Wagner, *High Acuity Nursing*, 6e
Chapter 3

Question 1
Type: MCSA

A nurse is assessing an 85-year-old patient who presented to the emergency department with a complaint of "not feeling like myself." What should the nurse consider during this assessment?

1. Aging causes sudden loss of function in organ systems.

2. In older adults diseases often present with uncharacteristic symptoms.

3. Many older adults do not participate in activities to support wellness.

4. Since the majority of 85-year-old patients live in an institutional setting they are exposed to more communicable diseases.

Correct Answer: 2

Rationale 1: Aging itself, in the absence of true pathology, causes a gradual reduction in the function of organ systems.

Rationale 2: Older adults often manifest diseases in uncharacteristic ways, so diagnosis can be difficult or may be missed.

Rationale 3: The propensity to participate in wellness activities is not age related.

Rationale 4: The majority of older patients do not live in institutional settings.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 3-1

Question 2
Type: MCSA

An older adult has been prescribed medication to control hypertension. Today she says, "I took this same medication years ago, but I'm having more side effects this time." What should the nurse consider before replying?

1. Many antihypertensive medications have similar names so the patient could have confused the drugs.

2. Older women often decrease oral fluid intake, which would change response to the drug.

3. The older pancreas cannot supply enzymes to metabolize the drugs as early in the digestive system.

4. Changes in the blood–brain barrier may make older patients more sensitive to some side effects.

Correct Answer: 4

Rationale 1: The names of some drugs are similar, but there is no reason to believe that this patient is confused.

Rationale 2: Some women do reduce fluid intake because of fears of incontinence, but the reduction is not sufficient to make this extensive a difference in response to the medication.

Rationale 3: There is no evidence that pancreatic insufficiency would increase side effects.

Rationale 4: The side effects of antihypertensive drugs are generally problems with dizziness or weakness. The blood–brain barrier changes allow the drug to have more of these effects in older patients.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 3-2

Question 3
Type: MCSA

An older adult being treated for a burn on her lower leg and foot is surprised at its severity. She says, "It really didn't hurt very badly when I did it." What should the nurse consider before responding?

1. Patients can block out portions of painful stimuli if it is overwhelming.

2. Aging can decrease touch sensitivity to the feet and lower legs.

3. Poor circulation has probably resulted in death of the nerve endings in the patient's legs.

4. Burns on the legs often appear very severe because the skin is so thin.

Correct Answer: 2

Rationale 1: This is not the most likely reason for this patient's statement.

Rationale 2: An age-related change to the neurosensory status is reduced sensitivity in the fingertips, palms, and feet. This is the response the nurse should make to the patient.

Rationale 3: The nerves do not die, but may change.

Rationale 4: The burn is just as severe as it looks. Thinness of the skin can make burns more severe.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 3-2

Question 4
Type: MCSA

An older adult says, "I cannot believe that I have had a heart attack. I thought I had stomach flu and a backache." What nursing response is indicated?

1. "I am also surprised that you had a heart attack. Your symptoms did not sound that severe."

2. "Usually a patient has chest and arm pain with a heart attack."

3. "The symptoms of heart attack change as people age and may include back pain or stomach problems."

4. "It is rare but a backache and a stomach ache can occur as a signal of a heart attack."

Correct Answer: 3

Rationale 1: The nurse should not say that the diagnosis is a surprise, but should take this opportunity to teach the patient about heart attack symptoms.

Rationale 2: This is true of younger patients, but should not be generalized as "usual" for an older patient.

Rationale 3: Elderly patients with cardiac ischemia and an acute myocardial infarction or heart attack may have atypical symptoms. These symptoms include shortness of breath, abdominal, throat, or back pain, syncope, acute confusion, flulike symptoms, stroke, and/or falls. Because these symptoms are atypical, diagnosis and treatment might be delayed.

Rationale 4: The nurse should not characterize these symptoms as rare indications of cardiac ischemia. The symptoms are not rare in older patients.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 3-3

Question 5
Type: MCSA

An older patient says, "I seem to get chest colds so often now." How should the nurse respond to this report?

1. "How often do you wash your hands?"

2. "Risk for colds and infections increase as we age."

3. "Do other people you are around have frequent colds?"

4. "Maybe you should consider taking antibiotics during the winter."

Correct Answer: 2

Rationale 1: This response seems to blame the patient for having poor hygiene and causing infection.

Rationale 2: This is a true statement and helps the patient understand that the colds may be a reflection of aging. It opens the discussion of how to reduce exposure.

Rationale 3: This statement may be interpreted as blaming the patient's surroundings for the infections.

Rationale 4: Most colds and upper respiratory infections are viral so antibiotics are not preventative. This statement also does not offer the patient information to understand the frequency of illness.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 3-3

Question 6
Type: MCMA

An older adult patient remarks that he has been experiencing constipation, which has never been a problem for him before now. What questions should the nurse ask?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

Standard Text: Select all that apply.

1. "Do you have a list of your medications?"

2. "How many fluids do you drink each day?"

3. "Do you get enough rest at night?"

4. "What kinds of fruits and vegetables do you eat daily?"

5. "How often do you have a bowel movement?"

Correct Answer: 1,2,4,5

Rationale 1: The nurse should review the patient's medications for those that can cause constipation.

Rationale 2: Constipation can be the result of inadequate fluid intake.

Rationale 3: Rest is not closely associated with constipation.

Rationale 4: Fruits and vegetables contain fiber, which helps to prevent and treat constipation.

Rationale 5: The nurse should assess the patient's bowel habits to compare them to what is normal range.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 3-5

Question 7
Type: MCMA

The nurse suspects urinary tract infection in an older adult patient who has sudden onset of incontinence. Which symptoms, atypical in a younger adult, would the nurse assess for in this patient?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

Standard Text: Select all that apply.

1. Confusion

2. Vomiting

3. Chills

4. Flank pain

5. Fever

Correct Answer: 1,2,3

Rationale 1: Urinary tract infection can affect the older patient's mentation resulting in confusion.

Rationale 2: Urinary tract infection can result in vomiting in the older patient.

Rationale 3: Chills are a typical finding of urinary tract infection.

Rationale 4: Flank pain is a typical finding in younger patients with urinary tract infection.

Rationale 5: Fever is a typical sign of infections.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 3-5

Question 8
Type: MCSA

A 70-year-old patient had a pneumonia vaccination 10 years ago. Which information should the nurse provide about this vaccination?

1. "A booster vaccination is warranted."

2. "As long as your kidney function is good you do not need a second immunization."

3. "You will never need another pneumonia vaccination."

4. "You should plan to get a pneumonia vaccination every year after September."

Correct Answer: 1

Rationale 1: The pneumonia vaccination should be provided to those who are age 65 or older. Since this patient is currently 70 years old and had the initial vaccination 10 years ago, the pneumonia booster should be provided.

Rationale 2: Renal function does not guide the need for pneumonia vaccination.

Rationale 3: The pneumonia vaccine is not a one-time for life immunization.

Rationale 4: There is no need to get an annual pneumonia vaccine.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 3-6

Question 9
Type: MCSA

After being medicated for postoperative pain an older patient becomes agitated and combative. Since this behavior has not been previously demonstrated the nurse conducts additional assessment for which most likely condition?

1. Depression

2. Delirium

3. Drug toxicity

4. Dementia

Correct Answer: 2

Rationale 1: Depression is characterized by low mood and is related to chronic stress or losses. It is not related to medications used to treat situational pain.

Rationale 2: Delirium is also called acute confusion and is the rapid onset of problems with cognition. Medications can be implicated in the development of delirium. Since this patient has an illness, an invasive procedure, and pain medication, the most likely condition is delirium.

Rationale 3: Since there is no information about which medication was administered, the dose, or the frequency of administration it is not possible to determine if this patient's agitation is related to drug toxicity.

Rationale 4: Dementia has gradual onset over months to years. Since this is the first episode of behavior change, dementia is not the most likely cause.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 3-7

Question 10
Type: MCSA

An older adult with osteoarthritis has been told that he cannot have his painful knee replaced because of his cardiac status. The patient is having progressive difficulty with normal self-care activities. The nurse should monitor this patient for which condition?

1. Depression

2. Noncompliance

3. Dementia

4. Delirium

Correct Answer: 1

Rationale 1: Older adults are at risk for depression when they suffer multiple losses. This patient has lost the ability to easily care for himself, has been told his physical condition is poor, and has been denied the surgical procedure to replace his knee. This situation places the older adult at risk for depression.

Rationale 2: There is no indication that this patient will be noncompliant with the suggested regimen.

Rationale 3: Dementia is a slowly developing change in ability to interpret and deal with environmental stimuli. There is no assessment information that indicates this patient is at risk for dementia.

Rationale 4: Delirium is related to a situational health change. This patient has been experiencing knee discomfort and decreased mobility for some time. Delirium is not likely.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Psychosocial Integrity
Client Need Sub:
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 3-7

Question 11

Type: MCSA

The nurse manages an acute care unit that is beginning to provide care for more and more older adults after surgery. The nurse manager would encourage nurses to add which interventions to the plan of care for these patients?

1. Use of restraints to prevent falls and disruption of invasive lines

2. Early return to ambulation and self-care activities

3. Get patients out of bed to a chair for most of the day

4. Keep patients on bedrest until strength returns

Correct Answer: 2

Rationale 1: Use of restraints does not prevent falls and is associated with increased risk of injury.

Rationale 2: Immobility and bedrest in the older patient can contribute to a cascade of dependence. For each day of immobility, 5% of muscle strength is lost. The best intervention for these patients would be an early return to ambulation and self-care activities to limit the loss of muscle strength.

Rationale 3: Having the patient sit out of bed in a chair is not enough activity to limit disability.

Rationale 4: The patient should not be kept on bedrest. This would encourage further disability and muscle loss.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 3-8

Question 12
Type: MCSA

An older adult patient tells the nurse that he is "tired" of having his medication doses changed so many times and wants to find a doctor who "knows what he's doing." How should the nurse respond to this patient?

1. "Have you thought about cutting pills or add pills together to get the correct dose?"

2. "If you seriously want to change providers know some of the other doctors in the building are taking new patients."

3. "Frequent dose changes are necessary until the correct dose for you is determined."

4. “I know what you mean. It is annoying, but it is necessary.”

Correct Answer: 3

Rationale 1: Before making this suggestion the nurse should carefully consider the medication and dosages. Some drugs should not be split. If the patient is to take more than one pill to achieve the dosage, the prescription should be written to indicate how many pills.

Rationale 2: It is not appropriate for the nurse to make this suggestion.

Rationale 3: The patient is complaining about the physician's plan to "start low and go slow" when prescribing medications. The nurse's best response would be to explain how the different doses react in the body and the physician's attempt to prevent side effects or other pharmacological effects from the medications.

Rationale 4: The nurse should not just agree with the patient, but should instead explain why the changes are necessary.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 3-8

Question 13
Type: MCSA

The primary nurse reports to the team caring for an older adult that the patient has a low Braden Scale score. The nurse would instruct the team to start interventions to prevent which complication?

1. Skin breakdown

2. Dehydration

3. Falls

4. Drug–food interactions

Correct Answer: 1

Rationale 1: The Braden Scale is used to predict risk for pressure ulcer development.

Rationale 2: The Braden Scale does not predict risk for dehydration.

Rationale 3: The Braden Scale does not predict risk for falls.

Rationale 4: The Braden Scale does not predict risk of drug–food interactions.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 3-9

Question 14
Type: MCMA

The nurse is admitting an older adult female who uses two canes for ambulation. The patient is attended by her daughter who quietly reorients her mother several times during the assessment process. The daughter reports that her mother was a smoker for many years, but has not smoked for the last 5 years. The patient wears incontinence underwear and has problems with constipation. The nurse would evaluate which of these findings as key risk factors from the Hendrich II Fall Risk Model?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

Standard Text: Select all that apply.

1. The patient is female.

2. The patient has a history of using tobacco.

3. The patient wears incontinence underwear.

4. The patient requires frequent reorientation.

5. The patient uses a cane.

Correct Answer: 3,4,5

Rationale 1: Male gender is a key risk factor according to the Hendrich II Fall Risk Model.

Rationale 2: There is no indication that previous tobacco use increases fall risk according to this model.

Rationale 3: Alteration in elimination is considered a key risk factor for falls by this model.

Rationale 4: Disorientation and confusion are key risk factors for falls according to the Hendrich II Fall Risk Model.

Rationale 5: The Hendrich II Fall Risk Model lists difficulty walking around as a risk for falls. Use of canes indicates difficulty walking around.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 3-9

Question 15
Type: MCSA

The daughter of an older adult calls the emergency department (ED) triage nurse and reports that her mother hit her head "very hard" while getting into the car about 10 minutes ago. There is no bleeding. The daughter asks what she should watch for in her mother. How should the nurse respond?

1. "As long as she does not develop a severe headache she is probably okay. Be sure to bring her to the ED if that happens."

2. "As long as your mother does not begin vomiting she is probably not severely injured. If she does begin to vomit, bring her in immediately."

3. "Watch her for the next hour or two. If she seems okay after that she is not likely to have a severe injury. Bring her in to the ED if you are concerned."

4. "In older adults the changes are very subtle and can develop over several hours or even days. Bring her to the ED if you have any concerns."

Correct Answer: 4

Rationale 1: Older adults may not develop the severe headache that younger people experience with intracranial bleeding.

Rationale 2: Older adults may not develop the vomiting often associated with intracranial bleeding in younger people.

Rationale 3: In older patients it may take some time before symptoms of severe head injury occur.

Rationale 4: In older adults the changes that indicate severe head injury may be very subtle. Any change is significant and should be investigated.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 3-10

Question 16
Type: MCMA

An older adult is admitted to the emergency department (ED) after being the restrained front seat passenger in a motor vehicle accident. The nurse assessing this patient should consider that which physiologic response to hypovolemia is not as likely in an older adult?

Standard Text: Select all that apply.

1. Decreased blood pressure

2. Tachycardia

3. Decreased cardiac output by hemodynamic monitor

4. Decreased urine output

5.

Correct Answer: 2

Rationale 1: Decrease in blood pressure can be related to decreased cardiac output from hypovolemia. This reaction does occur in older adults as well as younger adults.

Rationale 2: The older adult heart may not respond to hypovolemia by increasing rate.

Rationale 3: Hemodynamic monitoring will reveal decreased cardiac output regardless of the patient's age.

Rationale 4: The older adult kidney, just like the younger adult kidney, must be perfused to produce urine.

Rationale 5:

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 3-11

Question 17

Type: MCMA

The nurse has assessed that an older adult patient is at risk for impaired skin integrity. Which interventions are indicated?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

Standard Text: Select all that apply.

1. Secure IV catheters with paper tape.

2. Apply transparent film dressings to pressure prone areas.

3. Pull the patient up in bed every hour.

4. Keep the patient warm.

5. Monitor IV sites for infiltration.

Correct Answer: 1,2,4,5

Rationale 1: Paper tape is less difficult to remove and less irritating to the skin than is silk tape.

Rationale 2: The application of these film dressings adds a layer of protection in areas that are prone to breakdown.

Rationale 3: Pulling the patient up in bed causes friction and shear on the skin. The patient should be lifted and moved up in bed.

Rationale 4: Cold temperatures cause constriction of the blood vessels in the skin and can lead to increased fragility of tissues.

Rationale 5: IV sites in older adults may infiltrate quickly due to poor integrity of vessels and tissues. The nurse should increase surveillance of these sites.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 3-4

Question 18

Type: MCSA

An older adult patient's testing reveals decreased absorption of calcium, which is a common age-related change. The nurse would consider which nursing diagnosis when creating a care plan for this patient?

1. Impaired Swallowing

2. Risk for Constipation

3. Risk for Incontinence

4. Activity Intolerance

Correct Answer: 2

Rationale 1: Decreased calcium absorption does not impair swallowing.

Rationale 2: Decreased absorption of calcium leaves more free calcium in the gastrointestinal tract. Calcium can be constipating.

Rationale 3: Decreased calcium absorption would not increase risk for incontinence.

Rationale 4: Decreased calcium absorption does make the patient intolerant of activity.

Global Rationale:

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Diagnosis
Learning Outcome: 3-5

Question 19
Type: MCSA

The nurse has received emergency admission orders for an older adult patient who was severely injured in a fall. The nurse would question the use of which medication in this patient?

1. Digoxin 0.125 mg po daily

2. Diazepam 5 mg po every 6 hours prn agitation

3. Morphine sulfate 2 mg IV every hour prn severe pain

4. Furosemide 20 mg po daily

Correct Answer: 2

Rationale 1: Digoxin doses over 0.125 mg should be questioned.

Rationale 2: Diazepam has a long half-life in older patients and should be avoided.

Rationale 3: Morphine is a short acting opioid when given IV. This dose is not excessive.

Rationale 4: Furosemide is not contraindicated for use in older adults.

Global Rationale:

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Pharmacological and Parenteral Therapies
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 3-8

Question 20
Type: MCSA

Results of the CAM-ICU testing reveal that an older adult hospitalized in the intensive care unit has delirium. Which nursing interventions should be instituted?

1. Increase environmental stimuli in the patient's room.

2. Limit visiting hours.

3. Sedate the patient until ready for discharge from the intensive care unit.

4. Manage the patient's pain effectively.

Correct Answer: 4

Rationale 1: The environmental stimuli present in the intensive care unit can contribute to delirium. The nurse should intervene to reduce these stimuli.

Rationale 2: Presence of a calm family member may help to reorient the patient.

Rationale 3: Sedation will not benefit the patient in the long run and may increase delirium when reduced.

Rationale 4: Unrelieved pain is often the cause of delirium in the older patient.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 3-7