because nerve impulses are conducted at a slower rate in the elderly. There is also a reduction in the function of peripheral nerves. Medications used to calm or sedate may also contribute to a decrease in the sense of touch.9

These physiological changes lead to a decreased ability to perceive pain and temperature, which, in turn, can increase the risk for injury. For example, the older adult may not perceive the temperature of water in the bathtub or shower to be too hot, increasing the risk for burns. If the sense of pain is diminished, the elderly patient may not be aware that he has injured himself after falling or other types of blunt trauma.

The sense of touch is also important in conveying affection, and in some cultures, to communication in general. A loss of physical sensation may be detrimental emotionally as well as physically.

**Assessment tip:** Some diseases, such as diabetes mellitus, can cause peripheral neuropathies that add to the loss of the sensation of touch.9

One of the simplest ways to assess touch is to use a wisp of cotton. Patients close their eyes and are asked to indicate when they feel the sensation of touch. The nurse touches parts of the body, such as the face, the arms, the legs and the back. Additional techniques are to touch various areas of the body with a pin alternating with a wisp of cotton. The patient is asked to say whether he feels a sharp sensation (when touched with a pin) or dull (with the cotton wisp).5,24

Some nurses find it helpful to use objects of various sensations, such as sand paper, a piece of silk or fur and ask the patient if he feels a rough or a soft sensation. Tubes of hot and cold water may be placed against the patient’s skin as he is asked to state whether he feels a cold or a hot object.5,24

**Assessment tip:** Teach older adults to examine their skin, especially over bony prominences, the soles of their feet and between fingers and toes for open or broken areas of skin. Because of the decrease in the sensation of touch, open areas may not be noticed until they are severe and/or infected.

**The integumentary system**

The integument, or the skin, is the body’s largest organ and consists of three layers: the epidermis, the dermis and subcutaneous layers. The epidermis is the outermost layer of the skin and has up to five layers (depending on the specific part of the body). The dermis is the second layer of the skin, is made up of connective tissue, has an abundant blood supply, and lymph and neurosensory receptors. It supports and nourishes the dermis. The subcutaneous layer lies below the dermis, attaches to muscles and gives shape to the body and provides a protective cushion for bones and internal organs. There are also a number of accessory structures that are part of the integumentary system. These are the hair, nails, sebaceous glands (which produce sebum for skin lubrication) and eccrine glands that produce sweat.4,9

The skin is very important to health and wellness. It is responsible for:

- Regulation of body temperature.
- Regulation of body fluids.
- Provision of a barrier to infection and promotion of the immune system.
Hair and nails

The epidermis: The epidermis thins, and moisture is lost. The skin begins to have a dry and rough appearance. The rate of cell growth is decreased, which leads to an increased risk for infection. This decrease combined with a lack of moisture makes the skin more susceptible to damage. Liver or “age” spots appear and the number of moles and freckles may increase. The cosmetic aspects of these changes may have a negative impact on the older adult’s self-image and self-esteem.4,9

The dermis: Beginning in a person’s 30s, the dermis begins to decrease in thickness and effectiveness. The connective tissue decreases in function, which causes a loss of skin turgor that progresses with age. The capillaries thin, which leads to bruising. There is an accompanying reduction in sensation that increases the risk for injuries such as burns, infections and pressure sores.4,6

Subcutaneous layer of skin: This layer increases in some parts of the body and decreases in others, resulting in changes in fat distribution. It thins in the face, neck, hands and lower legs. With age, fat distribution becomes more pronounced in the abdomen and thighs in women, and in the abdomen in men.9

Hair and nails: The color of the hair becomes gray or white and becomes thin. There is a loss of axillary and pubic hair, and alopecia, or baldness, appears. Men generally experience more obvious loss of hair from the head than do women. Balding may have a significant impact on self-esteem. Men may also begin to experience the growth of facial hair on their faces. Nails become dull, and yellow or gray. They become thick and break or split easily.4,9

Damage from sun exposure: Persons who spend a lot of time in the sun, whether because of their occupations or simply from their desire to acquire a deep, dark tan, are at risk for a number of health problems, particularly skin cancer. It is estimated that more than 90 percent of skin cancers are related to exposure to the sun. The cumulative effects of years of sun exposure increase the amount of age-related changes, such as wrinkles and freckles, and often make people appear older than they really are.

Damage done by the sun is not reversible.9

Assessment tip: Some drugs increase a person’s sensitivity to sunlight. Some examples are antibiotics, antihistamines, antidepressants and antiarrhythmics. As always, educate patients about the risk for sun sensitivity if they are on medications that increase this problem.9

Skin cancer is a common problem among older adults. It is important that nurses recognize potentially malignant lesions and initiate appropriate follow-up and treatment. Skin cancer is the most common type of cancer in the United States. Its effects range from mild, easily curable lesions, to devastating, life-threatening malignancies.

Basal cell carcinomas: Basal cell cancer is the most common type of skin cancer in Caucasians. It is primarily due to sun exposure. Fortunately, if diagnosed early, basal cell cancer has a cure rate of 95 percent.9 When assessing the patient’s skin, be alert to the presence of basal cell cancers. This type of skin cancer can occur on any exposed surface of the skin, but is most common on the face, head, neck, nose, and ears.5

There are three types of basal cell cancers. They are:24

1. Nodululcerative lesions: Usually found on the face, these lesions are small, smooth, ink and translucent papules. As they grow, their centers become depressed with firm, elevated borders. They seldom metastasize, but if untreated they can become infected or lead to hemorrhage if they move into large blood vessels.

2. Superficial basal cell lesions: Commonly found on the chest and back, these cancers are oval or irregular in shape, lightly pigmented and have clearly defined, slightly elevated threadlike borders. They look scaly and may be mistaken for psoriasis or eczema. These lesions are associated with ingestion or exposure to arsenic-containing substances.

3. Sclerosing basal cell lesions: These lesions are waxy, yellow to white plaques and do not have clearly defined borders. They are most often found on the head and neck and appear in patches.

Report suspicious lesions for medical follow-up. Diagnosis is based on appearance and biopsy. Treatment involves careful excision and possibly chemotherapy and/or radiation, depending on the extent of the lesion.24

Squamous cell cancer is the second most common type of skin cancer in Caucasians and the most common type of skin cancer in persons with dark skin.9 It is an invasive tumor that has the potential to metastasize. Clues to the existence of squamous cell cancer are changes in existing skin lesions (e.g. moles, warts) or the appearance of a new lesion that ulcerates and fails to heal. This type of skin cancer, if diagnosed and treated early, has a high cure rate. But if it spreads, it can lead to disability or death.24

Squamous cell cancer often develops on the face, ears and dorsa of the hands and forearms. Risk factors for this type of skin cancer include sun overexposure or overexposure to X-rays, radiation therapy, chronic irritation of the skin, and ingestion of arsenic-containing substances. It is most commonly found in fair-skinned white men older than 60 years of age.24

Diagnosis is based on appearance and biopsy. Treatment includes excision, and if the tumor is extensive, radiation therapy, or possibly chemotherapy.

Malignant melanoma is the most serious of all skin cancers and is responsible for more than 75 percent of all deaths due to skin cancers. Melanoma lesions may grow from an existing mole or appear as a new lesion. In appearance, melanoma lesions grow and become brown, black or multicolored. They develop nodules or plaques with irregular black outlines. Melanomas may crust or bleed and are usually larger than 6 mm in diameter.9

Appearance and biopsy confirm diagnosis. These lesions are treated with surgical resection that may include removal of the lymph nodes. Chemotherapy may also be part of the treatment plan, depending on the size and extent of the lesion.24

Part of your assessment should include patient education regarding the prevention of skin cancers. Advise patients to avoid exposure to the sun, especially between the hours of 10 a.m. and 4 p.m. Sunscreen should be used year-round, and clothing should cover the arms and legs when spending time in the sun. A broad-brimmed hat should be worn to protect the face and scalp. Patients should perform regular skin checks to monitor the appearance of new lesions or changes in old ones. Be sure to explain the potential for photosensitivity that some medications can cause. Encourage that patient to have an adequate intake of vitamin D, because this vitamin may actually lower the risk of certain cancers.24

Older adults are also susceptible to skin breakdown and skin infections. Because of the fragility of the elderly person’s skin and decreasing sensation, older adults are at high risk for skin breakdown. A slight cut may go unnoticed until it becomes infected. Sitting or sleeping for long periods of time in one position may lead to redness and even breakdown of the skin over bony prominences. Persons who rely on wheelchairs for their mobility are at particular risk for skin breakdown over the sacrum and gluteal areas.

Teach patients how to prevent or reduce their risk for skin breakdown. Here are some points to include in your teaching.

Eat a nutritious diet. Proper nutrition helps all body systems to maintain a healthy balance.

Encourage adequate hydration. Older adults dehydrate easily and need adequate amounts of fluid. Discourage excessive intake of caffeine and alcohol.

Avoid sitting or lying in one position for extended periods. Change positions frequently. If using a wheelchair for mobility,
change your position by lifting the weight off the buttocks several times every hour.

- Massage bony prominences such as the heels, hips and elbows. Use moisturizing lotion. Use gentle motions. Vigorous massage may bruise or tear the skin. Avoid lotions with large amounts of perfume because these can further dry the skin.

- Examine the skin for reddened areas, cuts, abrasions, and lacerations. Seek medical attention for such areas that fail to heal, bleed, swell, become red and warm to the touch, or drain pus or foul-smelling discharge.

- Avoid having bath or shower water too hot. Older persons’ skin burns easily.

- Examine the skin for changes in moles, lesions, and freckles. Note any newly developing moles, lesions or freckles.

- Avoid wearing clothing that is too tight or too loose. Tight shoes can damage the skin. If shoes are too loose, they may rub up and down with walking, which can also cause skin irritation.

- Avoid wearing jewelry or watches that rub and irritate the skin.

**Assessment tip:** Help elders to identify a family member, close friend or caregiver to help perform skin examination and skin care as needed. It may not be possible to examine the entire body without help.

The cosmetic skin changes due to aging may cause a negative change in body image in the older adult. Monitor older adults for signs of depression or unrelied stress and anxiety related to appearance. Never assume that because a patient is “old,” he may not be concerned about his physical appearance. Remember that pride in appearance is a life-long trait and should be considered when working with patients of all ages.

**The cardiovascular system**

Cardiovascular disease is the No. 1 cause of death in the United States. Nurses, when assessing the geriatric patient’s cardiovascular system, should not only be alert to normal aging changes and pathology, but also to opportunities to teach patients ways to enhance their cardiovascular health throughout the life span.

Mr. Lewis is 80 years old. He is hypertensive, has an elevated cholesterol, and suffered a moderately significant myocardial infarction one year ago. He takes his medication on schedule but does not follow his recommended low-fat, low-cholesterol diet. Mr. Lewis arrives at his physician’s office for a routine check-up. His nurse performs the initial assessment and reviews his lab work, which indicates his cholesterol is still higher than normal, even though he takes his medication as prescribed. Mr. Lewis explains: “I eat bacon and eggs every morning. I’m not supposed to, but I’ve eaten bacon and eggs every morning for 60 years and I’m not changing now. Those egg substitutes are terrible!” Should the nurse reemphasize the importance of eliminating his morning breakfast eggs as recommended by the dietician? Or is there a compromise that can be reached with her geriatric patient?

This scenario illustrates one of the challenges of geriatric nursing practice. The nurse knows the clinical importance of adhering to his diet. But sometimes a compromise must be reached. As part of cardiovascular assessment (and patient education), the nurse must be able to work with, not in opposition to, her patient’s pursuit of health and wellness. Mr. Lewis may not be willing to eliminate eggs from his diet, but would he be willing to reduce the number of times a week he eats eggs? How much input has he had in his plan of care? What options has he been offered? Remember that the patient is the most important partner in the establishment of, and adherence to, an effective treatment plan.

**Age-related changes in the cardiovascular system**

It can be challenging to distinguish between disease pathology and normal aging changes in the cardiovascular system. A decrease in cardiac tolerance may be due to disease or simply an effect of the aging process.

However, age does not necessarily equate with cardiac health. A middle-aged person who eats a diet high in saturated fat, smokes and leads a sedentary lifestyle may very well have poorer cardiac functioning than an elderly person who has maintained an active lifestyle, exercises and eats a “heart healthy” diet. Here are some normal cardiovascular changes that are associated with aging.4,9

- Heart valves lose elasticity and stiffen, thus decreasing cardiac conductivity.
- Left ventricular wall thickens.
- Increased potential for postural hypotension.
- Increased risk for arrhythmias.
- Arterial elasticity decreases, which increases the risk for systolic hypertension and left ventricular hypertrophy.
- Increased risk for “silent” heart attack.
- Decreased blood perfusion to vital organs and the periphery of the body. This is due to arterial “stiffening,” and may make it difficult to palpate some peripheral pulses.
- Veins thicken, allowing for increased valvular reflux (backflow of blood) and increasing the risk for varicosities and dependency edema after sitting or standing for long periods of time.
- Decreased cardiac ability to handle stressful activities, such as shoveling snow.

**Assessment tip:** You may hear bruits (swishing or blowing sounds) over arteries such as the carotid arteries in elderly patients who have atherosclerosis. Pay special attention to this finding because there is a high incidence of stroke associated with bruits.4

Although the preceding normal aging changes must be acknowledged, nurses should not expect older adults to experience a debilitated cardiac system because of aging alone. By remaining physically active, not smoking, maintaining a normal weight, eating a healthy diet, and controlling blood pressure and cholesterol, geriatric patients can lead healthy lives and maintain a healthy cardiac status. However, chest pain, abnormal fatigue and significant sleep disturbances are not normal and may indicate cardiac pathology. Let’s review some of the more common cardiac problems seen in elderly persons: hypertension and myocardial infarction (heart attack).

**Hypertension**

About 25 percent of American adults have hypertension. Untreated, high blood pressure can lead to stroke, heart attack, blindness and renal dysfunction. It increases the workload of the heart, which can lead to heart failure and pulmonary edema.24

The National Institutes classify blood pressure based on stages as follows.1,24

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Diastolic</th>
<th>Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;120 mm Hg</td>
<td>&lt;80 mm Hg</td>
<td>Normal</td>
</tr>
<tr>
<td>120-139 mm Hg</td>
<td>Or 80 to 89 mm Hg</td>
<td>Pre-hypertension</td>
</tr>
<tr>
<td>140 to 159 mm Hg</td>
<td>Or 90 to 99 mm Hg</td>
<td>Hypertension Stage 1</td>
</tr>
<tr>
<td>&gt;160 mm Hg</td>
<td>Or &gt; 100 mm Hg</td>
<td>Hypertension Stage 2</td>
</tr>
</tbody>
</table>

**Assessment tip:** A systolic blood pressure greater than 140 mm Hg is a more significant cardiovascular disease risk factor than diastolic blood pressure.

If blood pressure readings indicate hypertension, make sure that the cuff size is appropriate for the patient’s arm circumference and that the cuff is properly applied. Check blood pressure in standing, sitting and supine positions. Ask the patient whether he drank beverages containing caffeine or if he is stressed or emotionally upset, which can cause an elevated reading. Do not initiate treatment based on one reading, especially if dietary or emotional factors influence readings.4,24

Patient education for older adults should include these items:24

- Maintain a healthy weight.
- Reduce salt intake.
- Stop or do not start smoking.
- Initiate a medically approved exercise program.
- Increase potassium, especially if taking potassium-depleting diuretics. Fruits and vegetables are good sources of potassium.
- Reduce stress. A consult concerning methods of relieving stress (counseling, relaxation techniques, etc.) may be necessary.

**Assessment tip:** Remember that the patient must be a partner in developing treatment regimens! His cooperation is essential if treatment and patient education are to be effective.
Heart attack
Most nurses are aware of the signs and symptoms of heart attack. Many patients are aware of them as well. Most clinicians and even laypersons think of crushing, substernal chest pain; jaw pain; pain that radiates to the left arm, neck, jaw or shoulder; sweating; nausea; vomiting; and some respiratory discomfort as typical presenting symptoms.23 However, these typical symptoms may not be present. In fact, women often present with atypical symptoms. Let's review the atypical symptoms as part of the assessment process because such signs and symptoms may not be as familiar as the typical symptoms.

Women and heart attack
After a woman experiences menopause, she is at as much risk as men. Women are typically older than men when they present with symptoms of cardiovascular disease. This is because, prior to menopause, estrogen seems to offer some protection against cardiovascular disease. Therefore, the earliest presenting age of symptoms is generally older, but this depends on the age of the woman when she experienced menopause.

One in four women die of heart disease in the United States. (One in 30 die of breast cancer). Twenty-three percent of women die within one year after having their first heart attack, and within six years of having a heart attack, approximately 46 percent of women become disabled with heart failure. About 66 percent of women who have heart attacks fail to make full recoveries.9 These statistics illustrate how important it is for older women to be assessed for heart disease. Part of this assessment is to identify those atypical symptoms of heart attack in women, who are more likely to experience:

- Indigestion or “gas-like” pain.
- Feelings of “tightness” in chest.
- Fullness or pressure in the chest.
- Discomfort in the back, neck, stomach or jaw.
- Dizziness.
- Shortness of breath.
- Nausea.
- Cold sweat.
- Unexplained feelings of weakness and extreme fatigue.
- Pain or discomfort between the shoulder blades.
- Sense of impending doom.

Women may also experience the typical symptoms the same as men. But their atypical symptoms are just as significant as those experienced by men. It is imperative that nurses teach their female patients about the symptoms women are likely to experience when having a heart attack. If they do not recognize signs and symptoms indicating a medical emergency, they may delay or refuse to seek help. In fact, findings from recent research show that women wait an average of 22 minutes longer than men to seek help when having a heart attack. This delay can cause serious complications, including death. The sooner treatment is initiated, the better are the chances of reducing damage to the heart and resulting complications.

In summary, cardiac status in older adults does not necessarily deteriorate enough to adversely affect health and well-being. Leading a “heart-healthy” life can promote cardiac wellness throughout the life span.

The respiratory system
As with the cardiovascular system, it can be difficult to distinguish normal age-related changes from pathology in the older person’s respiratory system. The following changes in lung physiology and structure occur with normal aging and can influence the effectiveness of respirations.9

- Decrease in lung elasticity, reducing the ability of the lungs to recoil.
- Decreased airway clearance, cough reflex and laryngeal reflex.
- Chest muscles are decreased in strength; chest wall stiffens.
- Ciliary action decreases, which increases the risk of respiratory infection as well as aspiration.
- Decreased ability of the lungs to respond to elevated levels of carbon dioxide.
- Immune system antibody production decreases, thus increasing susceptibility to lung infections.

Assessment tip: Smoking contributes to all forms of lung disease. Help patients to quit smoking. Be aware of smoking cessation programs that patients can access.

Here are some patient education items to help patients avoid or reduce the risk for lung disease:

- Stop smoking!
- Avoid contact with family and friends if they are ill.
- Wash hands frequently. Carry antibacterial hand wash and use it when in public.
- Receive the pneumonia vaccine if not contraindicated.
- Drink plenty of fluids to maintain hydration and keep lung secretions moist.
- Take 10 deep breaths every hour to expand lungs.

Let’s look at some lung diseases that are often found in older patients and treatment issues impacted by age.

Pneumonia
Pneumonia, an acute infection of the lungs, is among the leading causes of death in the United States.24 Prognosis is usually good for persons with normal lung function. However, age-related changes in the respiratory system can make it difficult for elderly patients to recover.

Currently the vaccination for pneumonia is recommended for all individuals aged 65 and older and for all adults who are dealing with chronic illnesses or have suppressed immune systems. The vaccine is about 80 percent effective, but effectiveness does decrease over time.9

Patients who are immobile after surgery, have limited mobility due to physical deterioration or who lead sedentary lifestyles are at risk for lung disease. Encourage patients to change position, become and stay ambulatory, and take frequent deep breaths. As always help patients access smoking cessation programs if they smoke!

Assessment tip: A word about influenza. Encourage elderly patients to be vaccinated against the flu annually. They may think that it is not a serious illness, but it can be fatal, especially in those of advanced age!

Chronic obstructive pulmonary disease
Chronic obstructive pulmonary disease (COPD) is chronic airway obstruction that is the result of emphysema, chronic bronchitis, asthma or any combination of these diseases.24 Smoking is probably responsible for more than 90 percent of diagnosed cases of COPD.9 Other contributing factors include chronic respiratory infections, air pollution and inflamed lung tissues.24 COPD also compromises cardiac function, placing strain on the right ventricle, which is responsible for pumping blood into the lungs.9 Older patients are particularly vulnerable to compromised cardiac function as a result of COPD.

The earliest clue to the presence of COPD is an early morning cough that produces clear sputum. Periods of wheezing may occur if the patient has a “cold.” As the disease progresses, shortness of breath develops and becomes progressively worse.9,24 The usual progression of COPD looks like this:

- There are usually no symptoms within the first 10 years after the patient starts to smoke.
- At about 10 years after starting to smoke, the patient develops a chronic cough that produces a clear sputum.
- At the age of 40 or 50, the patient begins to exhibit dyspnea.
- At about the age of 50, patients begin to be vulnerable to respiratory infections with progressively longer recovery times.
- As COPD progresses, shortness of breath occurs with the most minor activities, such as making a bed.

Assessment tip: Elderly patients who suffer from COPD often have calluses on their elbows. This is the result of leaning over tables to stretch out their upper body so that more air can enter and leave the lungs during respiration.9,22 Be alert for this sign. Watch for signs that your patient is attempting to stretch out his torso to facilitate breathing.

Lung cancer
Lung cancer is the most common cause of cancer deaths in men and women. The most current available statistics show that in 2004, lung cancer was responsible for more deaths than breast cancer, prostate cancer and colon cancer combined.9,24 Once more predominant in men, lung cancer rates in women are rapidly increasing as the incidence of female smokers increases.
Lung cancer is largely preventable. Smoking is the biggest risk factor for developing the disease. The pollutants in tobacco smoke cause progressive lung cell degeneration. Lung cancer is about 10 times more common in smokers than non-smokers, and 80 percent of patients with lung cancer are smokers.

Some older adults may think that they are more likely to return to smoking after they have quit. In fact, research shows that older smokers are much more likely than younger smokers to stay away from tobacco products. Older smokers also seem to know more about the health benefits of quitting smoking.

How can you help older patients to stop smoking? Here are some suggestions.

- Involve the patient’s family, friends and/or caregivers. It is not easy to quit smoking, and the support of significant others in the patients’ lives can be a big help.
- Find out if the patient lives with or has frequent contact with people who smoke. It is very difficult to stay away from tobacco products if constantly in the company of others who are smoking. If possible, the patient may be able to avoid the company of others who smoke.
- Consult with the patient’s physician or nurse practitioner about prescription and non-prescription aids for smoking cessation.
- Keep an objective, non-judgmental attitude. Stopping smoking is difficult, and feeling that nurses and other health care professionals disapprove of them or their behaviors only makes the process more difficult. Patients need encouragement and support to stop smoking.
- Find out about reputable smoking cessation programs in the community and on the Internet. Support groups can be very helpful. Many older adults often explore the Internet and seek out health information online. There are many excellent health resources on the Web. However, there are also many fraudulent, inaccurate sources of information. Familiarize yourself with websites that are good sources of information and support for those trying to quit smoking. Older adults who have limited access to transportation or who have limited mobility may rely on the Internet for information and communication with others. Be able to guide them towards reliable online sources of smoking cessation programs.

### Pulmonary embolism

Pulmonary embolism is not a disease but a complication of primarily hospitalized patients. It occurs when part of the pulmonary arterial bed is obstructed by a dislodged thrombus, an air bubble, or tissue fragment of lipids. Pulmonary embolism results in about 100,000 deaths every year and is the third leading cause of death in the United States. Symptoms of pulmonary embolism include rapid respirations, dyspnea, chest pain, hypoxia, decreased cardiac output and possibly shock.

Risk factors for pulmonary embolism include immobility, surgery, obesity, clotting disorders, dehydration, atherosclerotic changes in the elderly person’s circulatory system and atrial fibrillation. Many of these risk factors are found in the elderly population as part of normal aging changes. Teach your patients how to avoid this complication, especially if you know they are facing upcoming surgery.

- Teach and facilitate the patient’s ability to perform active range of motion exercises.
- If the patient is unable to perform active range of motion, teach caregivers how to perform passive range of motion exercises.
- Facilitate the administration of low-dose anticoagulant therapy.
- Implement compression stockings as appropriate.
- Encourage early postoperative ambulation.
- Teach patients to change position and move lower extremities frequently.

### Smoking cessation

Since smoking cessation is so critical to the prevention of and reducing the effects of lung disease, it is worthwhile to spend some time discussing ways to facilitate the process.

Some older adults (and some health care professionals as well) may believe that if they have smoked most of their lives, it will do no good to stop now. This is not true! The effects of smoking can actually begin to reverse themselves. If older adults stop smoking, their risk of heart attack, stroke and cancer goes down. Circulation improves and so does lung function. Eliminating tobacco products can also help to keep diseases such as COPD and bronchitis from getting worse.

### The endocrine system

The endocrine system is responsible for managing the body’s metabolic functioning. The endocrine glands manufacture and release hormones that trigger cellular responses and actions.

Normal age-related changes in the endocrine system include:

- Decreased pancreatic secretion of insulin.
- Decreased body sensitivity to insulin, which causes changes in blood glucose levels.
- The peripheral tissues of the body become resistant to insulin. This resistance is especially evident in persons who are obese.
- Changes in thyroid function that can cause systemic problems.

The normal age-related changes in the endocrine system most predominantly affect the body’s use of insulin and the ability of the thyroid to function. Therefore, let’s look at the effects of diabetes mellitus and thyroid malfunction.

### Diabetes mellitus

Diabetes mellitus (DM) is quite prevalent, and its incidence is increasing in people who are over the age of 65. This increase is especially evident in persons who belong to racial and ethnic minorities.

Type 1 DM is usually an autoimmune disease and most often affects children and young adults. Type 2 DM most often begins as insulin resistance because of changes in the endocrine system and is linked to old age, family history and obesity. The incidence of type 2 DM is increasing in the geriatric population.

### Risk factors for DM 2 include the following factors:

- Over 45 years of age: risk increases with age.
- Obesity.
- Inactive lifestyle.
- Hypertension.
- Family history of DM.
- Elevated cholesterol.
- Persons of African American, Hispanic, Pacific Islander, Asian American, and Native American origin.
- Impaired glucose tolerance.

Signs and symptoms include fatigue, polyuria, dehydration, thirst, poor skin turgor, dry mucous membranes and unexplained weight loss. Older patients with DM may most often exhibit the following:

- Excessive thirst: This is a cardinal symptom. However, older adults may not report excessive thirst because the thirst mechanism functions less effectively in older adults than in younger adults.
- Excessive hunger.
- Blurred vision.
- Vaginal infections.
- Frequent urinary tract infections in women.
- Skin infections.
- Difficulty healing.

**Assessment tip:** To help prevent urinary tract infections, encourage older patients to drink cranberry juice, which is believed to stop bacteria from sticking to the lining of the bladder.

The treatment regimen for DM in older adults is similar to that of younger adults. There are a few issues that deserve special emphasis in the older population, however. These include the following:

- **Meticulous foot care:** The older person must be taught (or his caregiver taught) to examine his feet for any open areas, cracks or evidence of compromised skin integrity. Feet should be washed and carefully dried every day. Special attention should be given to the areas between the toes, which are harder to keep dry. Socks should be changed daily and be kept clean and dry. Referral to a podiatrist is appropriate. Older persons with DM should not cut their own toenails because of the risk of cutting the skin of the feet, thus increasing...
the risk of infection and should visit a podiatrist regularly to have their toenails cut and feet evaluated. Shoes should be fit by someone who is familiar with the problems of DM. If cost is an issue, refer patients for financial counseling. Nurses should be aware of podiatrists in the community who make special arrangements for older persons in financial difficulty. Teach the patient never to walk barefoot.

- **Checking blood glucose:** Evaluate the older adult’s ability to perform blood glucose monitoring and evaluate the results. As necessary, teach other family members or caregivers to perform this task.

- **Medications:** Teach patients, families and/or caregivers about the medications the patient is taking and the potential for side effects.

- **Diet:** The dietician should be involved in helping the patient understand dietary implications. If the patient is unable to adhere to dietary restrictions, programs such as Meals on Wheels may be initiated.

- **Signs and symptoms:** Teach patients, family members and caregivers the signs of hyperglycemia and hypoglycemia and what to do in the event of occurrences.

- **Blood pressure:** Help the patient to adhere to blood pressure management regimen. If he is not hypertensive, teach him ways to avoid developing high blood pressure.

- **Exercise:** In conjunction with the patient’s physician, physical therapy and others, nurses must help the patient to design an exercise program appropriate for his state of health and wellness.

Management of DM is a lifelong endeavor. The nurse must help the patient, family and caregivers to adapt to the lifestyle modifications necessary for the maintenance (or achievement) of a maximum state of health and well-being. The elderly patient may have difficulty adjusting to some aspects of the ongoing nature of DM management. Physical limitations may prevent him from performing foot care or administering insulin, if needed. Nurses need to make sure that the patient has adequate resources and support systems to help him manage his care.

### Thyroid problems

The incidence of thyroid disorders increases with age. As a person ages, the thyroid slowly loses its ability to function and begins to atrophy. It becomes more nodular, and the occurrence of thyroid nodules and hypothyroidism increases significantly with age. The thyroid antibody levels rise with age, which makes it difficult to distinguish autogenous from external factors. Treatment of hyperthyroidism in older adults generally consists of ingesting radioactive sodium iodide instead of surgery. If treatment results in hypothyroidism, thyroid replacement therapy is initiated.

Hypothyroidism is rather common. Here are some points about hypothyroidism in the elderly population.9,24

- The older person who is diagnosed with hypothyroidism is typically a female over the age of 50.
- Older persons who have hypothyroidism present with fewer symptoms than do younger people. Generally, their symptoms are rather non-specific and can be attributed to a variety of other health problems.
- The symptoms of hypothyroidism most often noted in older people include mental deterioration, new patterns of incontinence, reduction in mobility and difficulty coping.
- Untreated hypothyroidism may lead to hypertension and hyperlipidemia, both of which are common in the elderly population. A life-threatening complication of untreated hypothyroidism is myxedema coma, a life-threatening medical emergency. In myxedema coma, mental confusion deteriorates to stupor and coma and significant electrolyte imbalances. Emergency intensive care hospitalization is required if this potentially lethal complication develops.

The goal of treatment of hypothyroidism in the older adult is to alleviate symptoms and return the thyroid-stimulating hormone (TSH) to normal levels. However, TSH replacement must be done with caution because an increase in levels may trigger significant cardiac problems.9

In summary, thyroid problems in the older patient are often difficult to diagnose. Presenting signs and symptoms may be subtle and mimic a variety of diseases and disorders commonly found in this population. It is important to rule out conditions such as heart disease and to determine whether two or more problems co-exist simultaneously.

Unfortunately, because of the vagueness of clinical presentation, thyroid disorders are often overlooked in the elderly patient. Nurses have excellent opportunities to serve as advocates for patients and to remain aware of the possibility of thyroid disease when they perform geriatric assessment. If thyroid disease is suspected, nurses should advocate for laboratory assessment of thyroid hormone levels.

Some of the nurse’s responsibilities include the provision of careful patient education. Patients will most likely be on some type of medication for the remainder of their lives. They need to understand the importance of taking their medication as prescribed. They also need to be aware of the signs and symptoms of hyper- and hypothyroidism. Patient education efforts should focus on disease management and adherence to treatment regimens.

### The hematologic system

The main function of the hematologic system is the ability of the circulating blood to transport oxygen and nutrients to the body’s internal organs and peripheral tissues and to remove carbon dioxide and waste products.9

There are a number of age-related changes that occur in the hematologic system. These include the following:9,24

- As the body ages, the bone marrow’s ability to manufacture red blood cells (RBC) swiftly in the event of blood loss or disease slows. This does not usually have a major impact on health and wellness unless the blood loss or disease process is extensive.
- Hemoglobin and hematocrit values are slightly decreased, but should remain within normal ranges.
- There is a reduction in the number of stem cells.
- There is a decreased production of intrinsic factor, which can trigger pernicious anemia.
- Cellular immunity decreases.
- The functional ability of the lymphocytes decreases.

The most common hematologic disorder is anemia. Although common in older adults, anemia is not a normal age-related change, contrary to what some health care professionals may believe. Anemia is a sign of disease, and if it occurs, it cannot be successfully treated until the underlying cause is addressed.9,24

Anemia exists when there is an inadequate amount of hemoglobin to meet the body’s needs. It is defined as a reduction in the number of circulating RBCs. This reduction can be due to loss of blood, an abnormally high rate of RBC destruction, or an inadequate or impaired production of RBCs.9
There are several types of anemia. Some of those most commonly found in elderly patients are as follows:

**Pernicious anemia**
Pernicious anemia is characterized by a decreased gastric production of hydrochloric acid and a deficiency of intrinsic factor. Factors that contribute to this problem are small bowel disease, infection, excessive use of antacids, overgrowth of intestinal bacteria and a strict vegetarian diet. The incidence of pernicious anemia increases with age. As people age, the body’s ability to absorb vitamin B12 diminishes. This vitamin is necessary for RBC growth. Signs and symptoms of pernicious anemia include:
- Cardinal signs of weakness, sore tongue, and numbness and tingling of the extremities.
- Lips, gums and tongue seem to be bloodless.
- Patients are quite vulnerable to infections.
- The sclera and skin may be jaundiced.
- GI symptoms may include nausea, vomiting, weight loss, diarrhea, flatulence and constipation. The tongue may become inflamed, and the gums may bleed.
- Neurologic symptoms: Weakness, poor coordination, ataxia, dizziness and loss of bowel and bladder control.
- Cardiovascular symptoms: Reduced hemoglobin levels, decreased cardiac output, rapid heart rate and arrhythmias.
- Musculoskeletal symptoms: Scissors gait may develop as a late sign if pernicious anemia goes untreated.

Pernicious anemia is treated with a high dose of parenteral vitamin B12 replacement therapy. This triggers rapid regeneration of RBCs. After hemoglobin levels return to normal, the body attempts to compensate for this destruction by increasing production of immature RBCs in the bone marrow. Hemolytic anemia becomes more common with aging. Infections, malignancies, trauma burns and exposure to toxic substances can cause this type of anemia. Drugs associated with its development include ibuprofen, aspirin, acetylsalicylic acid, and sulfonamides. The focus of treatment is folic acid supplements, because folic acid is depleted with increased bone marrow production of RBCs. Correction of underlying causes must also be accomplished. In addition to supplement administration, the patient’s diet should be rich in foods high in folic acid such as beans, nuts, whole grains and green leafy vegetables.

**Malignancies of the hematologic system**
Malignancies of the hematologic system are associated with overproduction of lymphoid and myeloid cells linked with bone marrow failure. They are characterized by the accrual of large numbers of white blood cells (WBC) in the bone marrow, liver, spleen, lymph nodes and central nervous system.

**Acute leukemia**
Acute leukemia is a proliferation of the precursors of WBCs in bone marrow or lymph tissue. They accumulate in bone marrow, body tissues and peripheral blood. With treatment, children between the ages of 2 and 8 have the best chance of survival (about 50 percent). Adults, however, generally survive about only one year after diagnosis, even with treatment.

Onset in children is quite dramatic. In older adults, the onset is more gradual, with presenting symptoms of weakness, pallor and acute confusion. The liver, spleen and lymph nodes are found to be enlarged upon palpation. Persons of advanced age have a poor prognosis. Treatment involves the administration of various combinations of drugs to inhibit WBC production. Bone marrow transplant is rarely initiated in persons over the age of 65. Infections are a leading cause of death in older patients, who, even with treatment, relapse within one year.

**Chronic lymphocytic leukemia**
Chronic lymphocytic leukemia (CLL) is a progressive disease that is common in the elderly. It is characterized by uncontrollable spread of abnormal lymphocytes in blood, bone marrow and lymphoid tissue. Almost all patients diagnosed with CLL are over the age of 50.

Typical symptoms include fever, fatigue, malaise and lymph node enlargement. As the disease reaches advanced stages, fatigue, weight loss, bone pain and liver or spleen enlargement become apparent. Treatment consists of chemotherapy and radiation. Curiously enough, early treatment is not associated with increased survival. Thus, treatment is not initiated in older persons until they manifest weight loss, night sweats, fever or enlarged lymph nodes.

**Non-Hodgkin’s lymphoma** is a malignancy of lymphoid tissue but is not diagnosed as Hodgkin’s disease. It is more systemic in nature than Hodgkin’s disease, and prognosis is usually poorer. Normal lymphoid tissue is replaced by cancerous cells. This compromises the immune system and leads to infections.

The first symptoms of the disease are usually swelling of the lymph glands, enlarged tonsils and adenoids, and painless, rubbery nodes in the cervical supraclavicular areas. Fatigue, malaise, weight loss, fever and night sweats may also be present.

The cause of non-Hodgkin’s lymphoma is unknown, but a viral link is suspected. Persons with impaired immune system abnormalities or those taking phenytoin seem to be at increased risk to develop the disease. Treatment includes chemotherapy and, in localized cases, radiation. Another option is the administration of monoclonal antibodies, specifically rituximab.

Both types of lymphoma may be curable, depending on the stage of the malignancy, with radiation and aggressive chemotherapy. However, older adults may not be able to tolerate such intense treatment. The geriatric patient may need assistance with activities of daily living as he undergoes treatment for the disease, which may take six months or longer.

Patients should also take every precaution to avoid infection. They should avoid crowds, and family members and friends who are ill, even...
with minor infections such as colds, should not come into contact with the patient.

**The nervous system**

The nervous system consists of two systems: the central nervous system and the peripheral nervous system. The central nervous system consists of the brain and the spinal cord. It is responsible for the integration of all nervous system activities.9

Parts of the brain include the cerebrum, the brain stem, the cerebellum, the limbic system and the reticular activating system (RAS).4 The cerebrum contains the nerve center that controls intelligence and motor and sensory function. The brain stem serves as the relay center for messages between the various parts of the nervous system. The cerebellum is responsible for maintaining muscle control, balance and coordination. The limbic system initiates the basic human drives such as hunger, emotional and sexual arousal and aggression. The RAS assesses all incoming sensory information and sends it to the appropriate areas of the brain for interpretation. It is also imperative for maintaining consciousness.4,9

The brain is divided into the right and left hemispheres, which are further divided into four lobes: frontal, temporal, parietal and occipital. It is important to know the functions of the various lobes because damage to one or more locations affects various body system functions.

- The frontal lobe is responsible for personality, judgment, abstract reasoning, some aspects of language (Broca’s area), motor function, problem solving, reasoning and memory.4,9
- The temporal lobe is responsible for language comprehension (Wernicke’s area), some memory recall and hearing.4,9
- The parietal lobe integrates sensory information such as temperature and taste. It also interprets, size, shape, texture and distance.4,9
- The occipital lobe interprets visual stimuli.4,9

The spinal cord reaches from the first cervical vertebrae to the lower border of the first lumbar vertebrae. The spinal cord is the major pathway for messages that travel back and forth between the brain and the body’s peripheral areas.4

The peripheral nervous system is composed of the cranial nerves, spinal nerves, the somatic and autonomic nervous system, and the reflex arc. There are 12 pairs of cranial nerves that transmit motor and/or sensory communications between the brain or brain stem and the head and neck.4

There are 31 pairs of spinal nerves that transmit messages to and from various regions of the body.4 The somatic nervous system functions as the link between the brain via the spinal cord to muscles and sensory receptors. The autonomic nervous system is responsible for maintaining homeostasis.9

It can be a challenge to differentiate between normal aging changes of the central nervous system and pathology. The impact of aging on the nervous system varies quite a bit among elderly adults. Experts recommend that health care professionals “not treat normal aging changes as disease. A common myth is that cognitive decline is inevitable.”9 There are some age-related changes in memory and attention, but older adults retain the ability to learn new things and live independently as long as neurological disease and pathologies do not occur.9

Here are some normal age-related changes of the nervous system.4,9
- Decrease in size and weight of the brain.
- Decrease in number of neurons.
- Decrease in short-term memory.
- Decrease in blood flow to the brain.
- Decrease in coordination.
- Decrease or absence of deep tendon reflexes.
- Decrease in responses and movements.
- Increase in pain threshold.
- Increase in incidence of physiologic tremor.
- Decreased reaction time.
- Sleep disturbances become more common, including insomnia and loss of REM sleep.
- Incidence of mood disorders and depression increase.

Normal age-related changes may mimic pathological changes. Here are some common diseases of the nervous system seen in elderly persons.

**Parkinson’s disease**

Parkinson’s disease is a chronic, progressive disease characterized by progressive muscle rigidity, involuntary tremor, akinesia and dementia. Complications include aspiration pneumonia, infection, injury from falls, urinary tract infections and compromised skin integrity. Parkinson’s disease in found in two out of every 1,000 people. It usually develops after the age of 50, but can occur in children and young adults.24

The cause of Parkinson’s disease is not known, but research suggests that exposure to environmental toxins or genetic predisposition may play significant parts in its development. Studies of the pathophysiology of the disease show that a dopamine deficiency inhibits the affected brain cells from functioning normally.23

There are no definitive diagnostic tests. Diagnosis depends on age, history and presenting signs and symptoms.4,9 Nursing assessment may be critical to the diagnosis of this and other diseases that occur in the elderly adult.

There is no cure for Parkinson’s disease. Treatment focuses on symptom relief and maximizing function for as long as possible. Drug therapy generally includes levodopa, a dopamine replacement; physical therapy; and in very severe cases, stereotactic neurosurgery or the controversial treatment of fetal cell transplantation.24

**Assessment tip:** Dosages of anti-Parkinson drugs may need to be decreased in elderly patients because of inability to tolerate higher doses of such medications. Patients must be taught to recognize medication side effects, such as orthostatic hypotension, irregular heartbeats, anxiety or confusion.24

**Transient ischemic attack (TIA) or “mini-stroke”**

Mrs. Stephens is 80 years old. She lives with her husband, who is 81 and dealing with prostate cancer. During an appointment with his oncologist, Mr. Stephens tells the nurse practitioner that he is worried about his wife. He says, “I think there might be something wrong with my wife. Sometimes she acts like she doesn’t know what’s going on. Her speech gets really funny, and she can hardly walk. It only lasts for a few minutes, and then she is OK. But I don’t think this is good.”

Mr. Stephens is right to be concerned about his wife. Transient ischemic attack (TIA), often referred to as a “mini-stroke,” is a neurologic deficit caused by microemboli that temporarily interrupt blood flow in the cerebral circulation. This interruption causes symptoms that correlate with the area of the brain affected and may include double vision, slurring speech, trouble walking, falling and dizziness. The effects last from seconds to hours and resolve spontaneously. There is not permanent damage from TIAs, but their occurrence is considered to be a warning sign of impending stroke. Incidence increases significantly after the age of 50 and is greatest among men and African-Americans.9,24

The occurrence of TIAs indicates a need for meticulous assessment and actions to prevent the occurrence of stroke.

**Cerebrovascular accident (stroke)**

Stroke is an abrupt impairment of cerebral circulation. This impairment interrupts the flow of oxygen to the brain, which can cause serious damage to brain tissue. Depending on the location and extent of damage, the patient can be left with serious disabilities that may affect all aspects of daily living.24

There are three major types of stroke.9,24

- **Thrombosis:** The most common cause in middle-aged and elderly adults, thrombosis causes ischemia in brain tissue affected by diminished circulation.
- **Embolism:** The second most common cause of stroke, embolism is due to the occlusion of a blood vessel by a fragmented clot, tumor, fat, or air.
- **Hemorrhage:** The third most common cause of stroke, hemorrhage is due to a sudden rupture of a cerebral artery.

Signs and symptoms depend on the location of the stroke and may include speech impediments, paralysis or weakness of the extremities, disorientation, vision disturbances, headaches, vomiting and coma.24

The sooner the patient receives emergency medical intervention, the better the chances for survival. Emergency administration of medications includes:24

- Tissue plasminogen activator to dissolve clots in non-hemorrhagic stroke. It must be
administered within three hours of symptom onset.

- The antiplatelet drug ticlopidine may be effective in preventing stroke and in reducing the risk for future strokes in patients who have already suffered one.
- Corticosteroids may be administered to reduce cerebral edema and anticonvulsants given to prevent seizures.

Patients will need long-term follow-up and rehabilitation.

Measures to reduce the risk for stroke include:

- Participate in a regular exercise program.
- Stop smoking.
- Monitor blood pressure and take anti-
  hypertensives as ordered.
- Reduce salt intake.
- Reduce the intake of saturated fats.
- Eat at least two servings of fish per week.
- Eat five or more servings of fruit and
  vegetables every day.
- Eat six or more servings of grain products
  every day.

**Seizures disorders**

Seizures occur when there is an acute, abnormal release of electrical activity in the brain. Seizures may be partial or focal or generalized. Focal seizures include a brief change in level of consciousness characterized by a blank stare, rolling of the eyes and/or a brief change in level of consciousness. Generalized seizures can include muscular jerks of the extremities or entire body, incontinence, difficulty breathing, apnea and loss of consciousness.

The nurse should assess when and how often seizures occur and what occurs during seizures. Some adults may have had seizures for many years due to problems such as epilepsy. They may also develop epilepsy in old age. Adults over 75 years due to problems such as epilepsy. They may develop seizures and what treatment measures are in place to control the occurrence of seizures. Patient education should stress the importance of adherence to treatment regimens and how to avoid injury in the event of seizures. Family members and caregivers must be involved in patient education as well.

**The gastrointestinal system**

The gastrointestinal system undergoes quite a few changes with aging. These changes can have significant impact on a person’s nutritional status and general health and well-being. The gastrointestinal (GI) system is responsible for digestion, absorption, secretion and motility.

Normal age-related changes in the GI system include:

- Decrease in salivary secretion and the number of taste buds.
- Decreased esophageal mobility.
- Decreased size and weight of the liver.
- Decreased rate of fat, mineral and vitamin absorption.
- Tooth enamel and dentin erode.
- Increased incidence of gastroesophageal reflux.
- Delay in gastric mobility and emptied.

**Assessment tip:** Many medications can add to the age-related changes in the GI system. These include antidepressants, antihistamines, antihypertensives, calcium channel blockers, diuretics and laxatives.

These changes contribute to a number of common age-related disorders in the geriatric patient.

**Dysphagia**

Dysphagia is the most common esophageal problem in older adults. It is characterized by trouble with any part of the mechanism of swallowing foods or liquids. This problem inhibits adequate nutritional intake and can adversely affect the older adult’s health and well-being.

When assessing swallowing, the nurse should be aware of factors that increase the risk of dysphagia:

- Reports of dysphagia from patients, families, or caregivers.
- Observation of drooling or dribbling.
- Observation that patient has trouble controlling food or liquids in the mouth.
- Facial drooping or facial paralysis.
- Changes in mental acuity that affect eating.
- Slurred speech.
- Coughing.
- Pocketing food in mouth.
- Changes in voice quality (e.g. weak voice, hoarse voice) when eating.
- Existence of neurologic problems and/or muscle disorders.

Underlying causes, such as tumors, dementia, neurologic diseases and so on, should be identified and corrected or treated. Here are some tips to help reduce dysphagia:

- Be sure that the patient is seated comfortably in an upright position.
- Encourage a calm, pleasant atmosphere during meals.
- Avoid extensive conversation. Allow patient to concentrate on eating and swallowing.
- Plan meals with patient’s food preferences in mind.

**Constipation**

Constipation affects up to 20 percent of older adults in the community and between 50 percent and 75 percent of those living in long-term care facilities. Factors that contribute to constipation in the elderly include lack of adequate fluid intake, lack of adequate fiber in the diet, and side effects of medications.

Here are some tips to reduce constipation:

- If constipation is due to medications, consult with physician or nurse practitioner about possible changes in medication regimen.
- Increase fluid intake unless contraindicated.
- Increase fiber intake.
- Increase whole grain, fruits and vegetables intake.
- Participate in exercise as tolerated.
- Add stool softeners or laxatives under medical supervision.

**Assessment tip:** Patients need to be evaluated for possible serious cause of constipation, such as impaction or bowel obstruction. Be alert to additional symptoms, such as severe abdominal pain, nausea and vomiting, which may indicate bowel obstruction, or a lump or thickening in the lower abdomen, indicating a growth or tumor.

**Fecal incontinence and diarrhea**

When evaluating diarrhea, determine the quality of diarrhea. For example, are the stools loose but formed, or watery? Is the diarrhea accompanied by cramps, frequency and/or urgency? How many times a day does diarrhea occur?

Diarrhea may be due to viral, bacterial or parasitic infection; medications; tumors; or stress. Treatment measures include identifying and correcting underlying causes and medications to relieve symptoms.

Fecal incontinence may accompany diarrhea or exist with normal quality bowel movements. It may be due to cognitive impairment, tumors or muscle weakness. Correction of underlying causes is necessary, and a bowel-training program is often indicated.

**Assessment tip:** Bloody stools or passage of blood is a medical emergency and requires immediate evaluation and intervention!

**Gastroesophageal reflux disease**

Gastroesophageal reflux disease (GERD) is the backflow of gastric and/or duodenal contents into the esophagus. GERD is due to problems with deficient pressure of the lower esophagus. Symptoms range from none at all to heartburn of varying degrees of severity, and pain that radiates to the neck, jaws and arms. The patient may awaken during the night with coughing and a mouthful of saliva.

Many patients, and even health care professionals, may believe that these symptoms are trivial and unlikely to indicate a serious health problem. In reality, GERD may be responsible for 1,700 deaths annually in the United States. Complications include esophageal ulcer, hemorrhage, esophageal stricture, hoarseness, esophagitis and inflammation of the esophagus that can predispose the patient to the development of adenocarcinoma.

Certain medications and substances can increase the risk of GERD. These include anticholinergics, caffeine and alcohol, nicotine, beta blockers, potassium supplements, and non-steroidal anti-inflammatory agents.

Treatment of GERD focuses on relief and control of symptoms and promotion of esophageal healing. Lifestyle changes are the first line of treatment and include the following:

- **Diet:** Avoid caffeine, chocolate, spicy foods, carbonated beverages, orange juice,
tomato juice, alcohol and other beverages that stimulate the production of gastric acid. Reduce fat content in diet.

- **Positioning**: Avoid lying down for at least two hours after eating. Sleep with the head of the bed elevated six to eight inches. Avoid lying on right side, which encourages reflux.

- **Weight**: Achieve or maintain normal weight.

- **Tobacco products**: Avoid use of tobacco products.

- **Stress**: Participate in stress reduction efforts.

- **Alcohol**: Reduce or avoid the intake of alcohol.

- **Medications**: Ask about possible alterations in medical regimen.

- **Clothing**: Avoid clothing that fits tightly.

- **Exercise**: Do not exercise within one hour after meals.

- **Hydration**: Drink six to eight ounces of water with medications.

If lifestyle changes do not control GERD, medications may be necessary. These include:14,24

- Promotility agents that improve lower esophageal sphincter tone and stimulate upper GI motility.
- Proton pump inhibitors and histamine receptor antagonists to reduce gastric acidity.
- Over-the-counter antacids, which may reduce symptoms but may cause side effects such as diarrhea, constipation and acid-base disturbances.

In severe cases, surgery may be necessary to control symptoms, prevent complications and stop hemorrhage.

**Assessment tip**: Stress the importance of lifestyle changes as the first line of treatment for GERD.

Such changes are also helpful to promote overall health and, if effective, can reduce or eliminate the need for medications and/or surgery.

### Peptic ulcers

It is estimated that 10 percent of adults in the United States have peptic ulcer disease. Hospitalization, morbidity and mortality rates for peptic ulcer disease are higher in older adults as compared to younger persons.9

Peptic ulcers are defined as circumscribed lesions in the mucus membrane and can be located in the lower esophagus, stomach, pylorus, duodenum, or jejunum. Most peptic ulcers (about 80 percent) are located in the duodenum. Gastric ulcers are most common in middle-aged and elderly men. Risk factors for peptic ulcer development include chronic use of nonsteroidal anti-inflammatory drugs, alcohol and tobacco products.24

Ulcer development is caused by infection with Helicobacter pylori and pathologic hypersecretory disorders. Gastric acid is believed to contribute to the development of infection.24

**Assessment tip**: Blood type seems to influence peptic ulcer development. Gastric ulcers are more common in people with type A blood, and duodenal ulcers are more common in people with type O blood.24

Signs and symptoms include heartburn and indigestion, bloating, abdominal distention, and nausea. Specific symptoms are as follows. Duodenal ulcers cause heartburn, localized mid-epigastric pain that is relieved with eating. weight gain because patients eat to relieve pain, and an unusual sensation of hot water bubbling at the back of the throat. Gastric ulcers cause heartburn and indigestion, pain with eating since food causes the gastric wall to stretch, thus causing pain, and feelings of fullness and bloating.24

Treatment includes antibiotic therapy, analgesics and drugs to reduce gastric acid production.24

### Colorectal cancer

Colorectal cancer is the most common cancer that develops after the age of 65.9 Early diagnosis and treatment is associated with improvement in survival. Routine colonoscopies are the best diagnostic tool for early diagnosis.

Signs and symptoms may not appear until the disease is advanced. They include overt or covert bleeding; change in quality and/or quantity of bowel movements; black, tarry stools; cramps; urgent need to defecate when first getting up in the morning; feelings of fullness or incomplete evacuation of stool; and blood or mucus in the stool.9,24

Treatment depends on the extent of the tumor and the stage of the disease. It can include simple removal of the tumor, removal of part of the intestine, radiation and/or chemotherapy. A colostomy may be needed. This could be temporary or permanent.24

**Assessment tip**: Elderly adults may assume that symptoms of colorectal cancer are due to aging changes and not report them. Educate patients, families and caregivers about the signs and symptoms of this type of cancer and the importance of appropriate preventive screening.

### The genitourinary system

The genitourinary system is composed of the kidneys, ureters, bladder, and urethra, and the reproductive organs. Since this system is so broad in scope, this section concentrates on those issues most closely associated with the aging process. Age-related changes associated with kidneys, ureters, bladder and urethra include the following:4,9

- Nighttime production of urine increases and ability to concentrate urine decreases.
- Blood flow to the kidneys decreases.
- Glomerular filtration rate decreases.
- Bladder capacity is decreased.
- Bladder contractility increases.
- Risk of overflow incontinence and urinary retention increases in men.
- Detrusor becomes unstable in women, causing an increased potential for incontinence.
- Prostate increases in size in men.
- Half-life of drugs is prolonged due to a reduction in renal function.

**Assessment tip**: Assess for signs of drug toxicity due to changes in excretion ability of the kidneys.9

### Urinary tract infections

Older adults are especially vulnerable to urinary tract infections (UTI). UTIs in older adults are often asymptomatic. Antibiotic therapy may be prescribed, although, in some asymptomatic cases, no treatment may be initiated.9

**Assessment tip**: In elderly adults, the most common symptoms of UTI are often lethargy and changes in mental status.24

Tips to prevent UTIs include:24

- Maintain adequate hydration. Cranberry juice may have some properties that fight infections.
- Void promptly when the urge to urinate occurs. Don’t wait a long time between voiding.
Wipe from front to back after going to the bathroom.
Avoid using products such as douches and perfumes and scented powders over the genital areas as these can irritate the urethra.

Benign prostatic hyperplasia
Benign prostatic hyperplasia (BPH) affects about half of men between 51 and 60 years of age and 90 percent of men over 80.9 Signs and symptoms include decreased urinary stream and force, feeling of incomplete bladder emptying, frequency and urgency, dribbling, incontinence, difficulty initiating voiding, and, at times, hematuria.24 The only effective treatment is surgical removal of the prostate tissue. Such tissue is always biopsied to rule out malignancy.

Malignancies
Bladder cancer is fairly common in older adults, with men nearly four times as likely as women to develop this malignancy. Symptoms are similar to UTI. The first symptom is often painless hematuria.24 As with other cancers, treatment depends on the stage of the disease and its exact location. Chemotherapy, surgery and radiation may be part of treatment plan.

The incidence of prostate cancer in men is even higher than that of bladder cancer.9 Symptoms are usually not evident until the disease is advanced. That is why it is so important to have a prostate examination as part of the annual physical exam. Symptoms include lower back pain, difficulty initiating urination, dribbling, retention of urine, and hematuria.24 Radiation is used to treat locally invasive lesions. Surgery and hormone therapy also may be used in conjunction with radiation therapy.24

Issues related to reproductive organs
Age-related changes in the reproductive system include:9
- Decreased libido.
- Breast tissue atrophies.
- Diminished ejaculation in men and the need for more time and stimulation to reach arousal.
- Increased incidence of erectile dysfunction in men.
- Drastically decreased estrogen levels in women, which leads to vaginal dryness and possibly painful sexual intercourse.
- Increase in facial hair in women.
- Increased length of time for arousal in women.

These changes do not prevent older adults from having a satisfying sex life. It is important to assess sexuality as part of physical assessment. For more detailed information about sexual assessment and interventions see the section on Sexual assessment presented earlier in this education program.

Common gynecological malignancies in older women
Uterine, breast and ovarian malignancies are more common in older women than in younger women. Uterine cancer is the most common gynecological cancer in older women.6 The most common symptom is bleeding from the vagina after menopause. Other signs and symptoms include weight loss and pain, but these do not appear until the disease is advanced.24

Treatment includes surgery, which is generally a total abdominal hysterectomy. Hormonal therapy, radiation therapy and chemotherapy in various combinations are generally part of the treatment regimen.24

Seventy-five percent of ovarian cancer cases occur in women over 55. Unfortunately, prognosis is often poor, especially in older women. There is no screening test at this time. However, the CA-125 blood test for tumor markers does exist. It is not recommended as a screening tool because there are no data to support the hope that such screening would decrease mortality.9

Ovarian cancer is the leading cause of gynecological deaths in the United States.24 Symptoms are generally vague and include abdominal discomfort, dyspepsia, feeling of being bloated, urinary frequency, abdominal distention and weight loss.9,24

Treatment includes removal of the uterus, ovaries, fallopian tubes and omentum. Aggressive therapy is usually indicated, including chemotherapy and sometimes radiation.24

According to the American Cancer Society, breast cancer affects approximately one in every 14 women over 60 years old. Risk factors include: age, family history of breast cancer, early menarche and late menopause, ingestion of hormonal contraceptives, use of hormonal replacement therapy for more than five years, never having been pregnant, had first pregnancy after the age of 30, personal history of breast cancer, regular use of alcohol, history of ovarian cancer and exposure to low-level ionizing radiation.9,24

Recent controversy over screening recommendations from various health care groups has led to some confusion about the value of screening. In general, recommendations include yearly mammograms for women over the age of 40, monthly self-breast examination, and yearly breast examination by a health care professional.3 There is some question about the value of mammography for the very old woman. Screening techniques and their value should be discussed with the woman’s health care provider.

Treatment of breast cancer includes a variety of options based on the stage of the disease. For localized tumors without metastasis, lumpectomy and radiation are often the treatments of choice.24 However, a growing number of women are choosing to have mastectomies to avoid the need for adjunct therapy and to decrease the chances of recurrence. Some women with unilateral breast cancer and some with a strong family history or the presence of genetic markers are choosing to have bilateral mastectomies to reduce their risk for developing the disease in the unaffected breast or to prevent the occurrence of the disease at all. Radiation and/or chemotherapy may also be part of the treatment regimen. Treatment options should be discussed at length with the woman’s health care team. Ultimately, she must make the choice (e.g. lumpectomy, mastectomy or even refusal to have surgery) herself. It is important that health care providers maintain an objective attitude. Breast cancer triggers not only fear of death but also the fear of disfigurement. Women are usually quite concerned with the cosmetic effects of breast cancer treatment. Reconstruction options should be presented to women undergoing mastectomy.

Assessment tip: Lymphedema is a potential complication of lymph node removal. The patient must be taught to exercise her arm(s) and hand(s) to avoid the development of this potentially debilitating complication.

The musculoskeletal system
The musculoskeletal system includes the bones, muscles, ligaments, bursae and joints. The bones or skeleton provides the forma and support of the body. Muscles move the various body parts. Joints, the areas where two bones are attached, provide stability and facilitate mobility.9

Changes in the musculoskeletal system may have adverse effects on mobility and decrease the independence of older adults. Normal age-related changes include:4,9
- Decreased range of motion of some joints.
- Loss of bone mass.
- Loss of height.
- Joint degeneration.
- Arthritic changes of the joints.
- Problems maintaining balance.
- Problems with the feet, such as corns, bunions and calluses.
- Muscles atrophy.
- Bones become stiffer and brittle.

These changes increase the risk of the following problems:

Osteoporosis
Osteoporosis is a metabolic bone disorder and is the most common metabolic disease, affecting half of all women during their lifetimes. Although its occurrence is higher in women, men are also affected by the disease.9,24

Osteoporosis occurs when the rate of bone resorption increases while the rate of bone formation decreases, leading to a loss of bone mass. The exact cause is unknown, but prolonged negative calcium imbalance is probably a contributing factor. The most common presenting symptom is back pain. A loss of height is common, and the risk of fractures and falls is high.24

There is no cure for osteoporosis. The goals of treatment are to slow or prevent loss of bone, avoid fractures and reduce pain. Calcium and vitamin D supplements may also be recommended.9,24
Participate in an appropriate exercise program. Exercise helps to slow the rate of bone loss and increase bone strength. Weight-bearing exercises are important to help increase bone strength. Exercise programs should be designed and implemented under the supervision of the geriatric patient’s health care provider.

Osteoarthritis
Osteoarthritis is the most common form of arthritis. It is a chronic disease that causes deterioration of the cartilage of the joints and development of new bone at the joints. Symptoms often begin after the age of 40 and progress with age.24 Signs and symptoms include a deep, aching joint pain, morning stiffness, weather-related aching pain, joint instability and poor posture.24 Treatment is aimed at symptom relief and minimizing disability. Joint replacement surgery may be necessary. Assistive mobility devices and anti-inflammatory medications are also used.24

Falls
Falls are certainly not a disease condition. But they are a significant health problem of older adults. In fact, falls are the leading cause of death in persons over the age of 65.24 As age increases, so does the risk of falls and the death rate from falls.

Fall prevention is a key goal of gerontological nursing. Some tips to prevent falls include:

- Ingest adequate amounts of calcium and vitamin D. Postmenopausal women and all women and men over the age of 65 should ingest 1,500 mg of calcium and at least 800 international units of vitamin D on a daily basis. Vitamin D is necessary for the absorption of calcium and enhances muscle strength. Some older adults may understand the need for calcium supplements but fail to realize the need for vitamin D. Patient education should include an explanation of the need for adequate amounts of calcium as well as vitamin D on a daily basis.
- Alcohol intake should be limited. Having more than two alcoholic drinks per day may decrease the formation of bone. Alcohol may also adversely affect the body’s ability to absorb calcium.
- Limit the intake of caffeine. No more than two to three cups of beverages containing caffeine should be consumed per day. Some patients may assume that caffeinated beverages means “coffee.” They should be taught that chocolate, cola, and tea also contain caffeine.
- Participate in an appropriate exercise program. Exercise helps to slow the rate of bone loss and increase bone strength. Weight-bearing exercises are important to help increase bone strength. Exercise programs should be designed and implemented under the supervision of the geriatric patient’s health care provider.

Assessment tip: More than 95 percent of hip fractures are the result of falls. Hip fractures are associated with complications such as permanently decreased mobility and death.3

The immune system
The immune system is responsible for defending the body against infection. The immune system must recognize the normal components of the body and differentiate between these components and foreign substances that are potentially harmful. There are three types of immunity. Natural immunity is “natural” to the body and not produced by an immune response (e.g., an immune response triggered by a vaccine). A human is born with natural immunity. Examples of natural immunity include immunity to diseases that affect animals but not humans. Natural passive immunity is natural immunity that comes as a mother’s antibodies cross the placental barrier to the fetus. This type of immunity is only temporary and generally lasts for the first three to six months of the infant’s life.4,9

Acquired active immunity occurs as a result of the body’s response to a foreign substance. For example, if a person has the mumps, his body responds by developing protection against future infections of the virus that causes mumps. Vaccines also cause the body to develop acquired active immunity. Booster vaccines may be necessary to maintain immunity.4,8 Acquired passive immunity is acquired when a serum that contains specific antibodies is given to a person who is vulnerable to a particular disease. For example, gamma globulin may be administered to prevent the development of hepatitis A.9

The components of the immune system include organs and tissues rich in lymphocytes. The two primary lymphocytes are B cells and T cells. These cells are found throughout the body, but are predominant in the lymph nodes and spleen. They possess receptors that respond to specific antigens.26 Antigens are substances (usually proteins) that are recognized by the body as foreign and can produce an immune response. This response involves producing antibodies to attack the foreign substance. Antibodies are specific to the antigens that trigger them.26

The older person’s immune system is not as effective as that of a younger person. However, exercise, diet and emotional well-being all contribute to boosting the immune system and enhancing health and wellness. Specific age-related immune system changes include:4,9
- Reduction in the rate and strength of the immune response.
- The number of available B cells decreases.
- The manufacture of antibodies that fail to differentiate between the person’s own body and foreign substances increases. This makes the older adult more vulnerable to autoimmune disease development.
- There is an overall decrease in cellular immunity.

As part of the assessment of the immune system, the nurse must recognize those factors that can have an impact on the immune system.

First, as with most body systems, a person’s general state of health and wellness impacts the effectiveness of the immune system. A nutritious diet, adequate rest and relaxation, and social interaction with family and friends all contribute to good health. Patients should also be encouraged to have preventive screenings as recommended by their health care providers.

Research suggests that the regular exercise may slow the rate or even prevent age-associated decline in the immune system. Benefits of regular exercise include reduced risk for infection, enhanced vaccine efficiency, increased rate of healing after infection and improvement in the performance of activities of daily living.

Older adults may find that the practice of moderate, slow-movements, such as those performed in tai chi, a Chinese exercise of ancient origin, have a positive impact on cardiovascular and respiratory function as well as mental acuity, balance, muscle strength, flexibility and immune system response.24

Stress reduction is important to most, if not all, aspects of health. Stress related to living alone, the death of loved ones, financial concerns and/or concerns about dealing with chronic illness all may have an impact on health. Additionally, many older adults are providing caregiver services to a spouse or other elderly significant others. This, too, is a stressful situation. Stress can elevate heart and respiratory rates, blood pressure, and adversely affect emotional stability and ability to concentrate. It may also have a negative effect on the immune system. The relationship between stress and the effectiveness of the immune system is currently the focus of a number of research endeavors.24

The effects of long-term and chronic illness can have an adverse effect on the ability of the immune system to function. Both physical and mental health problems can have a
negative impact on the immune system. Since the immune system is interrelated with many other body systems, problems in one system can affect one or more other systems.

There are a number of diseases related to defective immune system responses. Here are some that are common in the elderly population.

**Hypersensitivity problems**

Mrs. Slater is 68 years old. She recently retired from her job and is looking forward to spending more time with her family and friends. Mrs. Slater lives in Florida, where the climate allows her to spend time gardening year round. Mrs. Slater has a lengthy history of coughing and becoming slightly short of breath when working in her garden, especially in the spring, when her garden is in full bloom. She also sneezes and her eyes water. These symptoms, especially the cough and shortness of breath, have slowly, insidiously become worse with age. She has always attributed such symptoms to “allergies,” but at her husband’s insistence, she visits their family doctor for evaluation. Mrs. Slater is indeed allergic to some environmental substances, such as pollen, but she also has asthma, a frequently under-diagnosed problem in older adults.

Mrs. Slater’s situation illustrates what is referred to as a hypersensitivity problem. Hypersensitivity problems are excessive immune responses that occur when the immune system has an excessive response to various triggers.  

Hypersensitivity disorders or responses are classified as type I through type IV. Classification depends on which immune system activity causes tissue damage. A hypersensitivity response does not usually occur with the first exposure to the antigen that eventually causes a symptomatic response. As the body encounters the antigens on a recurring basis, the excessive immune response results in hypersensitivity reactions.

- **Type I hypersensitivity disorders** are immediate, usually occurring within 15 to 30 minutes after the person is exposed to an antigen (or allergen). These disorders are referred to as anaphylactic, immediate, atopic or IgE-mediated reactions. Sometimes, as in the case of anaphylactic reactions, the type I hypersensitivity reaction may be life-threatening. Other examples include reactions to insect stings, food and drug reactions, and some cases of urticaria (hives).
  
**Assessment tip:** Asthma is a common type I hypersensitivity reaction that is often both under-diagnosed and under-treated in older adults.

- **Type II hypersensitivity disorders** are referred to as cytotoxic, lytic or complement-dependent cytotoxicity reactions. They also occur within 15 to 30 minutes of exposure and include such problems as transfusion reactions, drug reactions and autoimmune hemolytic anemia.

- **Type III hypersensitivity disorders** are referred to as immune complex disease reactions. They are characterized by the body’s failure to remove antigen-antibody complexes from the circulation and tissues. Examples of type III disorders include reactions that are associated with infections such as hepatitis B and bacterial endocarditis, cancers, and autoimmune disorders such as systemic lupus erythematosus (SLE). Rheumatoid arthritis also is thought to be a type III disorder that affects older adults.

- **Type IV hypersensitivity disorders** are referred to as delayed or cell-mediated hypersensitivity reactions. Tissue damage occurs due to a delayed T-cell reaction to an antigen. Reactions after exposure take place within one day to two weeks, but may be even slower in older adults. Examples of type IV hypersensitivity disorders include dermatitis from a latex allergy, sarcoidosis, tuberculin reactions and transplant rejections.

**Immunodeficiency disorders**

Mr. St. John is a 75-year-old retired construction worker who is infected with the human immunodeficiency virus (HIV). His infection has been traced to a blood transfusion Mr. St. John received many years ago. He has difficulty dealing with the disorder and says he is “ashamed.” He is doing well on his treatment regimen, and his wife of 50 years is supportive. But Mr. St. John needs help dealing not only with the physical components of HIV infection but with its emotional consequences as well.

Infection with HIV is often underreported and under-diagnosed in the elderly population. Although the average age of patients who are first identified as HIV positive is progressively increasing, both older adults and some health care workers seem to lack knowledge about the potential for HIV infection in the elderly population. Older persons who have had multiple sexual partners in their youth continue to have multiple partners as they age. Unfortunately, many older adults have unprotected sex, believing that since the risk of pregnancy is no longer an issue among older couples, there is no need for protection.

The rates of sexually transmitted disease are increasing among persons who live in retirement communities. This also includes an increase in the incidence of HIV infection in this population.

When HIV was first recognized as a serious health problem, the primary means of transmission of the virus in older adults was via blood transfusion. But today, the risk of infection seems to be primarily due to intravenous drug use and sexual activities. As a result of the increasing incidence of HIV infection, the Centers for Disease Control (CDC) recommends that routine HIV testing should be initiated in all health care settings for persons between the ages of 13 to 64.

**Vulnerability to infections in the older adult**

As the immune system undergoes age-related changes that reduce its effectiveness, nurses need to be aware that older patients are at increased risk of infection. This risk includes viral infections such as influenza; bacterial infections, such as pneumonia; and infections following surgery or other open wounds. Even a slight laceration may result in a serious infection.

Because of its prevalence, it is appropriate to discuss pneumonia as a problem of particular concern among the elderly. The prognosis is generally good for persons with normal respiratory function and intact immune systems. However, among the elderly, who may have a compromised immune system or are dealing with chronic disease or disorders, pneumonia is a leading cause of death in people over the age of 65. Not only is it the most common hospital-acquired infection (nosocomial infection), but it also has the highest mortality rate of such infections.

To add to the problem of pneumonia among older adults, the signs and symptoms of the disease in this population are often atypical. The cardinal signs of fever, chest pain, chills and shortness of breath may be subtle and not obviously apparent.

Persons over the age of 65 are urged to receive pneumococcal vaccine.

**Assessment tip:** Older adults who live alone in the community seem to be at particular risk for not being diagnosed until pneumonia has reached an advanced stage. This could be that the symptoms are so subtle that the patient may assume he has a cold or simple viral infection. Teach older patients to be aware of the prevalence of pneumonia and to recognize the signs and symptoms as they appear in the older population. When possible, teach family members, friends and caregivers about the signs and symptoms that indicate pneumonia. The earlier the disease is recognized, the more prompt and effective the treatment.

**Summary**

Nurses working with geriatric patients have unique opportunities to promote health and wellness throughout a long and hopefully productive life span. Although basic assessment techniques of interview, observation, auscultation, percussion, and palpation are similar for all age groups, the unique aspects of geriatric assessment require that the nurse have an in-depth understanding of how the body ages and a respect for older patients and their wealth of life experiences.
Nurses also have unique opportunities to teach their colleagues about the older population and to dispel myths about this age group. All health care professionals should understand that “old” does not equate with “sick.” Most older adults live independently and enjoy their lives. Too many people believe that older adults are inactive physically, mentally and sexually. Nothing could be farther from the truth.

The people in this age group deserves the respect and support of the health care profession. They also deserve the opportunity to access health care services provided by professionals who understand how the body ages and want to serve as advocates for older adults. Work with your older patients to not only promote their health and well-being, but to also promote community awareness of the contributions older adults have made, and can continue to make, to their families, friends and communities.

References