A NATIONAL EPIDEMIC

WE ALL KNOW . . .

. . . that U.S. Copyright Law grants to the copyright owner the exclusive right to duplicate copyrighted, printed and recorded materials. Piracy involves the illegal duplication of copyrighted materials.

YOU MAY NOT KNOW . . .

. . . that every time you use or make an illegal copy of any printed material in any form or by any method you may be liable for further litigation.

. . . that your institution's duplication or processing equipment may also be confiscated and destroyed if involved in illegal duplication.

. . . that the penalty for criminal violation is up to five years in prison and/or a $250,000 fine under a tough new law. (Title 17, U.S. Code, Section 506, and Title 18, U.S. Code Section 2319).

. . . that civil or criminal litigation may be costly and embarrassing to any organization or individual. We request you contact us immediately regarding illegal duplication of these copyrighted, printed materials. The National Center of Continuing Education will pay a substantial reward for information leading to the conviction of any individual or institution making any unauthorized duplication of material copyrighted by J.R. Ivanoff or The National Center of Continuing Education, Inc.
Table of Contents

Disclosures ........................................................................................................................................................................3
Description ........................................................................................................................................................................3
Criteria for Successful Completion .................................................................................................................................3
Accreditation ....................................................................................................................................................................3
Conflicts of Interest ..........................................................................................................................................................3
Expiration Date ..................................................................................................................................................................3
About the Author ...............................................................................................................................................................3
Purpose ...............................................................................................................................................................................3
Learning Outcomes ..........................................................................................................................................................3
Introduction .......................................................................................................................................................................3
Gordon’s 11 Functional Health Patterns ..................................................................................................................................4
Nutrition-metabolic ................................................................................................................................................................4
Elimination ...........................................................................................................................................................................4
Activity–exercise ................................................................................................................................................................4
Cognitive-perceptual ..........................................................................................................................................................4
Sleep-rest ............................................................................................................................................................................5
Self-perception/self-concept ...............................................................................................................................................5
Role-relationship .............................................................................................................................................................5
Sexuality-reproductive ......................................................................................................................................................5
Coping/stress tolerance ......................................................................................................................................................5
Values-beliefs ....................................................................................................................................................................6
Communication Considerations ........................................................................................................................................6
Chronic Disease ..................................................................................................................................................................8
Impaired Cognition and Memory .......................................................................................................................................8
Reminiscence ....................................................................................................................................................................9
Managing Repetitive Actions ...............................................................................................................................................9
Games, Arts, Crafts ..........................................................................................................................................................9
Service and Emotional Support Animals ..................................................................................................................................9
Assuring Safety and Protection from Injury ......................................................................................................................9
Assure Privacy & Confidentiality ..........................................................................................................................................10
Elder Abuse, Maltreatment & Neglect ............................................................................................................................10
End-of-Life Decisions ........................................................................................................................................................11
Hospice Care .......................................................................................................................................................................11
Palliative care ......................................................................................................................................................................11
To learn more: ....................................................................................................................................................................11
References ..........................................................................................................................................................................12
Resources ............................................................................................................................................................................13

No part of this publication may be reproduced stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the prior written permission of the publisher.
Understanding the Aging Process and Health Care Needs of the Older Adult

Disclosures

Description
This course reviews aging processes and care of the older adult. The goal is to stimulate a positive yet realistic attitude about aging and health care needs of older adults. Health-related resources are provided that can be useful for health professionals when planning and evaluating care for this population.

Criteria for Successful Completion
After reading the material, complete the online evaluation. If you have a Florida nursing license or an electrology license you must also complete the multiple choice test online with a score of 70% or better. Upon completion of the requirements you may immediately print your CE certificate of completion.

Accreditation
• American Nurses Credentialing Center’s Commission on Accreditation (ANCC)
• California Board of Registered Nursing Provider No. CEP 1704.
• This course has been approved by the Florida Board of Nursing No. 50-1408.

Conflicts of Interest
No conflict of interest exists for any individual in a position to control the content of the educational activity.

Expiration Date
This course expires March 31, 2022.

About the Author
Angeline Bushy, PhD, RN, FAAN is the Bert Fish Eminent Scholar Endowed Chair, University of Central Florida, College of Nursing. Professor Bushy is recognized for advancing nursing education and community healthcare. She has published extensively, including textbooks, and presented various aspects of rural healthcare delivery at numerous national and international conferences. She has practiced in a variety of rural health care settings including community, acute care and educational settings, and served in the U.S. Army Nurse Corps (LTC, Ret.) for more than 20 years.

Purpose
The purpose of this course is to inform about the aging processes and to create awareness of the health-related needs of older adults. Nursing care strategies and resources are highlighted to address an older adult’s developmental, physical, cognitive, and psychosocial needs.

Learning Outcomes
With successful completion of this learning activity, participants should be able to:
1. Describe changing demographics of the older adult populations.
2. Identify pertinent Healthy People 2020 Goals for older adults.
3. Apply Gordon Functional Health patterns to assess and plan care for the older adult.
4. Identify pertinent Erickson stages of human development for older adults.
5. Highlight communication strategies to more effectively care for older adults.
6. Outline the burden of chronic disease and impaired cognition on older adults.
7. Assess for abuse and describe the nurse’s role when encountering these situations.
8. Discuss strategies to assure safety and protection from injury for older adults.
9. Describe end of life decisions that confront older adults and their families.
10. Identify screening assessment tools focusing on older adults.
11. List health-related resources dedicated to older adults.

Introduction
The demographic profile in the United States (US) is slowly but dramatically changing. At the beginning of the 20th century, the US population was relatively “young” due to high birth rates and lower life expectancy. However, in the 21st century, the demographic profile is slowly but dramatically changing in age and cultural diversity. The US Bureau of the Census projects that by 2050 people over the age of 65 will make up more than 20% of the total population. In fact, the fastest growing older adult population are those 85 years and older. The percentages of African-Americans, Hispanics, and Asians are projected to increase, while the percentage of Caucasians is expected to decrease over the next 30 years. These demographic projections also are reflected in the growing diversity among older adults in the US population (https://www.census.gov/)

People are living longer which, in turn, contributes to a growing elderly population. Longevity is associated with biomedical technological advancements to treat and cure illnesses, coupled with health promotion and illness prevention interventions. Globally, the population is increasing in number, getting older and overall generally healthier compared to past decades. Consequently, increased life expectancy has contributed to a growing awareness of the health care needs coupled with an increased prevalence of chronic health conditions associated with the aging process.

An individual possesses two different ages: chronological age and biological age. Chronological age refers to the actual time in years that the person has been alive. Biological age refers to the age of the human body taking into consideration genetics, lifestyle behaviors, chronic diseases, and disabilities. A person’s biological age generally is not congruent with chronological age. In fact, chronological age probably is not a reliable index of the older adult’s physical and mental development, quality of life, and health status. In other words, a 50- or 55-year-old male may have a poorer health status compared to a 95-year-old female classified as a “frail elderly.” Hence, chronological age in and of itself is not the definition of “elderly.” Considering the discrepancy between biological versus chronological age, this course will use the classification “older adult” in lieu of “elderly”.

Contrary to popular stereotypical views, an adult in later years does not automatically degenerate in physical ability or intellectual function. Cognitive function assessments must be directed toward the healthy characteristics (i.e., level of formal education, hobbies, and socialization activities) as well as taking into consideration limitations that may occur with the aging process (e.g., current health status/illnesses, cognitive impairment, etc.). Likewise, chronological age is not a reliable index of the older adult’s mental development. An individual’s innate level of ability is a critical factor in the older adult’s mental abilities. For instance, some with high IQ scores as a child have progressive gains as they develop across the lifespan in the areas of general information, comprehension, vocabulary, and mathematics. Likewise, a highly intelligent 20-year-old male probably will be a mentally acute 70-year-old adult. Or, a mentally acute 70-year-old female will function better with certain cognitive skills compared to the 20-year-old female with an “average” level of intelligence.

Choice of lifestyle behaviors in one’s younger years can precipitate and sometimes exacerbate chronic health conditions later in life. For example, nutritional preferences, obesity, sedentary lifestyle, and tobacco usage are risk factors for developing cardiovascular conditions, hypertension, diabetes, and some types of cancer. Moreover, participating in health promotion and illness prevention interventions—such as screening for hypertension or obtaining the recommended mammography, colonoscopy, prostate screenings,
Pap smear and immunizations—may delay or even prevent a chronic health condition from developing.

About 35% of all Americans have two or more chronic conditions. Medical care for this population accounts for about 66% of the US health care budget. Compared to the general population, the most health care dollars are used during the last seven years of life. Several reasons are cited for this finding. For example, it has been postulated that since Medicare does not become available to individuals until age 65, some may delay seeking medical care for a chronic condition until after they have Medicare benefits. Consequently, a health problem that could have been more effectively treated at an earlier time progresses into a serious chronic diagnosis while waiting to rely on Medicare benefits.

Acknowledging the needs of changing US demographics, Healthy People 2020 (https://www.healthypeople.gov/) identifies the following health-related goals for the United States population:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and health behaviors across all stages of life.

Healthy People added several topics focusing on older adults, including Alzheimer’s Disease and other dementias, health-related quality of life and overall well-being, healthcare-associated infections, and sleep health.

Gordon’s 11 Functional Health Patterns

Gordon identified 11 functional health patterns that are relevant across the lifespan. Gordon’s model is a particularly useful tool to assess the health status of an older person, (compared to normal developmental patterns), develop appropriate healthcare intervention, and evaluate outcomes of the care plan.

Gordon’s 11 Functional Patterns include:
1. Health perception/health management
2. Nutrition-metabolic
3. Elimination
4. Activity–exercise
5. Cognitive-perceptual
6. Sleep-rest
7. Self-perception/self-concept
8. Role-relationship
9. Sexuality-reproductive
10. Coping/stress tolerance
11. Values-beliefs

The next section elaborates on each functional area relative to the aging process and the older adult. Highlighted for each functional area are exemplar assessment criteria (Edelman & Mandle, 2017; Gordon, 2017). (Table 1: Gordon’s Functional Patterns, Description, and Assessment Exemplars).

Health Perception/Health Management

Regardless of age, motivation is an important factor in health promotion and illness prevention. For instance, self-motivation is a critical element in whether an individual engages in regular exercise, eats an appropriate diet, and makes efforts to manage weight. But modifications must be made to accommodate one’s developmental, physiological, and emotional changes. For an older adult, the motivation to engage in such behaviors becomes even more critical to maintain an active and quality life. Nursing assessment criteria focusing on health perception and health management includes adherence with recommended medication regimen, engaging in health promotion activities such as routine exercise/activities, adhering to CDC recommended immunizations, screenings, and medical visits.

Nutrition-metabolic

Adequate and appropriate nutrition is critical at every age, with nutritional needs changing over one’s lifespan. Nutrition is important to manage gastrointestinal disorders, wound healing and skin integrity, energy levels, and overall health status. Obesity is pervasive among the older adult population, particularly among women, and is a risk factor for developing chronic health problems including cardiovascular diseases, diabetes, some cancers, and hypertension. Anorexia is another concern that is seen in the older adult. Common contributing factors to anorexia or lack of appetite in older adults include medication side effects, oral conditions, ill-fitting dentures, cultural factors, and progression of a chronic disease. Dehydration often is a side effect of medications, along with impaired or decline of taste receptors in the mouth and tongue.

Nursing assessment criteria focusing on nutrition and metabolic status in older adults include examining condition of the skin integrity (e.g., bruising, decubitus, dryness, slow healing wounds); examining the teeth, mucus membrane, and oral cavity (fit of dentures); and, the ability to chew and swallow food. Another important consideration is the individual’s access to a well-balanced diet (resources to purchase food, food preparation, etc.). It is important to routinely weigh older adults to assess for changes that could reflect nutrition-metabolic conditions.

Elimination

Associated with the normal aging process in older adults are changes in bowel and bladder functions. Bladder capacity decreases, resulting in more trips to the bathroom and, in many instances, disrupted sleep patterns. Frequency is especially common in males associated with benign prostatic hypertrophy (BPH). Urinary incontinence and “dribbling” (stress incontinence) are often reported by older women. Changes in genitourinary patterns can lead to incontinence, infections and skin breakdown, and even social isolation. Medication side effects can exacerbate elimination problems such as opiates and diuretics. Common complaints by older adults include irregularity, persistent or acute abdominal cramping, excessive straining with incomplete evacuation, and blood in the stool. Elimination symptoms often lead to the use and increased reliance on laxatives or enemas, which can exacerbate gastrointestinal disorders.

Nursing assessment criteria focusing on elimination include frequency of bowel movement, voiding pattern, pain with urination, and the appearance of urine and stool. If constipation is a problem, inquire how the individual manages this condition (e.g., intake of high fiber foods, laxatives, suppositories, enema, etc.).

Activity–exercise

Healthy People 2020 national objectives include a specific goal focusing on the increasing percentage of adults who exercise on a regular basis. Regular physical activity is critical for preventing and managing chronic health problems such as obesity, diabetes, depression, and musculoskeletal conditions. Physical activity generally decreases associated with aging processes. However, regular physical exercise can enhance the quality of life for older adults. It is important to stress that the normal changes associated with aging should not be a deterrent to remaining physically active. A combination of muscle strengthening activities along with aerobic and anaerobic exercises are important to maintain balance and musculoskeletal integrity. Popular activities for older adults should include muscle and strength-building along with weight-bearing exercises. Before beginning any exercise program, the older adult should first consult with a medical practitioner. Nursing assessment criteria focusing on activity/exercise include assessing cardiovascular and respiratory status, assessing mobility and balance, and inquiring about activities of daily living and whether this includes physical activities.
Cognitive-perceptual

Cognition (i.e., thinking processes) has been of interest to researchers over the past decade in response to the growing prevalence of various types of dementia in older adults. Numerous theories are offered as to the physiological changes in the human brain during the aging process. However, no consensus of evidence exists as to why some centenarians experience cognitive decline while others remain mentally sharp. Factors that contribute to cognition status associated with aging include cultural patterns, level of formal education, heredity, lifestyle behaviors, medication side effects, nutrition, environmental exposures, and occupational exposures, among others.

Nursing assessment criteria focusing on cognitive perceptual patterns in older adults include appraisal of vision, hearing, taste, touch, smell, pain perception, and lifestyle behaviors. Mental health assessment should address orientation to person, time, and place. Other components of cognitive functions include language skills, memory/recall, and decision-making. Common symptoms of dementia include short-term memory loss, disorganized thinking, perceptual disturbances, sleep wake disorders, psychomotor challenges, and disorientation. One must be cautious when assessing an older adult who presents with confusion or reported cognitive impairment. Confusion may not be indicative of dementia, but could be associated with health problems such as diabetes and Parkinson’s disease, hypoxia, electrolyte imbalance, hearing or vision loss, medication side effects, and depression.

Sleep-rest

Disruption in sleep and insomnia are commonly reported problems by older adults. Sleep disorders include insomnia, sleep apnea, waking up early with an inability to go back to sleep, and fatigue upon awakening. Concomitantly, other subjective reported symptoms include excessive sleepiness during the day and falling asleep at inopportune times. Consequently, the older adult may resort to medications such as benzodiazepines or barbiturates, which can lead to dependence, falls/fall-related injuries, metabolic disorders (e.g., constipation, anorexia, hypoxia), and impaired cognition.

Nursing assessment criteria should focus on sleep/rest patterns in older adults and their perceived (subjective) sleep experiences. Include questions focusing on sleep pattern during the night, napping during the day, urinary frequency, and sleep hygiene (i.e., bedtime routines, sleep aids, etc.). If possible, ask the individual older adult to keep a written journal of sleep patterns over a 24-hour period for several weeks.

Self-perception/self-concept

Erik Erikson’s theory focusing on stages of psychosocial development specifies “generativity versus stagnation” for middle adulthood (40 years to 65 years); and “ego integrity versus despair” as the developmental task associated with maturity (65+ years). Depending on one’s biological age someone in either of these two groups could be classified as “older adult” (See Table 2). During middle adulthood, major life changes occur as the individual attempts to redefine his or her life purpose associated with children leaving the home along with career and relationship changes. Erickson’s maturity stage entails achieving an identity apart from work roles, adjusting to normal aging changes, and accepting the inevitability of losses and death.

Nursing assessment criteria focusing on self-perception/self-concept should include open-ended questions related to the individual’s comfort with their body image in light of the physiological changes associated with aging, such as self-perception of one’s abilities along with major life role changes. Objective assessment data would include body posture, eye contact, voice tone, and activities of daily living.

Role-relationship

Associated with Erikson development tasks are one’s roles, responsibilities, and relationship changes across the lifespan. Roles such as parenting, or being a child, sibling, or spouse will change in the event of a child leaving the home, illness, debilitating injury, or death. The manner in which the older adult adapts to these changes contributes to lifestyle behaviors, socialization, and ultimately health status.

Nursing assessment criteria focusing on role-relationships in the older adult should include a review of perceived roles and responsibilities, and perceived quality of life related to these changing dynamics. Ultimately, health care providers should assess current and potential changes and offer appropriate anticipatory guidance to help the older adult adapt to developmental and situational life events and changes.

Sexuality-reproductive

The Centers For Disease Control indicates that sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity (https://www.cdc.gov/sexualhealth). Sexual health requires positive and respectful approach to sexuality and intimate relationships as well as the possibility of having pleasurable and safe sexual experiences. Older adults continue to have the human need for intimacy, love, and touch, an integral dimension of human sexuality. Physiological and emotional factors, along with health status and medication, can impact an older adult’s intimacy and sexuality experiences.

Nursing assessment criteria focusing on sexual/reproductive pattern in older adults include history and satisfaction with pregnancies/childbirth, satisfaction with sexual relationship, and sexual functioning. Nurses are in an ideal position to help older adults understand changes in sexuality associated with aging processes. However, nurses often are hesitant to address this human dimension associated with myths about adult human sexuality. It is essential that the nurses be educated, informed, and confident to discuss this important but highly sensitive issue with older adults.

Coping/stress tolerance

A critical component of human development relates to one’s ability to effectively cope with life’s stresses, which, in turn, influence self-concept. As individuals age they encounter numerous losses (spouse, friends, siblings, employment, income, etc.). Living arrangements also can contribute to stress experiences, such as downsizing from the established family home and moving to a smaller living situation (e.g., apartment or progressive care facility such as independent living, assisted living, and long-term care). There may be a decline in income, physical functioning, and health status. Multiple changes often are overwhelming for the older adult as well as for family members. An individual who had productive coping patterns early on in life may be overwhelmed with the stressors that occur with aging and no longer able to adhere to reliable coping patterns. Older adults may be depressed, which can manifest in symptoms and behaviors that may be reported as confusion, dementia, or cognitive impairment. Medication side effects may exacerbate mood disorders and further interfere with former coping behaviors. Self-medicating and alcohol use may come to be relied upon as the preferred coping strategy. Depression, too, remains undiagnosed or misdiagnosed and misconstrued as impaired cognition. These coping behaviors increase the risk for falls and other types of trauma-inducing events. It is important to note that suicide rates remain high among older adults and the potential should always be included in the assessment.

Nursing assessment criteria focusing on cop-
Belief systems and values develop early in life but are modified with life experiences. Spirituality often establishes an underlying guide to an older adult’s belief systems and corresponding behaviors. ‘Spirituality’ is highly personal and differs somewhat from the concept of ‘religiosity’. For instance, a person may belong to a particular religious denomination/sect, but may not adhere to all of its tenants or doctrine. Spirituality influences a person’s values– beliefs about life, aging, illness, and death. When addressing spirituality, the nurse must be non-judgmental, highly sensitive, and unobtrusive when inquiring about the older adult’s values and beliefs.

Nursing assessment criteria focusing on values/beliefs include inquiring about religious affiliation and what the older adult perceives as important in life; if there are values/beliefs that conflict with their religious affiliation; and special religious practices and rituals. Discusssions about spirituality can be rather uncomfortable for a less experienced provider. Moreover, exposure to a belief system that is different than one’s own may contribute to moral distress, which can lead to the nurse avoiding the topic or, perhaps, even becoming argumentative.

**Communication Considerations**

Associated with aging processes are declining sensory organs, such as impaired vision, hearing, and sense of balance. Admission to an acute or long term care facility places the individual in an unfamiliar environment and in a highly “dependent” role. Effective communication is a critical element in identifying, planning, delivering, and evaluating health care interventions.

With older adults, patience is essential, but do not confuse patience with a patronizing approach. A hurried and impatient communica

**Table 1: Gordon’s Functional Patterns, Description, and Assessment Exemplars**

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Description</th>
<th>Assessment Examples</th>
</tr>
</thead>
</table>
| Health perception-health management | Older adults perceived pattern of health and well-being; how this is managed on a day-to-day basis | • How does the older adult describe current health status?  
• What does the older adult do to improve/maintain health?  
• Ask older adult to provide information on current medications and their purpose. |
| Nutritional – metabolic     | Food/fluid consumption relative to need; access to nutrient supply | • Does the older adult appear well-nourished?  
• What constitutes the older adult’s daily nutrient intake? (Recall; diary)  
• Does the individual have a condition that impacts nutritional – metabolic function?  
• Inquire about related self-care practices, medications/side effects that could influence nutritional/fluid intake. |
<table>
<thead>
<tr>
<th>Pattern</th>
<th>Description</th>
<th>Assessment Examples</th>
</tr>
</thead>
</table>
| Elimination         | Excretory functions (bowel, bladder, skin)                                  | • What are the older adult’s perceptions of ‘normal’ excretory functions?  
• Are the older adult’s excretory functions within normal range?  
• Does the individual have any disease/health problems that can impact excretory function (digestive, urinary, skin)?  
• Inquire about self-care practices, medications/side effects related to elimination. |
| Activity – exercise | Daily/weekly activity/leisure/recreation routine                            | • Inquire about the older person’s routine physical activity and leisure habits.  
• How does the older individual perceive his/her adequacy of activity habits?  
• Does the individual have any disease/health problem that interfere with being physically active? |
| Cognitive – perceptual | Sensory – perceptual/cognitive patterns                                                                 | • Does the older adult have any sensory deficits (vision, hearing, taste, touch, smell, pain perception_management)? Are these corrected?  
• Can the individual clearly and logically verbalize these deficits?  
• What is the older adult’s knowledge level regarding a health condition/chronic diagnosis and how to manage this condition (e.g., medications, lifestyle changes, screening)?  
• Inquire about related self-care practices, medications/side effects. |
| Sleep – rest        | Habits related to sleep, rest/relaxation                                    | • What is the older adult’s sleep habits? Have there been any deviations?  
• What is the individual’s sleep – wake cycle (e.g., sleep hygiene, medication use)?  
• Does the older adult appear rested, relaxed, and alert?  
• Inquire about related self-care sleep-rest practices, reading, e.g., listening to music, medications/side effects. |
| Self-perception – self-concept | Body image, self-concept, and perception of self | • Is there anything unusual about this adult person’s appearance (grooming, attire, disabilities)? Is it appropriate for the chronological age?  
• Does the older adult seem comfortable with changes associated with the aging process?  
• How does the individual feel about changing physical and emotional limitations that may occur with normal aging processes?  
• Inquire about related self-care practices, need for medications/prosthetics/biomedical devices to manage health conditions. |
| Roles – relationship | Level of understanding/satisfaction associated with changing developmental roles/relationships | • How does the older adult describe various/changing life roles and responsibilities?  
• Does the individual have a role model to emulate?  
• Is the older adult currently experiencing changes in roles/relationships? How are these impacting roles and relationships? |
| Sexuality – reproduction | Level of satisfaction with intimacy/sexuality/reproductive experiences | • How satisfied is the individual related to intimacy and sexuality?  
• Does the individual have any diseases or dysfunction that impact the reproductive system/sexuality? (e.g., diabetes, prostatic hypertrophy, cancer)  
• How satisfied is the individual regarding childbearing?  
• Inquire about self-care practices, medications/side effects to manage perceived sexuality (e.g., erectile dysfunction, hormone replacement therapy, etc.) |
| Coping/stress tolerance | Generally used coping strategies; effectiveness in managing stress level | • What activities does the older adult generally engage in to cope with stress or personal problems?  
• How effective are these behaviors? Do these actions help or make things worse?  
• Has the person had treatment for anxiety, emotional/behavioral disorders?  
• Inquire about related self-care practices, medications/side effects. |
| Value – belief       | Values and beliefs that guide the older adults choices or decisions         | • Does the older adult identify with a particular culture (ethnicity, religion, regional, group [occupation, hobby, recreational])?  
• Does the individual espouse to principles/ values learned as a child (strong work ethic, minimizing pain, religious doctrine that guidelines behaviors)?  
• Are there particular religious practices that should be addressed in the nursing care plan (nutrition, spiritual advisor/priest, practices, rites of passage/events). |

Adapted from Gordon, 1987; Edelman & Mandle, 2017
Table 2: Erik Erikson’s Stages of Psychosocial Development

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Psychosocial Developmental Task</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>Trust vs. mistrust</td>
<td>0-1 ½ years</td>
</tr>
<tr>
<td>Early childhood</td>
<td>Autonomy vs. shame and doubt</td>
<td>1 ½ - 3 years</td>
</tr>
<tr>
<td>Preschool</td>
<td>Initiative vs. guilt</td>
<td>3- 5 years</td>
</tr>
<tr>
<td>School age</td>
<td>Industry vs. inferiority</td>
<td>5-12 years</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Identify vs. role confusion</td>
<td>12- 18 years</td>
</tr>
<tr>
<td>Young adult</td>
<td>Intimacy vs. isolation</td>
<td>18-40 years</td>
</tr>
<tr>
<td>Middle adulthood</td>
<td>Generativity vs. stagnation</td>
<td>40 – 65 years</td>
</tr>
<tr>
<td>Maturity</td>
<td>Ego integrity vs. despair</td>
<td>65 +</td>
</tr>
</tbody>
</table>

Source: https://www.simplypsychology.org/Erik-Erikson.html

Impaired Cognition and Memory

Cognitive functions refer to mental and intellectual processes of perception, interest, motivation, memory, reasoning, thought, learning, problem solving, and judgment. These functions include the ability to examine a situation; take in, process, and recall information; the orientation of self in time and place, the ability to organize complex data, and to respond appropriately to stimuli. Dementia is a broad term that includes a variety of specific diagnosis including memory impairment, serious depressions and psychoses. The most common form of dementia, Alzheimer’s disease, is a chronic progressive condition ranging from mild to severe over an average time span of four to eight years from diagnosis.

The first assessment is to determine if the individual is oriented to person, time, and place. Most people are able to state their name; however, a person who is very confused and disoriented may provide a non-coherent or inappropriate response. Sometimes the individual is able to state his or her name, but when asked about age, the person may not correctly recall or incorrectly state a much younger age, such as from childhood or adolescence. Some cognitively- impaired individuals are unable to state the precise date or time. Time orientation may be better evaluated according to the time of day (daytime, lunchtime, nighttime), month, or season of the year. The individual should be able to specify where he or she is currently located, perhaps, not precisely (e.g., room 516), but rather the general location (e.g., hospital, nursing home). With relocation stress and illness, it is not unusual for short-term memory recall to be impaired, especially when the individual is hospitalized or placed in a long-term or extended care facility.

Previous lifestyle, present behavior patterns, and general coping mechanisms all affect cognitive function and must be considered in assessment. Observe behavior in a variety of situations and listen to the person’s conversation and reminiscences. Talk with family members or friends. Consider the total, unique individual physically, emotionally, and socially for an accurate cognitive assessment. Irritability, agitation, and belligerence are behaviors that often are associated with impaired cognition. Sometimes agitation, confusion, and belligerence may signal an impending medical problem. If the person is able to communicate, carefully listen, observe nonverbal communication patterns, validate, and then address the problem in a timely and appropriate manner.

Creativity may be necessary to assess and remedy the source of discomfort for someone who is cognitively impaired. Refocusing or diversion may be a useful strategy when caring for someone who is resistant or uncooperative. However, before instituting this approach, assess the person for changes in health status, physical discomfort, or pain. For example, older females may have a urinary tract infection without having the typical symptoms or may not be able to verbalize the discomfort. A common source of agitation and irritability is the presence of a “tube” placed somewhere in the body. When appropriate remove the offending device or reposition the tube which may relive the discomfort. For instance, with an intravenous tube the person picks at or attempts to remove, wrap with a compression dressing; or, replace with a capped IV line. A more annoying device is the urinary catheter. If the individual must have a urinary catheter, reposition it on the body to reduce pressure and movement, or as a last option, secure on a body region that cannot be reached by the person. Oxygen nasal cannulas too can be quite irritating to the skin. Interventions that may address some of this discomfort include humidifying the oxygen flow, lubricating nares, placement of a nasal tube stabilizer, or tapping the cannula comfortably to the cheek. In the case where an abdominal tube is in position, consider use of a tube stabilizer, an abdominal binder, or both. (US Preventive Services Task Force, Screening for Cognitive Impairment, 2014, https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/1882

Hospitalization is stressful regardless of the individual’s age; fear, uncertainty and feelings of helplessness are common. In today’s high tech health care environment, even a patient or resident room can be frightening, especially for someone who is cognitively impaired. Relocation to an unfamiliar environment poses serious risk for falls. Relocation often can lead
to changes in cognitive function, memory impairment, and confusion.

Progressive loss of memory, or the ability to retain or recall past thoughts, images, ideas, or experiences, does not necessarily occur in later maturity. However, memory loss becomes more prevalent as people age. Loss of short-term memory (recall for recent events) is more likely to occur than loss of remote memory (recall of events that occurred in the past). Recall (memory) involves an organized network of concepts that are interrelated in specific ways. When the connection among concepts is impaired, the result is decreased retrieval or slower access (rather than spontaneous) to memory links and recall. Memory loss can occur at any point in life; however, it is more likely to occur in older adults and among those who are institutionalized. Various strategies may be useful when caring for someone who is cognitively impaired.

Redirecting, refocusing diversion strategies can be useful to deescalate an agitated, resistant, or belligerent situation that caregivers often encounter with cognitively impaired individuals. First assess the individual for potential contributing factors to the situation, such as pain, hunger, or response to a visitor and, if appropriate, remedy the situation. If there is no obvious underlying contributing factor consider redirecting or refocusing the individual to divert attention to another stimulus or experience. When available, occupational and recreational therapists have an array of techniques to redirect, refocus, and entertain individuals and groups of older adults. The next few paragraphs highlight simple diversion strategies that can be used by the caregiver.

Memory prompts such as the use of photos, home movies, and relevant memorabilia are a strategy that may promote recall. This strategy can be readily used in home, hospital, and long-term care settings. Memory prompts are most effective in the early stages of a disease while the ability to read and comprehend instructions is still reasonably intact. When an older adult does not fully comprehend what is happening, facial expression, touch, and tone of voice can create a more comfortable atmosphere. Frequently, the person needs extra time, patience, or “tender loving care.” The person with an impaired memory or impaired cognition often is highly sensitive to someone having an empathic and caring attitude as well as someone who is intolerant and impatient.

Reality Orientation reinforcing techniques include identifying the person’s room with a clearly visible name plate or photograph and strategic placement of large clocks, calendars, daily schedules, and seasonal decorations. Should the individual provide incorrect details, the caregiver must use judgment in determining the best approach to respond to the older adult if reality orientation is appropriate given the stage of dementia. Generally, re-orienting and correcting an individual is effective only for those in early stages of the disease. Some confused individuals react in anger or become agitated or even belligerent when correcting a misperception. A general rule of thumb is to redirect only if doing so is critical to the health and well-being of the confused older adult. Assess and reinforce reality orientation in the course of conversations.

“Music produces a kind of pleasure that human nature cannot do without” Confucius claimed over 2500 years ago. In many instances, music can provide a readily accessible and appropriate diversion to refocus someone who may be confused, belligerent, or agitated and evoke positive emotions. Placing a radio, musical device or television in the individual’s room, played at a low volume with the person’s favorites, is an inexpensive and readily accessible strategy that can sometimes calm and refocus someone who is restless and agitated. Studies have shown that using earphones when playing music allows for greater listening pleasure and enhances memory but make sure that the music selections are those that the person would choose himself. (https://musicandmemory.org/music-brain-resources/current%20research/) Physical movement/exercise/dancing with music is another effective strategy for older adults who are not physically impaired, and for whom accommodations for existing impairments can be made.

Reminiscence

Another effective refocusing strategy is to ask an older adult about certain life events; for instance, “How did your family celebrate (holiday or day event)?” This approach encourages the individual to recall past experiences and roles he or she may have had while refocusing and deescalating a stressful situation. Another effective refocusing approach is to ask, “Have you ever served in the military?” Veterans generally are proud of their service and, given an opportunity, eager to share their stories. Invite family members to become involved by providing photos or memorabilia of familiar loved ones and significant life events. Providing books and magazines with colorful pictures of landscapes, animals, and children can evoke memories and reminiscent conversations.

Managing Repetitive Actions

It is not unusual for an individual with impaired cognition or dementia to engage in repetitive movement and activities, such as tugging on bedding or personal items, picking at skin, or pacing. A diversion activity that may be useful is to provide laundry in a basket that can be removed, folded, and replaced, or simple puzzles that can be disassembled/reassembled to keep both mind and hands occupied. Or provide a “rummage box” containing soft items such as washcloths, towels, balls of yarn, or stuffed animals for the person to take out, examine, and replace. These diversions may keep someone with impaired memories entertained for hours by removing/replacing the items, folding/unfolding, or winding/unwinding. For individuals who remain at home folding/unfolding, arranging/rearranging laundry is another strategy that can occupy the person who may feel he or she is contributing to family efforts.

Games, Arts, Crafts

Simple games with large pieces or print (checkers, playing cards) along with art and craft activities (watercolor painting, coloring, creating simple crafts) can facilitate positive social interactions, promote cognitive processes, and allow for creative expression. These activities offer an acceptable emotional outlet for anxiety which can help to manage agitation and belligerence.

Service and Emotional Support Animals

A growing body of evidence is acknowledging the role of animals in human health and healing. Many individuals and families have pets in the home. Likewise, a growing number of institutions allow small animals (i.e., pets or service/assistive animals) to accompany residents. Animals can offer a calming and reassuring effect for the older adult. Assistive animals are extensively relied on by the owner. Some facilities have a resident cat or dog (i.e., pet), while others have visiting pets (therapists) for residents to touch and hold. It is important, however, to take into consideration the “rest” needs of the animal and arrange for time away from being with residents. As with human caregivers, animals too can experience caregiver fatigue or burnout that can pose safety risks (i.e., nips, bites, scratches). (Americans With Disabilities (ADA), 2014, Service Animals and Emotional Support Animals. https://adata.org/publication/service-animals-booklet

Assuring Safety and Protection from Injury

Protection from injury is one of the most important considerations when caring for older adults; and, especially for an individual who is physically or cognitively challenged. Falls frequently occur when a patient or resident...
Communication Strategies When Caring For Adult With Impaired Cognition

- Always introduce yourself. Inquire about the person’s preferred title/name.
- Assess orientation to person, time, and place, and knowledge level about diagnosis.
- Use short, concise sentences with a direct message. “Your shirt is on the chair.” (Rather than, “Here it is.” or “Stay sitting in the chair while I get your shirt.” or “Do you want to sit in this chair or would you rather go to the TV room?”)
- Avoid ambiguous language and slang terms. Such as, “Jump into bed”; rather state, “Lie down on the bed now.”
- Be aware of your actions. Individuals with memory impairment and dementia are highly sensitive; having an uncanny ability (sometimes paranoid) to cue in to another’s mood, attitude, and nonverbal language.
- Display calmness in actions, demeanor, and tone of voice. Slower, deliberate, patient behaviors send a calming message which help to prevent and manage agitation.
- Be sensitive to hidden emotions that may be masked by the person’s words. For example: Asking, “When is mommy going to be here?” the person may mean, “I want to go home, I am scared of this strange place.”
- Do not argue with, scold, or quiz the person. Distraction or refocusing may prevent a difficult situation from escalating into agitation. (e.g., invite the person to join others in dining facility for a cup of coffee, going for a walk, watching TV, etc.)
- If the person refuses to carry out a request (e.g., take medicine, bathing) and becomes upset, drop the topic of discussion. Return later (15 to 30 minutes) and try again.
- Focus on one activity; complete one task before progressing to another. (“Brush teeth.” Next, “comb hair.” Next, “sit in chair.” Next, “eat breakfast.”)
- Give simple instructions. Check for comprehension. Allow time for repetition.
- Inform about every activity before carrying out the action, even when the older adult does not seem alert enough to understand.
- Avoid startling the older adult. Speak calmly, gently, and pleasantly when approaching the bedside. Position yourself so the individual can see you; establish eye contact.
- Be sensitive to complaints of hunger or thirst even if the individual has recently eaten. When possible, offer nourishment when requested (fluids such as water, juice, milk; crackers; nutrient dense supplementary feeding). Do not refute or disregard complaints of feeling tired or weak.
- When the individual is resisting all efforts to provide care, stop what you are doing and try at a later time (e.g., bathing, eating).
- When the person speaks in a loud, aggressive voice, wait for an opportunity to speak then do so in a calm manner with a gentle voice.
- Performing activities in a routine manner may help to prevent and alleviate agitation which can lead to confusion, resistance, not cooperating, and belligerence. Consider interventions that promote oxygenation, such as deep breathing and passive range of motion with extremities to promote circulation and increase blood supply to the brain.
- When individual exhibits agitation or belligerence, assess the situation to determine potential causative factors. Then, try distraction or refocusing the individual.

Attempts to get to a bathroom. Implementing a routine toileting schedule can help to reduce the risk for falls (e.g., every two hours; in the morning, after meals, at bedtime.) Numerous factors contribute to the risk for falls, including, but not limited to: diagnosis of osteoporosis; medications that affect judgment and reduce reflexes; relocation stress; history of falls and/or fractures; and advancing age. Nursing interventions include placing the bed in a low position, leaving the call bell within reach, and utilizing bed and chair alarms if allowed according to facility policy. On a routine basis the older adult must be assessed for safety risks for potential injuries, both in the home and in institutional living arrangements. For those at high risk, locate where staff can readily observe the person; or, ask family members to remain with the person. Use of physical restraints and/or chemical restraints with older adults involves ethical and legal considerations, and should only be used as a last resort. Although most long-term care facilities are transitioning to restraint-free standards, each institution must have documented policies and procedures regarding use of restraints and are only permitted with a physician’s order. (Gastmans & Milisen, 2006, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2564468/; Whatever strategy is implemented, frequently evaluate the approach for effectiveness or adverse reactions. The Code of Federal Regulations specifically 42 CFR 483.358 identifies regulatory information for the use of restraint or seclusion. (https://www.govinfo.gov/app/details/CFR-2013-title42-vol5/CFR-2013-title42-vol5-sec483-358)

The most common lawsuit filed for negligence in health care facilities are associated with falls. On admission, the nursing assessment should determine if the person is at high risk for falls and other safety risks. A commonly used fall assessment tool is the Hendrich II Fall Risk Scale (Hendrick, 2016). While risk appraisal tools are useful, these scales should not replace routine nurse assessments of the environment for safety and fall risks to protect older adults from injury. https://consultgeri.org/try-this/general-assessment/issue-8.pdf

Effective communication about safety risks is essential for everyone providing care for the older adult, including other caregivers as well as family members. Consider obtaining a physical therapy consult to assess for strength, balance issues, and need for assistive devices for older adults who may be physically or cognitively challenged.

Assure Privacy & Confidentiality

Assuring privacy, confidentiality, respect, and dignity is critical for all individuals regardless of age. Only essential information about health care needs should be shared with other health care providers and with other individuals specifically designated by the older adult. The Health Insurance Portability and Accountability Act (HIPAA, 1996) established “national standards to protect individuals’ medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.” https://www.hhs.gov/hipaa/for-professionals/privacy/index.html https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html
Elder Abuse, Maltreatment & Neglect

Annually, thousands of older adults are neglected, abused, and exploited by family members and others. The term “abuse” is a broad concept, and refers to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult. https://www.cdc.gov/violenceprevention/elderabuse/

Older adults at risk for abuse are older, frail, and dependent on others to meet their most basic needs. Abusers of older adults are both women and men, and may be family members, friends, or “trusted others.”

The CDC recognizes elder abuse as a serious public health issue because of associated pain, suffering, and diminished quality of life. The personal costs of elder abuse are catastrophic and include loss of independence, health, security, and dignity. Unfortunately, the problem of elder abuse is likely to get worse as the percentage of older adults increases. About five million older adults are abused in the US annually; of these, at least 85% are never reported. Most elder abuse victims are female with 40% being 80 years of age and older. While most elder abuse occurs in the home, it also occurs in extended care facilities and assisted living facilities. Broadly defined, abuse includes:

- Physical Abuse - inflicting physical pain or injury on a senior, e.g., slapping, bruising, or restraining by physical or chemical means.
- Emotional Abuse - inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts, e.g., humiliating, intimidating, or threatening.
- Sexual Abuse - non-consensual sexual contact of any kind.
- Neglect - the failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder.
- Exploitation - the illegal taking, misuse, or concealment of funds, property, or assets of a senior for someone else’s benefit.
- Abandonment - desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.
- Self-neglect - characterized as the failure of a person to perform essential, self-care tasks and that such failure threatens his/her own health or safety.

When suspecting abuse, assessment of the older adult by the healthcare professional is critical. It is important to interview the individual privately, especially if the suspected abuser may be the caregiver. When abuse is suspected, it is important to be nonjudgmental and allow plenty of time to interact with the individual. Interview and assess the victim in a private setting to make the elder more comfortable with discussing his or her situation. Legislatures in all 50 states have passed some form of elder abuse prevention laws and most have a mandatory reporting requirement for anyone who provides care to older adults. As mandatory reporters of abuse and neglect, healthcare professionals have both an ethical and legal responsibility to advocate for victims of abuse by screening, identifying, and reporting cases of abuse.

Education is essential to inform healthcare professionals to recognize signs of abuse and intervene appropriately. The United States Preventive Services Task Force (USPSTF) publishes standards for screening older or physically or mentally dysfunctional adults for abuse and neglect.

Unfortunately its recommendation summary from October 2018 “concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults.” In fact, USPSTF found no valid, reliable screening tools “without recognized signs and symptoms of abuse”, nor did they determine an appropriate interval for testing.


End-of-Life Decisions

Health professionals rarely can predict when the dying process will begin or end. Some people pass quickly, while others recover from severe illness several times before death. Even individuals of the same age, gender, and disease progression are unlikely to reach their end of life at the same time. Consequently, documenting an individual’s preferences regarding end-of-life decisions should be done while one is in good health.

Table 4: Comparison of Hospice Care and Palliative Care

Comparison of Hospice Care and Palliative Care

<table>
<thead>
<tr>
<th>Hospice Care</th>
<th>Palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involves a program of care and support for a dying person whose doctor and a hospice medical director certify has less than six months to live. The focus of hospice is on comfort, not cure. Medicare offers hospice benefits to individuals choosing this end of life option. <a href="https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF">https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF</a></td>
<td>Includes interventions to relieve the discomforts, symptoms, and stress of a serious illness. Palliative care interventions not only are meant for end-of-life but may be an option for both serious illness and chronic non-acute conditions. Unfortunately, the term “palliative care” often is mistakenly associated only with end-of-life care. The older adult diagnosed with one or more chronic illnesses may benefit from palliative care long before they need end-of-life or hospice care. Unlike hospice care, palliative care may be used for as long as necessary. The AHRQ provides guidelines for palliative care. <a href="https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/healthyliving/supportive.html">https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/healthyliving/supportive.html</a></td>
</tr>
</tbody>
</table>

To learn more:

Table 5. Older Adult Assessment Screens & Resources

<table>
<thead>
<tr>
<th>Assessment Screens &amp; Resources</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hendrick II Fall Risk Model: Screen</td>
<td>Accessed February 27, 2019</td>
</tr>
<tr>
<td>Stanford Medicine Elder Abuse: How to Screen</td>
<td>Accessed February 27, 2019</td>
</tr>
<tr>
<td>Canadian Association of Gerontology – Elder Caregiver Abuse: Screen (CASE)</td>
<td>Accessed February 27, 2019</td>
</tr>
<tr>
<td>Impaired Visual Acuity in Older Adults: Screening</td>
<td>Accessed February 25, 2019</td>
</tr>
<tr>
<td>Hearing Loss in Older Adults: Screening</td>
<td>Accessed February 25, 2019</td>
</tr>
<tr>
<td>SAMHSA HRSA – Screening Tools</td>
<td></td>
</tr>
<tr>
<td>• Depression</td>
<td></td>
</tr>
<tr>
<td>• Drug &amp; Alcohol Use</td>
<td></td>
</tr>
<tr>
<td>• Suicide Risk</td>
<td></td>
</tr>
<tr>
<td>• Anxiety Disorder</td>
<td></td>
</tr>
<tr>
<td>Accessed February 27, 2019</td>
<td></td>
</tr>
<tr>
<td><a href="https://www.integration.samhsa.gov/">https://www.integration.samhsa.gov/</a></td>
<td></td>
</tr>
<tr>
<td>US Preventive Services Task Force (USPSTF)</td>
<td></td>
</tr>
<tr>
<td>Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Screening</td>
<td></td>
</tr>
<tr>
<td><a href="https://www.uspreventiveservicestask-force.org/">https://www.uspreventiveservicestask-force.org/</a></td>
<td></td>
</tr>
</tbody>
</table>

and before becoming ill.

The National Institute on Aging (NIA) states:

At the end of life, each story is different. Death comes suddenly, or a person lingers, gradually fading. For some older people, the body weakens while the mind stays alert. Others remain physically strong, but cognitive losses take a huge toll. Although everyone dies, each loss is personally felt by those close to the one who has died. End-of-life care is the term used to describe the support and medical care given during the time surrounding death. Such care does not happen only in the moments before breathing ceases and the heart stops beating. Older people often live with one or more chronic illnesses and need a lot of care for days, weeks, and even months before death.

https://www.nia.nih.gov/health/what-end-life-care

Communication is critical between the older adult and family members regarding end of life preferences. Planning for end of life should include preferences as to place of death (i.e., home, hospital, or hospice); who should be in attendance at the time of death (i.e., alone, select family members, etc.); and specific interventions that should or should not be offered (i.e., level of pain management, retaining mental alertness, resuscitation measures, etc.). An individual’s preferences may change over time. For example, someone initially may want everything possible to prolong life, but later decide on “comfort measures only” subsequent to a diagnosis of metastatic cancer. Or, someone else who initially declined treatment may decide to try an “experimental therapy” in an effort to prolong life.

Regardless of age, the public must be educated about Advance Directives.

**Advance Directives** are legal documents that include a living will and health care power of attorney. The living will specifies types of end-of-life medical treatment the person wants or does not want if for some reason he or she is not able to tell medical professionals (e.g., mechanical ventilation, tube feeding, etc.). A health care durable power of attorney designates someone (on one’s behalf) to make end of life health care decisions, not only regarding life-prolonging treatments. This individual has the power of attorney/proxy to become the spokesperson (i.e., advocate, agent, proxy) to make decisions as specified in the legal document.

Older adults should be educated about the importance of having an advance directive and providing a copy of this document to family members as well as health care providers (e.g., physicians, hospitals, institutions, etc.). Regardless of a person’s choices for treatment and care at the end of life, it is important to preserve the dignity of the dying person.

The American Association of Retired Persons (AARP) provides free downloadable advance directive forms according to state https://www.aarp.org/caregiving/financial-legal/free-printable-advance-directives/

In summary, there is wide diversity among older adults. The aging process is associated with physical changes, and a proportion of older adults have been diagnosed and are living with one or more chronic disease or some degree of impaired cognition. Many older adults, even those in advanced age, remain physically and socially active and are well-read and highly informed about their diagnosis, treatment approach, and likely prognosis. For this reason the nurse must assess the older adult’s knowledge level about his or her diagnosis and familiarity with the health care environment. Subsequently, communication style and treatment approaches must be tailored to fit the individual’s knowledge level, learning style, and treatment preferences. This health care approach relays an attitude of respect and promotes rapport with older adults, which does much to avoid misunderstandings and facilitates older adults’ satisfaction with care.

References


attorney.html?CMP=KNC-DSO-Adobe-Bing-Caregiving-EndOfCaregiving-Caregiver&s_kwcid=AL45201107339254639487173392511126851&ef_id=WVvZQAHHvqUJnp;20181121144453:ss
Resources
Administration on Aging (AoA)/Administration for Community Living (ACL).
https://acl.gov
Agency for Healthcare Research and Quality (AHRQ).
https://www.ahrq.gov
The American Association of Retired Persons (AARP).
Alzheimer Association.
https://www.alz.org/
Centers for Disease Control and Prevention (CDC).
https://www.cdc.gov
Centers for Medicare and Medicaid (CMMS).
https://www.medicare.gov
National Center on Elder Abuse (NCEA)
https://ncea.acl.gov/
National Heart, Lung, and Blood Institute.
https://www.nhlbi.nih.gov
National Institute on Aging (NIA).
https://www.nia.nih.gov
US Bureau of the Census.
https://factfinder.census.gov
US Department of Health and Human Services (DHHS).
http://www.hhs.gov
US Preventive Services Task Force
https://www.uspreventiveservicestaskforce.org