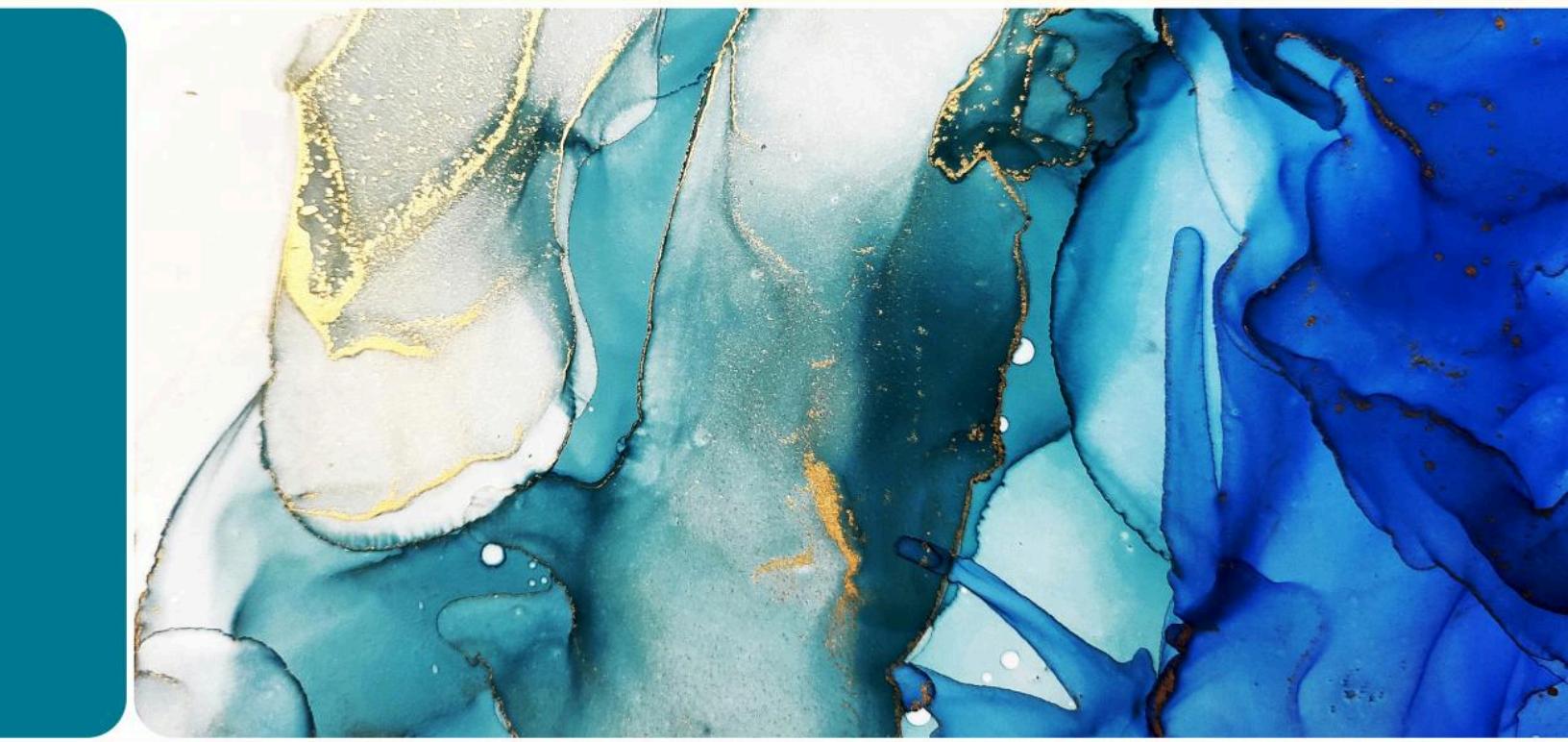
EDITION
8

Basic Geriatric Nursing

Williams



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Basic Geriatric Nursing

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EDITION
8

Basic Geriatric Nursing

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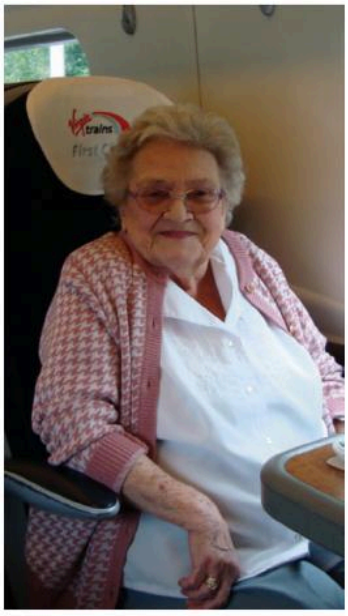

I dedicate this book to Cynthia—
You were deeply loved, are terribly missed,
and your legacy lives on through your grandchildren.

Patricia

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LPN/LVN Advisory Board

To the Instructor

The changing demographic of today's world presents an immense challenge to health care providers and society as a whole. Nurses must be well prepared to recognize and respond appropriately to the needs of our aging population. The goal of this text is to give the beginning nurse a balanced perspective on the realities of aging and to broaden the beginning nurse's viewpoint regarding aging people so that their needs can be met in a compassionate, caring, and professional manner.

ABOUT THE TEXT

The eighth edition of *Basic Geriatric Nursing* presents the theories and concepts of aging, the physiological and psychosocial changes and problems associated with the process, and the appropriate nursing interventions. The *LPN Threads* design provides consistency among Elsevier's LPN/LVN textbooks. Key features include extensive coverage of cultural issues, clinical situations, delegation, home health care, health promotion, patient teaching, and complementary health approaches. Numerous Critical Thinking exercises provide practice in synthesizing information and applying it to nursing care of the older adult.

LPN THREADS

The eighth edition of *Basic Geriatric Nursing* shares some features and design elements with other Elsevier LPN/LVN textbooks. The purpose of these *LPN Threads* is to make it easier for students and instructors to use the variety of books required by the relatively brief and demanding LPN/LVN curriculum. The following features are included in the *LPN Threads*:

- The **full-color design**, **cover**, **photos**, and **illustrations** are visually appealing and pedagogically useful.
- **Objectives** (numbered) begin each chapter and provide a framework for content and are especially important in providing the structure for the TEACH Lesson Plans for the textbook.
- **Key Terms** with phonetic pronunciations and page number references are listed at the beginning of each chapter. They appear in color in the chapter and are defined briefly, with full definitions in the **Glossary**. The goal is to help the student with limited proficiency in English to develop a greater command of the pronunciation of scientific and nonscientific English terminology.
- **Key Points** at the end of each chapter correlate to the objectives and serve as a useful chapter review.
- In addition to consistent content, design, and support resources, these textbooks benefit from the advice and input of the Elsevier **LPN/LVN Advisory Board** (see p. vii).

ORGANIZATION

Unit I presents an overview of aging, examining the trends and issues affecting the older adult. These include demographic factors and economic, social, cultural, and family influences. The unit explores various theories and myths associated with aging and reviews the physiologic changes that occur with aging.

Unit II includes a wide range of information on modifying basic nursing skills for the aging population. There is a strong focus on (1) health promotion and health maintenance for older adults; (2) age-appropriate verbal and nonverbal communication; (3) relevant nutritional and fluid needs, alterations in pharmacodynamics, and concerns related to medication administration for older adults; (4) health assessment of older adults; and (5) meeting safety needs of the older adults.

Unit III addresses the psychosocial needs of the older adult through the nursing process and clinical judgment model. Psychosocial care precedes physiologic care, reflecting the order in which the content is most often taught. Areas of content include (1) cognition problems, (2) self-perception and self-concept, (3) changing roles and relationships, (4) coping and stress management, (5) values and beliefs, and (6) sexuality.

Unit IV addresses the physical needs of the older adult through the nursing process and clinical judgment model. Areas of content include (1) safety, (2) hygiene and skin care, (3) elimination, (4) activity and exercise, and (5) sleep and rest. Units III and IV both offer assessment (data collection), data analysis/problem identification, planning, and implementation of nursing interventions across care settings.

SPECIAL FEATURES

- **Nursing process/Clinical Judgment Model** sections that provide a strong framework for discussing care of older adults in the context of specific disorders
- **Nursing interventions** grouped by health care setting (e.g., acute care, extended care, home care)
- **Special boxes** for critical thinking, clinical situations, health promotion, safety, patient education,

complementary health approaches, delegation, nurse alerts, and more
- **QSEN** highlighting information related to the six prelicensure competency categories
- Increased **cultural content** on the impact of aging in various cultures
- Focus on **changing demographics** including baby boomers and the impact of their aging on health care
- Additional information on **home health** for both patients and caregivers
- **Review Questions for the Next Generation NCLEX® Examination** at the end of every chapter
- Updated **Laboratory Values for Older Adults** (Appendix A)
- The **Geriatric Depression Scale** (Appendix B)
- **Daily Nutritional Goals for Older Adults** (Appendix C)
- Revised list of **Resources for Older Adults**, including relevant websites (Appendix D)
- **References** grouped by chapter and listed at the end of the book for easy access

TEACHING AND LEARNING PACKAGE

FOR INSTRUCTORS

The comprehensive and free *Evolve Resources with TEACH Instructor Resource* include the following:
- **Test Bank** with approximately 400 multiple-choice and alternate-format questions with topic, step of the nursing process, objective, cognitive level, NCLEX® category of client needs, correct answer, rationale, and textbook page reference
- **6 All New Next Generation NCLEX®Exam–style Case Studies and Review Questions** provide thorough preparation and practice for the Next Generation NCLEX Examination
- **TEACH Instructor Resource** with Lesson Plans, Lecture Outlines, and PowerPoint slides—with Audience Response System questions embedded—that correlate each text and ancillary component
- **Image Collection** that contains all the illustrations and photographs in the textbook

FOR STUDENTS

The *Evolve Student Resources* include the following assets:
- **Answers and Rationales** for Review Questions for the Next Generation NCLEX® Examination
- **Review Questions for the NCLEX® Exam**
- **Study Guide** for additional practice.
- **Audio Glossary** with pronunciations in English and Spanish
- **Calculators** for determining body mass index (BMI), body surface area, fluid deficit, Glasgow Coma Scale score, intravenously administered dosages, and conversion of units
- **Fluids and Electrolytes Tutorial**

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I would like to thank Nancy O'Brien, Brandi Graham, Brooke Kannady, Shereen Jameel, Renee Duenow and Vishnu T. Jiji as well as the other staff at Elsevier for their professional expertise, tenacity, insights, infinite patience, and steady encouragement throughout the development of this edition. I would also like to extend thanks to reviewers of this book as well as writers of the ancillary materials—your questions and critique were helpful in making this book even stronger. Thanks also to Dr. V. J. Periyakoil of Stanford University for her mentorship during my mini-fellowship on Successful Aging and for providing valuable resources for this text. Thanks to my colleague Diana Whittiker, RN, MDiv. We had so much fun implementing our Stanford fieldwork with the Hispanic older adults and really brought our projects to life. Last but not least—I thank Karen Anderson, Susan Schmitz, Sheri Saretsky, and Cherie Rebar for their wonderful contributions to and suggestions for the textbook.

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To the Student

Nurses are privileged to share in some of the most intimate aspects of people's lives. We not only help people when they are weak and vulnerable but also help people gain and appreciate new strengths. Although much of our youth and young adulthood focus on achieving independence, our older adult years demonstrate the value in interdependence—being able to rely on others, as well as give back to others in new and different ways. As nurses, we help others compensate for their deficits and build upon their strengths. We rejoice in and point out small successes and help build these to greater successes. It is important to remember that the older person for whom you are caring was once a lot like you. Try to view the older adult under your care not just as the person in need that you see in front of you but rather in the context of their whole life: Was he a three-star general who now needs your help getting dressed? Was she someone who devoted her life to raising children and caring for grandchildren and now needs care of her own? Was he a neurosurgeon who now cannot control his movement because of Parkinson disease? Was she a judge who is now unable to express her preferences because of Alzheimer disease? Care for every older adult the way you would care for your aunt, your grandmother, your grandfather, or the way you wish to be cared for one day. The older adults under your care are fortunate: reaching an advanced age is a privilege not granted to everyone.

READING AND REVIEW TOOLS

- **Objectives** introduce the chapter topics.
- **Key Terms** are listed with page number references, and difficult medical, nursing, or scientific terms are accompanied by simple phonetic pronunciations.
- Each chapter ends with a Get Ready for the Next Generation NCLEX® Examination! **section** that includes (1) **Key Points** that reiterate the chapter objectives and serve as a useful review of concepts, (2) a list of **Additional Resources** including the Study Guide and Evolve Resources, and (3) an extensive set of **Review Questions for the Next Generation NCLEX® Examination** with Answers and Rationales on Evolve.
- **References** at the end of each chapter cite evidence-based information and provide resources for enhancing knowledge.
- A **Glossary** of key terms provides definitions of all the terms that appear at the beginning of chapters.

SPECIAL FEATURES

The following special features are designed to foster effective learning and comprehension and reflect the LPN Threads design:

Clinical Situation boxes relate the text to patient situations and care scenarios.

Complementary Health Approaches boxes address nontraditional and adjunct therapies.

Coordinated Care boxes address leadership and management issues for the LPN/LVN and include topics, such as supervision of ancillary personnel and end-of-life care.

Critical Thinking boxes pose questions designed to stimulate thought and to help students develop and improve their critical thinking skills.

Cultural Considerations boxes provide advice on culturally diverse patient care of older adults.

Health Promotion boxes recommend quality-of-life tips for older adults.

Home Health Consideration boxes give essential information for home care for the older adult.

Medication tables provide quick access to information about medications commonly used in geriatric nursing care.

Nursing Care Plans with Applying Clinical Judgment Questions provide students with real-world examples of nursing care plans and encourage them to think critically about the given scenarios.

Patient Education boxes instruct and inform both older patients and their caregivers about health promotion, disease prevention, and age-specific interventions.

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Trends and Issues

1

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Objectives

1. Describe the subjective and objective ways in which aging is defined.
2. Identify personal and societal attitudes toward aging.
3. Define ageism.
4. Discuss the myths that exist with regard to aging.
5. Identify recent demographic trends and their impact on society.
6. Describe the effects of recent legislation on the economic status of older adults.
7. Identify the political interest groups that work as advocates for older adults.
8. Identify the major economic concerns of older adults.
9. Describe the housing options available to older adults.
10. Discuss the health care implications of a growing population of older adults.
11. Describe the changes in family dynamics that occur as family members become older.
12. Examine the role of nurses in dealing with an aging family.
13. Identify the different forms of elder abuse.
14. Recognize the most common signs of abuse.
15. Describe effective approaches for the prevention of elder abuse.

Key Terms

abuse (p. 22)
ageism (p. 4)
chronologic age (krŏ-nŏ-LŎJ-ĭk, p. 2)
cohort (KŌ-hŏrt, p. 8)
demographics (dĕm-ŏ-GRĂF-ĭks, p. 6)
geriatric (jĕr-ē-ĂT-rĭk, p. 2)
gerontics (p. 2)
gerontology (p. 2)
gerontophobia (p. 4)
mandated reporter (p. 26)
neglect (nĭ-glĕkt, p. 22)
respite (RĔS-pĭt, p. 26)

INTRODUCTION TO GERIATRIC NURSING

HISTORICAL PERSPECTIVE ON THE STUDY OF AGING

Until the middle of the 19th century, only two stages of human growth and development were identified: childhood and adulthood. In many ways, children were treated like small adults. No special attention was given to them or to their needs. Families had to produce many children to ensure that a few would survive and reach adulthood. In turn, children were expected to contribute to the family's survival. Little or no attention was given to those characteristics and behaviors that set one child apart from another.

As time passed, society began to view children differently. People learned that there are significant differences between children of different ages and that children's needs change as they develop. Childhood is now divided into substages (i.e., infant, toddler, preschool, school age, and adolescence). Each stage is associated with unique challenges related to the individual child's stage of growth and development. Because the substages are related to obvious physical changes or to significant life events, this classification is now accepted as logical and necessary.

Until recently, society also viewed adults of all ages interchangeably. Once you became an adult, you remained an adult. Perhaps society perceived dimly that older adults were different from younger adults, but there was not much concern about these differences because few people lived to old age. In addition, the physical and developmental changes of adulthood are more subtle than those of childhood; therefore these changes received little attention.

Until the 1960s, sociologists, psychologists, and health care providers focused their attention on meeting the needs of the typical or average adult: people between 20 and 65 years of age. This group was the largest and most economically productive segment of the population; they were raising families, working, and contributing to the economy. Only a small percentage of the population lived beyond 65 years of age. Disability, illness, and early death were accepted as natural and unavoidable.

In the late 1960s, research began to indicate that adults of all ages are not the same. Then also, the focus of health care shifted from illness to wellness. Disability and disease were no longer considered unavoidable parts of aging. Increased medical knowledge, improved preventive health practices, and technologic advances helped more people live longer, healthier lives.

Older adults now constitute a significant group in society, and interest in the study of aging is growing. The study of aging will be a major area of attention for years to come.

WHAT'S IN A NAME: GERIATRICS, GERONTOLOGY, AND GERONTICS

The term **geriatric** comes from the Greek words *geras*, meaning "old age," and *iatro*, meaning "relating to medical treatment." Thus geriatrics is the medical specialty that deals with the physiology of aging and with the diagnosis and treatment of diseases affecting older adults. Geriatrics, by definition, focuses on abnormal conditions and their medical treatment.

The term **gerontology** comes from the Greek words *gero*, meaning "related to old age," and *ology*, meaning "the study of." Thus gerontology is the study of all aspects of the aging process, including the clinical, psychologic, economic, and sociologic problems of older adults and the consequences of these problems for older adults and society. Gerontology affects nursing, health care, and all areas of our society—including housing, education, business, and politics.

The term **gerontics**, or *gerontic nursing*, was coined by Gunter and Estes in 1979 to define the nursing care and service provided to older adults. Gerontic nursing comprises a holistic view of aging, with the goal of increasing health, providing comfort, and caring for older adults' needs. This textbook focuses on gerontic nursing. It addresses ways in which to promote high-level functioning and methods of giving care and comfort to older adults.

The objectives of this book are to

- Examine trends and issues that affect the older adult's ability to remain healthy
- Explore theories and myths of aging
- Study the normal changes that occur with aging
- Review pathologic conditions that are commonly observed in older adults
- Emphasize the importance of effective communication when working with older adults
- Explore the general methods used to assess the health status of older adults
- Describe the specific methods of assessing functional needs
- Identify the most common patient problems experienced by older adults and discuss nursing interventions aimed at solving these problems
- Explore the effects of medication and medication administration on older adults

The dictionary defines *old* as "having lived or existed for a long time." The meaning of this word is highly subjective; to a great degree, it depends on how old we ourselves are. Few people like to describe themselves as old. A recent study reveals that people younger than age 30 view those older than age 63 as "getting older." People over the age of 65, however, do not think people are "getting older" until they are 75 years old.

Aging is a complex process that can be described chronologically, physiologically, and functionally. **Chronologic age**, the number of years a person has lived, is most often used when we speak of aging because it is the easiest to identify and measure. Many people who have lived a long time remain functionally and physiologically young. These individuals remain physically fit, stay mentally active, and are productive members of society. Others are chronologically young but physically or functionally old. Thus chronologic age is not the most meaningful measurement of aging.

In using chronologic age as the measure, authorities use various systems to categorize the aging population (Table 1.1). To many people, 65 years is a magic number in terms of aging. The wide acceptance of age 65 as a landmark of aging is interesting. Since the 1930s, the age of 65 has come to be accepted as the age of retirement, when it is expected that a person willingly or unwillingly stops paid employment. However, before the 1930s, most people worked until they decided to stop working, until they became too ill to work, or until they died. When the New Deal established the Social Security program, 65 was set as the age at which benefits could be collected. However, the average life expectancy of the time was 63 years of age. The Social Security program was designed as a fairly low-cost way to win votes because most people would not live long enough to collect the benefits. Although age 65 was considered old then, it certainly is not considered old now. If the same standards were applied today, the retirement age would arrive at age 77. However, society clings to age 65 as the retirement age and resists political proposals designed to move the start of Social Security benefits to a later age. Despite the resistance, the age to qualify for full Social Security benefits is

Table 1.1 Categorizing the Aging Population

AGE (YEARS)	CATEGORY
55 to 64	Older
65 to 74	Elderly
75 to 84	Aged
85 and older	Extremely aged
Or	
60 to 74	Young old
75 to 84	Middle old
85 and older	Old old

changing. Individuals born before 1937 still qualify for full benefits at 65 years of age, but there are incremental increases in age for all persons born after that time. Individuals born in 1960 or later must wait until age 67 to qualify for full benefits. Reduced benefits are calculated for individuals who claim Social Security benefits after age 62 but before the full retirement age. To be consistent with other sources, however, this text will refer to individuals of age 65 and above as "older adults."

ATTITUDES TOWARD AGING

Before we look at the attitudes of others, it is important to examine our own attitudes, values, and knowledge about aging. The three following Critical Thinking boxes that follow are designed to help you assess how you feel about aging.

After you have filled out these Critical Thinking boxes, look at the characteristics you described and think about the feelings you experienced as you considered your answers. Do your feelings correspond to your attitudes about aging? In the Critical Thinking Box about Values, were the three people's characteristics similar or different? What do these characteristics say about your values? Our attitudes are the product of our knowledge and values. Our life experiences and our current age strongly influence our views about aging and older adults. Most of us have a rather narrow perspective, and our attitudes may reflect this. We tend to project our personal experiences onto the rest of the world. Because many of us have a somewhat limited exposure to older adults, we may believe quite a bit of inaccurate information. In dealing with older adults, our limited understanding and vision can lead to serious errors and mistaken conclusions. If we view old age as a time of physical decay, mental confusion, and social boredom, we are likely to have negative feelings toward aging. Conversely, if we see old age as a time for sustained physical vigor, renewed mental challenges, and social usefulness, our perspective on aging will be quite different.

Critical Thinking

Your Current Knowledge About Aging

Respond to the following questions to the best of your knowledge.

You are "old" at age _____
_____.

There are _____
_____ older adults in the United States.

Most older adults live in_____.

Economically, older adults are _____
_____.

With regard to health, older adults are _____
_____.

Mentally, older adults are _____
_____.

Critical Thinking

Your Views and Attitudes About Aging

- How many older adults do you know personally?
- Do you think they are "old"? Do *they* consider themselves "old"?
- How do you personally define "old"?
- Why is aging an issue today?
- Should Social Security laws be changed to reflect today's longer life expectancy?

Please complete the following statements. Write as many applicable comments as you can. *There are no right or wrong answers.*

A person can be considered "old" when _____
_____.

When I think about getting older, I _____
_____.

Growing older means _____
_____.

When I get older, I will lose my _____
_____.

Seeing an older person makes me feel _____
_____.

Older people always _____
_____.

Older people never _____
_____.

The best thing about aging is _____
_____.

The worst thing about aging is _____
_____.

Looking back at my responses, I feel that aging is _____
_____.

It is important to separate facts from myths as we examine our attitudes toward aging. The single most important factor that influences how poorly or well a person will age is attitude. This statement is true not only for others but also for ourselves.

Throughout time, youth and beauty have been viewed as desirable, and old age and physical infirmity have been loathed and feared. Greek statues portray youths of physical perfection. Artists' works throughout history have shown heroes and heroines as young and beautiful and evildoers as old and ugly. Little has changed to this day. A few cultures cherish their older members and view them as keepers of wisdom. Even in Asia, where tradition demands respect for older adults, societal changes are destroying this venerable mindset.

For the most part, mainstream American society does not value its older adults. The United States tends to be a youth-oriented society in which people are judged by age, appearance, and wealth. Young, attractive, and wealthy people are viewed positively; old, imperfect, and poor people are not. It is difficult for young people to imagine that they will ever be old. Despite some cultural changes, aging continues to have negative connotations. Many people continue to do everything they can to appear young. Wrinkles, gray hair, and other physical

Critical Thinking

Your Values About Aging

Quickly name three older adults who have had an impact on your life. List five characteristics that you associate with each person. *There are no right or wrong answers.*

PERSON 1	PERSON 2	PERSON 3
Name _____	Name _____	Name _____
Relationship _____	Relationship _____	Relationship _____
Characteristics:		
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____

changes of aging are actively confronted with makeup, hair dye, and cosmetic surgery. Until recently, advertising seldom portrayed people older than age 50 except to sell eyeglasses, hearing aids, hair dye, laxatives, and other rather unappealing products. The message seemed to be, "Young is good, old is bad; therefore everyone should fight getting old." It is significant that trends in advertising appear to be changing. As the number of healthier, dynamic senior citizens with significant spending power has increased, advertising campaigns have become increasingly likely to portray older adults as the consumers of their products, including exercise equipment, health beverages, and cruises. Despite these societal improvements, many people do not know enough about the realities of aging and, because of ignorance, are afraid to get old. Some media studies have found that people who watch more television are likely to have more negative perceptions of aging.

Cultural Considerations

The Role of the Family

Cultural heritage may work as a barrier to getting help for an older parent. Many cultures emphasize the importance of intergenerational obligation and dictate that it is the role of the family to provide for both the financial and personal care needs of older adults. This can lead to high stress and excessive demands, particularly on lower-income families.

Nurses need to recognize the impact that culture has on expectations and values and how these cultural values affect the willingness of families to accept outside assistance. Nurses need to be able to identify the workings of complex family dynamics and to determine how decision-making takes place within a unique cultural context.

Critical Thinking

Caregiver Choices

- What expectations does your cultural heritage dictate regarding your obligation to frail older family members?
- Who in your family culture makes decisions regarding the care of older family members?
- Should Medicare or insurance plans pay low-income family members to stay at home and provide care for infirm older adults?
- To what extent should family members sacrifice their personal lives to keep frail or infirm older adults out of institutional care?
- Can family obligations be met in a society that provides little support or relief for caregivers?

GERONTOPHOBIA

The fear of aging and refusal to accept older adults into the mainstream of society is known as ***gerontophobia***. Senior citizens and younger persons can fall prey to such irrational fears (Box 1.1). Gerontophobia sometimes results in very odd behavior. Teenagers buy antiwrinkle creams. Thirty-year-old women consider facelifts. Forty-year-old women have hair transplants. Long-term marriages dissolve so that one spouse can pursue someone younger. Often these behaviors arise from the fear of growing older.

AGEISM

The extreme forms of gerontophobia are ageism and age discrimination. **Ageism** involves a negative attitude toward aging and older adults based on the belief that aging makes people unattractive, unintelligent, and unproductive. It is an emotional prejudice or discrimination against people based solely on age. Ageism allows the young to separate themselves physically and emotionally from the old and to view older adults as somehow having less human value. Like sexism or racism, ageism is a negative belief pattern that can result in irrational thoughts and destructive behaviors, such as intergenerational conflict and name calling. Like other forms of prejudice, ageism occurs because of myths and stereotypes about a group of people who are "different."

Box 1.1 Aging: Myth Versus Fact

MYTHS: OLDER ADULTS…

- Are pretty much all alike.
- In general, are lonely and alone.
- Tend to be sick and frail and to live in nursing homes.
- Are often cognitively impaired.
- Have no interest in sex.
- Suffer from depression more than younger adults.
- Become more difficult and rigid in their thinking.
- Have difficulty coping with age-related changes.

FACTS: OLDER ADULTS…

- Are a very diverse age group.
- Typically remain engaged and productive, often working or volunteering or keeping in contact via social networks.
- Usually live independently. Only about 1% of older adults between the ages of 65 and 74 and 2% of those between 74 and 85 live in nursing homes.
- May experience some cognitive decline, but this is usually not severe enough to cause problems in daily living.
- Typically remain sexually active, although frequency may decline.
- In general, have lower rates of depression as compared with younger adults, although the consequences can be more severe.
- Tend to maintain a consistent personality throughout the lifespan.
- Typically adjust well to the challenges of aging.

The combination of societal stereotyping and a lack of positive personal experiences with older adults affects a cross section of society. Studies have shown that health care providers share the views of the general public and are not immune to ageism. Specializing in geriatrics is unpopular by nursing and medical students, even though older adults are frequent users of the health care system (Hebditch et al., 2020); therefore many nurses actually do function as geriatric nurses to a great extent. Some health care providers erroneously believe that they are not fully using their skills when working with the aging population. Working in intensive care, the emergency department, or any other high technology area is viewed as exciting and challenging. Working with older adults is viewed as routine, boring, and depressing. As long as negative attitudes such as these are held by health care providers, this challenging and potentially rewarding area of service will continue to be underrated and the older adult population will suffer for it.

Because ageism can have a negative effect on the way health care providers relate to older patients, such patients can, as a result, have poor health care outcomes. Ageism leads to significantly worse health outcomes worldwide; this can be due to external factors, such as denied access to health services and treatment, or internal factors, as when a recipient of ageism develops a disease-causing inflammation (Chang et al., 2020). Because the older adult population is growing, health care providers need to think carefully about their own attitudes. Furthermore, they must confront signs of ageism whenever and wherever they appear. Activities such as greater positive interactions with older adults and improved professional training designed to address misconceptions regarding aging are two ways of fighting ageism. The Hartford Institute for Geriatric Nursing (HIGN), formed in 1996, has the goal of shaping the health care of older adults by promoting excellent nursing practice. Their website, www.hign.org, is a treasure trove of geriatric nursing resources, including the *Try This* series of assessment tools. Research shows that negative perceptions of aging are predictive of mental and physical decline (Chang et al., 2020); therefore keeping a positive attitude toward aging might just prevent someone from becoming frail in their older years.

AGE DISCRIMINATION

Age discrimination reaches beyond emotions and leads to actions; older adults are often treated differently simply because of their age. Examples of age discrimination include refusing to hire older people, not approving them for home loans, and limiting the type or amount of health care they receive. Age discrimination is illegal. Some older adults respond to age discrimination with passive acceptance, whereas others are banding together to speak up for their rights.

The reality of getting old is that no one knows what it will be like until it happens. But that is the nature of life—growing older is just the continuation of a process that started at birth. Older adults are fundamentally no different from the people they were when they were younger. Physical, financial, social, and political conditions may change, but the person remains essentially the same. Old age has been described as the "more-so" stage of life because some personality characteristics may appear to amplify. Older adults are not a homogeneous group. They differ as widely as any other age group. They are unique individuals with unique values, beliefs, experiences, and life stories. Because of their extended years, their stories are longer and often far more interesting than those of younger persons.

Aging can be a liberating experience. Aging seems to decrease the need to maintain pretenses, and the older adult may finally be comfortable enough to reveal the real person beneath the facade. If a person has been essentially kind and caring throughout life, they will generally reveal more of these positive personal characteristics over time. Likewise, if a person was miserly or unkind, they will often reveal more of these negative personality characteristics with age. The more successful a person has been at meeting the developmental tasks of life, the more likely they will be to face aging successfully. Perhaps the best advice to

all who are preparing for old age is to be found in the Serenity Prayer:

> *O God, give us the serenity to accept what cannot be changed; courage to change what should be changed; and wisdom to distinguish one from the other.*
>
> Reinhold Niebuhr

DEMOGRAPHICS

Demographics is the statistical study of human populations. Demographers are concerned with a population's size, distribution, and vital statistics. Vital statistics include birth, death, age at death, marriage(s), race, and many other variables. The collection of demographic information is an ongoing process. The Bureau of the Census conducts the most inclusive demographic research in the United States every 10 years. The most recent census was completed in the year 2020.

Demographic research is important to many groups. Demographic information is used by the government as a basis for granting aid to cities and states, by cities to project their budget needs for schools, by hospitals to determine the number of beds needed, by public health agencies to determine the immunization needs of a community, and by marketers to sell products. The politicians of the 1930s used demographics to formulate plans for the Social Security program. Demographic studies provide information about the present that allows projections into the future.

One important piece of demographic information is life expectancy, or the number of years an average person can expect to live. Projected from the time of birth, life expectancy is based on the ages of all people who have died in a given year. If a large number of infants die at birth or during childhood, the life expectancy of that year's group tends to be low. Life expectancy throughout history has been low because of environmental hazards, wars, accidents, the scarcity of food and water, inadequate sanitation, and contagious diseases.

- During biblical times, the average life expectancy was approximately 20 years. Some people did live significantly longer, but 40 years was considered a good long life.
- By 1776, when the Declaration of Independence was signed, the life expectancy had risen to 35 years. It was very uncommon for anyone to live into their 60s.
- By the 1860s, at the time of the American Civil War, life expectancy had increased to 40 years. The 1860 census revealed that 2.7% of the American population was older than age 65.
- By the beginning of the 20th century, the overall life expectancy had increased to 47 years, and 4% of the American population was 65 years of age or older. In a span of more than 2000 years, life expectancy had increased by only 27 years.
- During the 20th century, the life expectancy of Americans increased by approximately 29 years. A child born in the United States in the year 2004 has an average life expectancy of nearly 77.4 years.
- Projections indicate that a male child born in 2017 will have a life expectancy of 75.97 years and a female child born in the same year will have a life expectancy of 80.96 years (Social Security Administration, 2020a).
- The COVID-19 pandemic has already decreased life expectancy projections by one full year in the United States (Thompson, 2021).

Since the beginning of the 20th century, advances in technology and health care have dramatically changed the world, especially in industrialized nations, where food production exceeds the needs of the population. Diseases such as cholera and typhoid have been eliminated or significantly reduced by improved sanitation and hygiene practices. Dreaded communicable diseases that at one time were often fatal (e.g., smallpox, measles, whooping cough, and diphtheria) are now preventable through immunization. Even pneumonia and influenza are no longer the fatal diseases they once were—or so we thought until the recent COVID-19 pandemic appeared; before effective vaccines were developed, it killed a disproportionate number of older adults. Today, vaccines for many diseases can be given to those who are at higher risk, and treatment can be given to those who become infected.

A longer life is a worldwide phenomenon. Some 9% of the world's population is 65 years of age or older (United Nations, Department of Economic and Social Affairs, Population Division, 2019). Monaco is the top ranked country for longevity; Singapore, Japan, Iceland, and Hong Kong are also in the top 10. The standing of the United States has steadily declined and, according to the Central Intelligence Agency's estimates (Central Intelligence Agency, 2020), it now ranks 43rd of 224 countries. Some possible explanations for the disparity between the United States and other countries include higher levels of accidental and violent deaths, obesity, relatively high infant mortality, and the high cost of health care. Much of the world's net gain in older persons has occurred in the developing countries of Africa, South America, and Asia (Fig. 1.1).

SCOPE OF THE AGING POPULATION

According to the U.S. Census Bureau (2018), by 2034, for the first time in recorded history, the number of people over 65 years of age is projected to exceed the number of children under age 18. In 2018, there were 52.4 million people in the United States, or 16% of the population, who were 65 years of age and older. By 2040, this number is expected to increase to 80.8 million people 65 years of age or older, or roughly 21.6% of the total population. The number of those 85 years of age and older is expected to double from 6.5 million in 2018 to more than 14 million in 2040 (Administration on Aging, 2020). We are becoming an increasingly older society (Fig. 1.2).

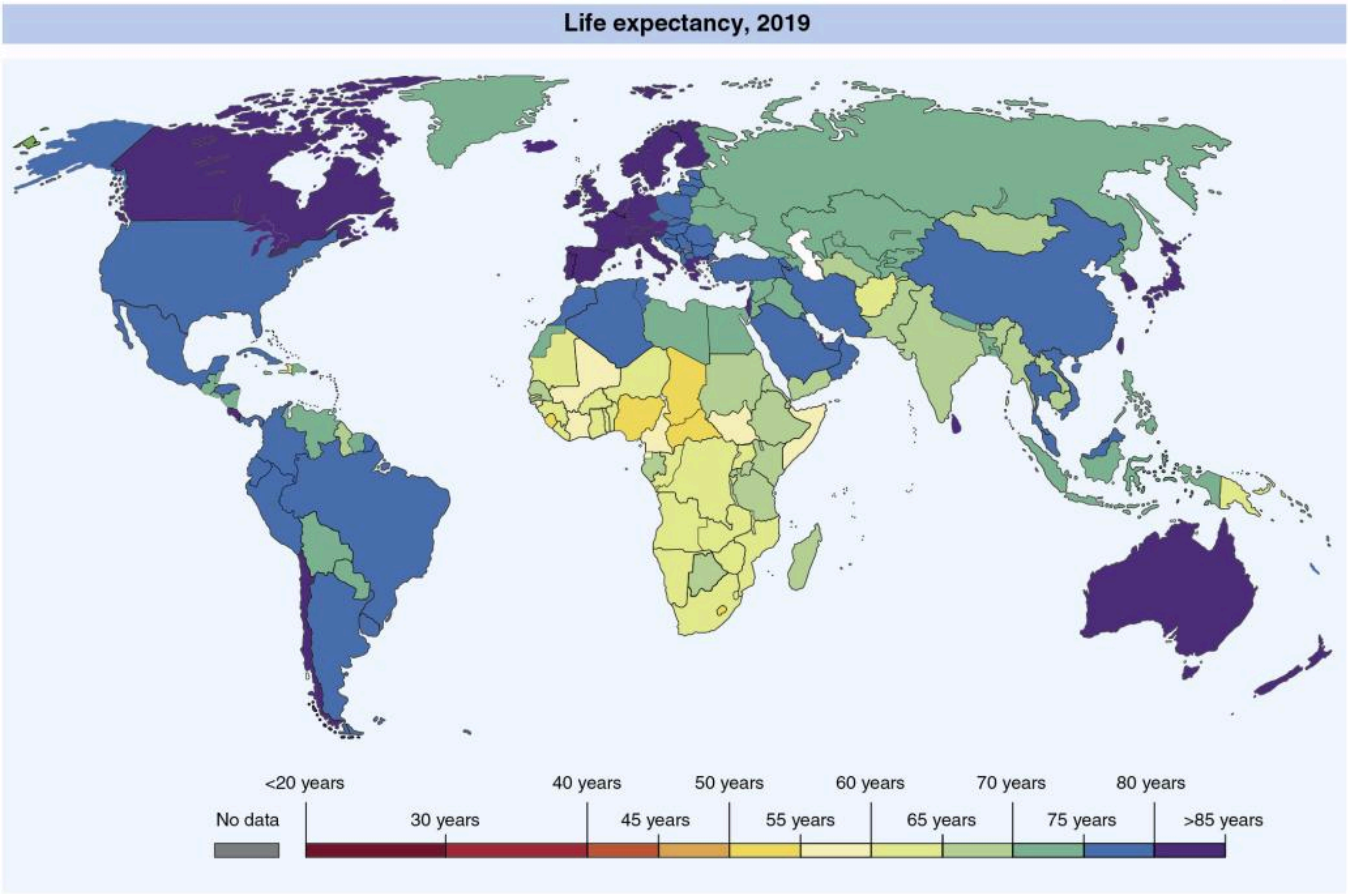

Fig. 1.1 Life expectancy world map. (From Roser, M., Ortiz-Ospina, E., Ritchie, H. [2013, revised 2019]. "Life Expectancy." Published online at *OurWorldInData.org.* Retrieved from https://ourworldindata.org/life-expectancy [Online Resource].)

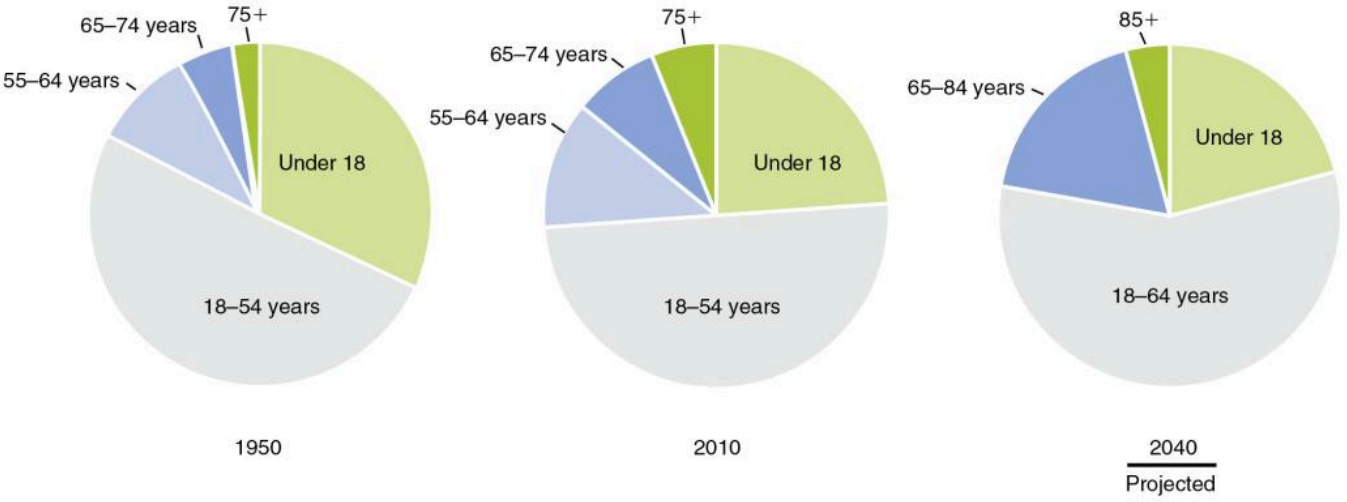

Fig. 1.2 Percentage of the population in five age groups: United States, 1950, 2010, and 2060. (Data from the U.S. Census Bureau.)

GENDER AND ETHNIC DISPARITY

The Administration on Aging (2020) projects that racial and ethnic minority populations will represent 34% of the older population by 2040, an increase from 19% in 2008. It is projected that by 2040, the White non-Hispanic population will increase by 32%. During the same time period, the percentage of racial and ethnic minority persons of the same age cohort is expected to grow by 125% (Hispanics, 175%; African Americans, 88%; American Indian and Alaska Natives, 75%; and Asians, 113%).

Life expectancy within the U.S. population is variable. The populations of men and women are not

equal, and in the older-than-65 age group, this disproportion is very noticeable. There are now 29.1 million older women to 23.3 million older men. Women currently outlive men by 2.6 years, and Whites tend to live longer than Blacks, although disparities seem to be declining (Administration on Aging, 2020).

Current life expectancies in terms of race are as follows: White women, about 81 years; Black women, about 77.9 years; White men, 76.1 years; and Black men, 71.5 years. Hispanic people in the United States have a lower mortality and higher life expectancy than both non-Hispanic White and non-Hispanic Black people. Hispanic men can expect to live to 79.1 years; Hispanic women have the longest life expectancy of 84.2 years (Centers for Disease Control and Prevention, 2017). This longer life expectancy is known as the *Hispanic* or *Latino paradox*, suggesting that despite any socioeconomic disadvantages that may exist, Latino populations in the United States have lower premature mortality rates than White and Black populations; this has been documented in several Latin American countries as well (Chen et al., 2020).

In 2018, 23% of those over age 65 were identified as minorities. Approximately 9% were African American (not Hispanic), 5% Asian (not Hispanic), 0.5% American Indian and Alaska Native (not Hispanic), 0.1% Native Hawaiian/Pacific Islander (not Hispanic). Some 0.8% identified themselves as being descended from two or more races. People identifying as "Hispanic origin (who may be of any race)" constituted 8% of the older population (Administration on Aging, 2020).

THE BABY BOOMERS

A major contributing factor to this rapid explosion in the older adult population is the aging of the cohort commonly called the *baby boomers*. *Age* ***cohort*** is a term used by demographers to describe a group of people born within a specified time period. The baby boomers are people born after World War II, between 1946 and 1964. Although now outnumbered by the millennials (those born between 1982 and 2000), the baby boomers account for approximately 21% of the population (Statistica, 2020b) and continue to have a significant influence in all areas of society. In fact, at present, 10,000 baby boomers reach 65 years of age every day! It remains to be seen whether this group will experience aging in the same way that previous generations have or whether they will reinvent the aging and retirement experience. The oldest baby boomers reached age 65 in 2011; by 2029, all baby boomers will be 65 years of age or older. Based on the sheer size of this group, the older population in 2030 will be twice the size it was in 2000. The implications of this for all areas of society, particularly health care, are unprecedented.

Critical Thinking

Demographics and You

- What impact will the changing demographics have on you personally?
- How is your community's age distribution changing?
- Are you a baby boomer? Do you find this to be an advantage or disadvantage as you age?
- Were you born after the baby boom? Before the baby boom? What difficulties do you expect to encounter as you age?

GEOGRAPHIC DISTRIBUTION OF THE OLDER ADULT POPULATION

The older adult population is not equally distributed throughout the United States. Climate, taxes, and other issues regarding the quality of life influence where older adults choose to live. All regions of the country are affected by the increase in life expectancy, but not to the same degree. In 2018, about half of the older-than-65 population resided in 9 states. In descending order of the older adult population, these states are California (5.7 million); Florida (4.4 million); Texas and New York (more than 3 million each); and Pennsylvania, Ohio, and Illinois (more than 2 million each). Michigan and North Carolina round out the list, each with 1.7 million residents over the age of 65 (Fig. 1.3). Three states reported more than 20% of their residents as being over the age of 65: Florida, Maine, and West Virginia. Three states—including Alaska, Nevada, and Colorado—have shown an increase in the older-than-65 population of 57% or more (U.S. Department of Health and Human Services, Administration for Community Living, 2020a).

MARITAL STATUS

In 2019, some 69% of men over age 65 were married, compared with 47% of older women. About one-third of older women were widows; there were more than 3 times as many widows (8.9 million) as widowers (2.6 million). The percentage of older adults who were separated or divorced was approximately 15%. A further increase in the number of divorced elders is predicted as a result of a higher incidence of divorce in the population approaching 65 years of age.

The number of single, never-married seniors remains somewhat consistent at about 5% (women) to 6% (men) of the older-than-65 population (U.S. Department of Health and Human Services, 2020).

EDUCATIONAL STATUS

The educational level of the older adult population in the United States has increased dramatically over the past 3 decades. In 1970, only 28% of senior citizens had graduated from high school. By 2019, some 88% were high school graduates or more, and 31% had a

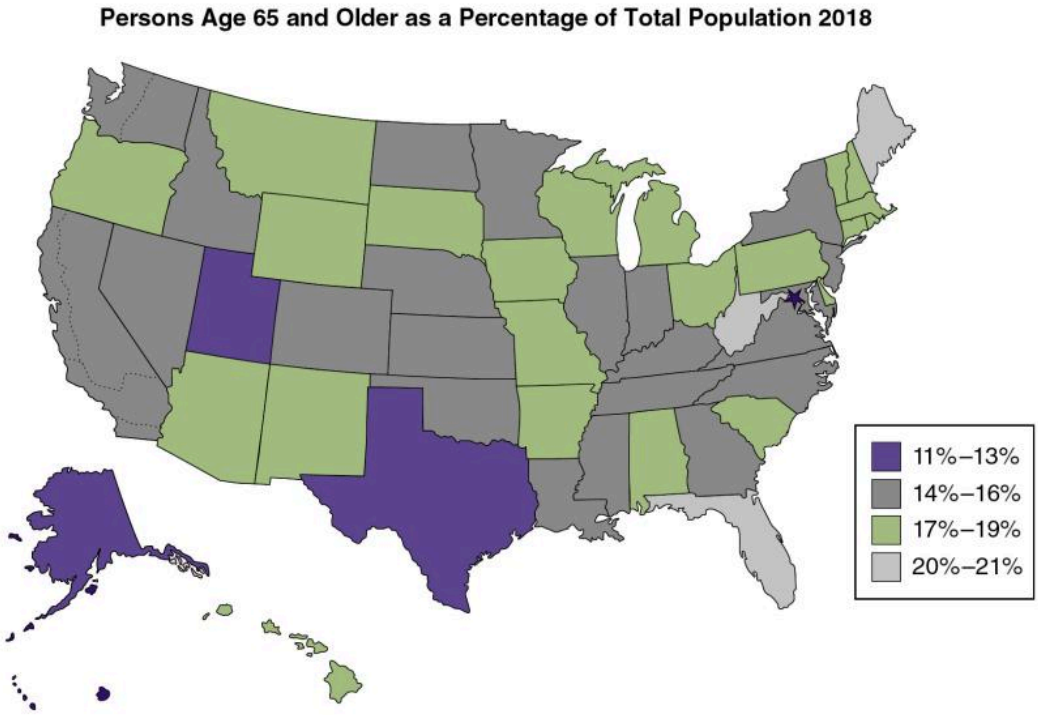

Fig. 1.3 Persons 65 years or older as a percentage of total population, 2018. (From the U.S. Department of Health and Human Services, Administration for Community Living. https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans)

bachelor's degree or higher. Completion of high school varied by race and ethnicity, with Whites (92%) completing high school at higher rates, followed by Asians (80%), African Americans (79%), and Hispanics (59%).

In addition to being better educated, today's older adult population is more technologically sophisticated. The World Economic Forum (2019) reports that 70% of Americans over age 65 use the internet. Also popular among older adults are apps such as Google Maps, with parking spot reminders, and Medisafe, a mobile medication management system. About 81% of adults in their 60s use a smartphone, dropping to 62% after age 70 (AARP, 2020a). Social networking sites, such as Facebook and LinkedIn, are used by a growing number of older adults.

ECONOMICS OF AGING

The stereotypical belief that many older adults are poor is not necessarily true. The economic status of older persons is as varied as that of other age groups. Some of the poorest people in the country are old, but so are some of the richest.

POVERTY

In 2018, over 5.1 million (9.7%) older adults lived at or below the poverty level A second indicator called the Supplemental Poverty Measure—which considers regional variations in housing costs, medical out-of-pocket expenses, and other factors—showed an even greater percentage of older adults (12.8%) living in poverty in 2019. Older women were more likely to be impoverished than older men. The highest rates of poverty were among older Hispanic women who live alone (37.8%).

INCOME

As of 2018, the median income of men over age 65 was $34,267, whereas that for women over age 65 was only $20,431. The median income of households headed by a person 65 years of age or older was approximately $64,023. Median income is the middle of the group, with half earning less and half earning more. It is not an average amount. Median figures can be deceptive because income is not distributed equally among Whites and minority groups (Fig. 1.4).

The major sources of aggregate income for older adults include Social Security benefits, asset income, pensions, and other earnings. Fig. 1.5 shows the sources of income for five different income levels (income quintiles).

Overall, Social Security income accounts for approximately 33% of the income for people age 65 and older. Of older adults who receive Social Security, half of those married and 70% of those unmarried rely on this benefit for 50% of their income. Average monthly Social Security income in 2020 was $1545 for a retired worker (Social Security Administration, 2020b). Low-earning

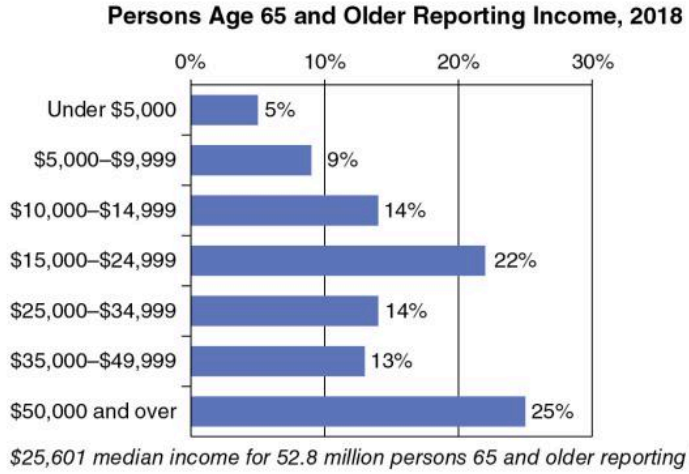

Fig. 1.4 Percent distribution of the U.S. population by income, 2018. (From the U.S. Department of Health and Human Services, Administration for Community Living. https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans)

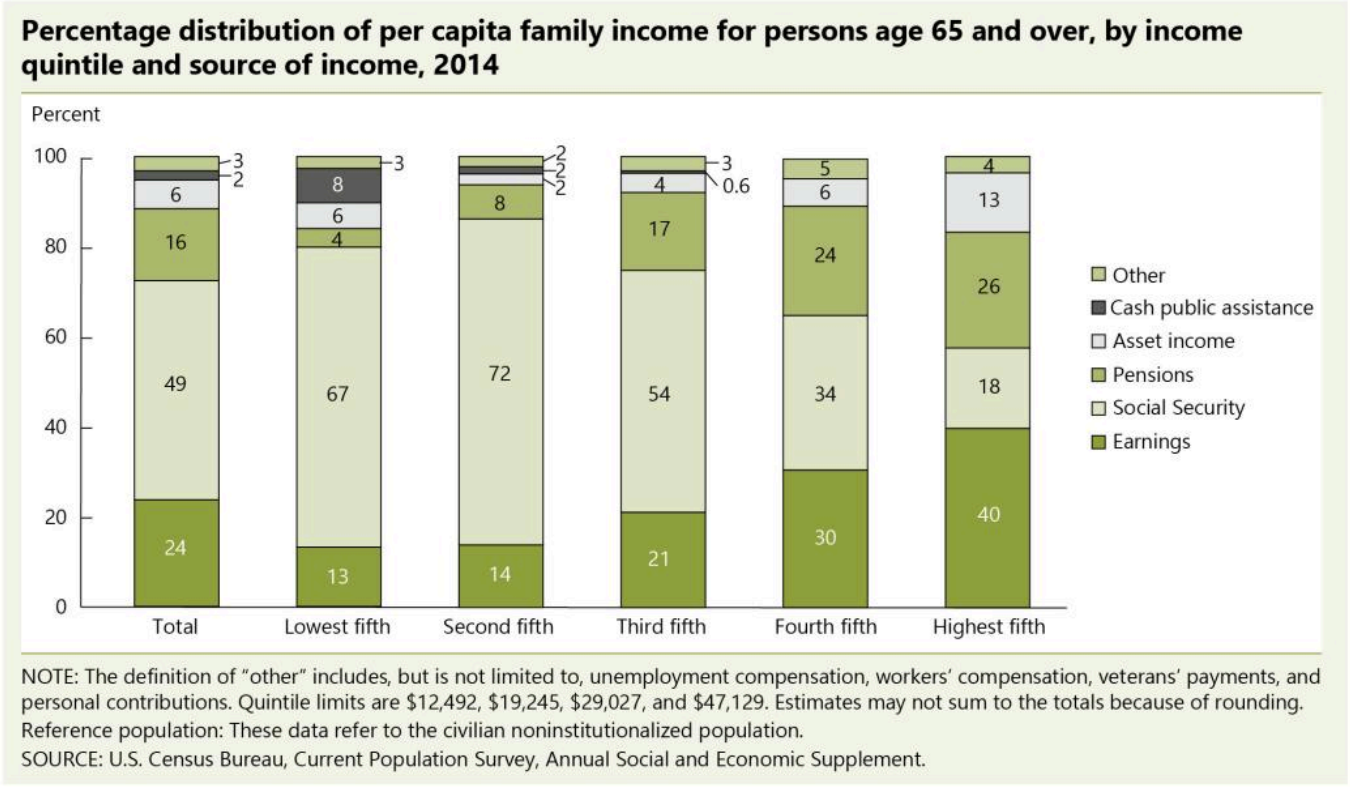

Fig. 1.5 Sources of income in the United States. (From the U.S. Census Bureau. https://agingstats.gov/docs/LatestReport/Older-Americans-2016-Key-Indicators-of-WellBeing.pdf)

individuals and couples are more likely to rely on Social Security as their major source of income. High earners are less reliant on Social Security.

Social Security funding may become inadequate as the number of retirees drawing benefits increases, while the pool of workers paying into the system decreases. There are presently 2.8 workers for each Social Security beneficiary; by 2035, this number will decrease to 2.3. People both within and outside the government have proposed plans to ensure the long-term survival of the Social Security program. If no changes are made, it is estimated that Social Security cash reserves will be depleted in 2034 (AARP, 2020b). This does not mean that the program will be bankrupt; rather, it will be able to pay out only what it collects through Social Security taxes.

Asset income—or income derived from investments such as stocks, bonds, and other retirement accounts—has dropped drastically since 2008. The economic downturn has been compared in severity with the Great Depression of the 1930s. Many retirees and those near retirement lost a large percentage of the monies they had saved and invested for retirement. Many of those who invested personally and those who had their money in employer-directed programs were severely affected. These financial losses have forced many individuals nearing retirement to continue working.

Approximately one-fifth of people age 65 and older receive pensions from public or private sources, although this varies by income quintile (see Fig. 1.5). People who retire from a government agency are more likely to receive a pension than those who retire from a private industry. Not only are former government employees more likely to receive pensions, but government pensions also tend to be more generous than those in the private sector because government wages have historically been below those of the private sector. The median federal government pension in 2018 was $30,061, the median state or local government pension was $22,546, and the median private pension or annuity was $9827 (Pension Rights Center, 2020).

Early retirement was popular from the 1970s until about 1985. Since then, the trend has shown more people working for pay after age 65. For those over age 65 who worked, the median weekly wage in the third quarter of 2020 was $1006 ($52,000 annually) (Bureau of Labor Statistics, 2020). This is typically significantly less than what the person earned earlier in life and reflects a decrease in hours worked and in wages. Additionally, these data were gathered during a pandemic that imposed unusual work practices on all people, but they are consistent with data trends of prior years.

Earnings make up a substantial portion of income for many people over age 65. Those who are in higher income brackets, generally professionals, may continue to work well beyond age 65 as long as they are healthy and interested in what they are doing. Socialization, time away from a retired spouse, intellectual challenge, and a sense of self-worth are verbalized as reasons for working, particularly by those in the baby boom generation. Some baby boomers need to continue to work to maintain the standard of living they desire. Some need to work because they neglected to save enough for retirement or need to make up for losses in their investments. Those in lower income brackets may need to continue to work, or to seek work, to pay for necessities of life or a few luxuries.

Legislation and political activism among older people have helped improve the economic outlook for older adults (Table 1.2). Beginning in 1965, key legislation was passed, including Medicare and Medicaid, establishment of the Administration on Aging, and the Older Americans Act, which supports numerous home- and community-based services such as Meals on Wheels, in-home services for older adults, elder abuse prevention, and caregiver support. In 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act provided nearly $1 billion in grant funding to assist older adults who wished to shelter in place, pay for home-delivered meals, and offer many other resources designed to minimize exposure to COVID-19 (U.S. Department of Health and Human Services, Administration for Community Living, 2020b). Through activist organizations, older adults have united to consolidate their political power and to use the power of the vote to initiate programs that benefit them (Box 1.2). Over the past 25 years, these groups have helped to improve the economic welfare of older adults. The Federal Housing Authority and other lending agencies have proposed the use of reverse mortgages, which are plans that allow older adults to remain in their homes and receive monthly payments based on their home equity. Monthly income realized from these plans could range from hundreds to several thousands of dollars, depending on the property value and the age of the residents. The most common type of reverse mortgage is a Home Equity Conversion Mortgage (HECM). This money could be a much-needed income supplement for many older adults.

Table 1.2 Legislation That Has Helped Older Adults

YEAR	LEGISLATION
1965	Medicare and Medicaid established Administration on Aging established Older Americans Act (OAA) passed
1967	Age Discrimination Act passed
1972	Supplemental Security Income Program instituted
	Social Security benefits indexed to reflect inflation, cost-of-living adjustment
	Nutrition Act passed, providing nutrition programs for older adults
1973	Council on Aging established
1978	Mandatory retirement age changed to 70 years
1986	Mandatory retirement age eliminated for most employees
1988	Catastrophic health insurance made part of Medicare
1990	Americans With Disabilities Act passed
1992	Vulnerable Elder Rights Protection Program initiated
1997	Balanced Budget Act (Medicare Part C) passed
2000	Amendment to Older Americans Act (nutrition programs) passed
2006	Drug Benefit Program added to Medicare
2010	The Patient Protection and Affordable Care Act passed
2016	Reauthorization of the Older Americans Act
2020	CARES Act passed

Box 1.2 Politically Active Senior Citizen Groups

AARP (FORMERLY KNOWN AS THE AMERICAN ASSOCIATION OF RETIRED PERSONS)

- Membership is open to people who are at least 50 years of age and their spouses (regardless of age).
- Currently has 38 million members.
- Uses volunteers and lobbyists to advance the political and economic interests of older adults.
- Provides a wide variety of membership benefits, including insurance programs and discounts.
- Was instrumental in helping to enact Medicare in 1965.

AMERICAN SENIORS ASSOCIATION (ASA)

- Does not report current numbers but claims to be the fastest-growing senior advocacy group in America.
- Describes itself as the "conservative alternative to AARP."

ALLIANCE FOR RETIRED AMERICANS (ARA)

- Reports 4.3 million members.
- Focuses on political and legislative issues.
- Formerly known as the National Council of Senior Citizens.
- Occasionally clashes with AARP on issues such as Medicare drug benefits.

NATIONAL COUNCIL OF GRAY PANTHERS NETWORKS (NCGPN, FORMERLY GRAY PANTHERS)

- As a social justice action network, is involved in the promotion of economic security, civil rights, marriage equality, and other issues.
- Has approximately 500 activists from 32 states.
- In addition, has 16 local Gray Panthers Networks with an estimated 500 additional activists.
- Issues action alerts on important senior issues; maintains an active NCGPN Facebook page.

Reverse mortgages are not right for everyone, however. Extremely high fees, up to $40,000, are associated with them, and such payments can become due in full if the older person moves out of the home for a year or more—which is not outside the realm of possibilities if the person experienced a serious illness and placement in a care facility. In such a case, it is possible that such a person might need to sell the home to repay the HECM (Nolo.com, 2020).

Some older adults may choose not to seek economic help despite the numerous assistance programs designed for them. Many people are suspicious of "getting something for nothing" or are reluctant to disclose personal financial details, which is necessary to qualify for most assistance programs. Many older people feel that asking for help is humiliating. Some fear that they will lose what little they have if they seek assistance. As in all age groups, other older people have no difficulty seeking or, in some cases, demanding financial assistance or concessions. Factors that can affect the financial well-being of older adults are described in Box 1.3.

Box 1.3 Factors That Influence the Economic Conditions of Older Adults

- Many older adults bought their homes when housing costs and inflation were low. If they have paid off their mortgages, their housing costs are limited to taxes, maintenance, and utility bills.
- The number of older adults who receive pensions is greater now than it will be in the future. Businesses now offer smaller pensions to fewer employees, and the traditional "defined benefit" pensions have largely been replaced by "defined contribution" pensions, which are affected by stock market fluctuations.
- Older adults qualify for several tax breaks that are unavailable to younger people.
- Most older adults pay no Social Security taxes; younger working adults pay increasingly higher rates.
- Social Security and government pensions are largely exempt from taxation.
- Taxpayers older than 65 years of age can take additional tax deductions.
- If an older adult is a homeowner and sells the home, a one-time capital gains tax exclusion applies.
- Most older adults qualify for government income programs.
- Some 97% of people over age 60 receive Social Security benefits or will in the future (Center on Budget and Policy Priorities, 2020a).
- More than 61 million people were Medicare recipients in 2015 (Kaiser Family Foundation, 2020).
- More than 2 million low-income, blind, or disabled older adults receive Supplemental Security Income (SSI) (Center on Budget and Policy Priorities, 2018).

Be sensitive in dealing with the financial issues of older adults. The Critical Thinking box should help you assess your attitudes, and therefore your sensitivity, toward these kinds of situations. Many older adults who find it easy to talk about their intimate physical and medical problems are reluctant to discuss finances. Nurses may suspect financial need if an older person lacks adequate shelter, clothing, heat, food, or medical attention. When an economic problem causes real or potential dangers, be prepared to respond appropriately.

Critical Thinking

Your Sensitivity to the Financial Problems of Older Adults

Respond to the following statements:

- Older adults control all of the money in the country.
- Most older adults are poor.
- Older adults have it easy; the younger working people have it rough.
- Older adults have too much political power, and they get too many benefits and entitlements.
- Older adults worked for what they are getting, and they deserve everything they receive from the government.
- A society that does not care for its older people is cruel and uncivilized.
- The properties of older adults should be used to pay for their physical needs and medical care.

Because regulations covering assistance programs often change, it is difficult for older patients and the nurses trying to help them to keep current and up to date. Nurses may be called on to help older adults deal with the paperwork required when they are applying for assistance, to provide emotional support as they work through frustrating bureaucratic processes, or to arrange transportation to the appropriate agencies. Nurses usually are not expected to be experts in this area, but they should know how to locate appropriate resources. Nurses working in community health should be aware of community agencies providing assistance to older adults so that appropriate referrals can be made. Nurses working in hospitals and nursing homes can initiate referrals to social workers or other professionals who are knowledgeable about assistance programs. Most states and counties throughout the United States have services for older adults or departments on aging. These are typically listed in the government section of a telephone directory or on government websites. Many publish directories of resources available in their specific community.

WEALTH

Although many older people receive less cash on a yearly basis from Social Security and pensions than some younger individuals earn, a substantial number have accumulated assets and savings from their working years. Frugal lifestyles and self-reports by older adults of being "poor" should be viewed cautiously. Some individuals are truly impoverished, whereas others have significant assets.

In 2019, approximately 78% of Americans over 65 years of age owned their homes (Statistica, 2020a). A home is usually an older person's largest asset. Many older people choose not to sell their homes because they fear that they will have nowhere to live. Many prefer to remain "house rich and cash poor," making do on a limited income, rather than sell their homes.

Economic well-being is usually measured in terms of income, which is the amount of money a household receives on a weekly, monthly, or yearly basis. However, this measurement is not always a reliable indicator of financial security in older adults. People older than 65 years of age generally have more discretionary income (i.e., money left after paying for necessities, such as housing, food, and medical care) available than do younger people. Younger individuals, particularly those with growing families, may have a higher income, but they also have higher nondiscretionary demands.

HOUSING ARRANGEMENTS

Many people assume that older adults live in senior citizen housing or nursing homes. They are wrong. Most older adults live either with a spouse or alone. Approximately 3% of adults over age 75 live in institutional settings, such as nursing homes, although this figure increases to about 10% for people over age 85 (Federal Interagency Forum on Aging-Related Statistics, 2020).

Older individuals often try to keep their homes, despite the physical or economic difficulties of doing so. A home is more than just a physical shelter; it represents independence and security. The home holds many memories. Being in a familiar neighborhood close to friends and church is important. A sense of community is important to many older adults, who dislike the thought of leaving security for the unknown. The physical exertion and emotional trauma involved in moving can be intimidating, even overwhelming, to older adults. Moving to a different, often smaller residence is a difficult decision, particularly when it involves giving up precious possessions due to lack of space.

For some older people, keeping the family home is not a sensible option for many reasons. Many of the homes owned by older adults are in central cities with high crime rates. Expenses, such as increasingly high property taxes and ongoing maintenance costs, often put excessive strain on older persons with limited financial resources. Home maintenance, including even simple tasks such as housecleaning, becomes increasingly difficult with advancing age or illness. Ownership may require more effort in terms of money and time than some older people possess, yet many struggle to remain independent and keep their homes.

Some older individuals remain in their own homes and refuse to give them up long after it is safe for them to be alone. They may be able to cope as long as family, friends, and neighbors are willing to help. However, if there is a change in their support system, dangerous, life-threatening situations may arise. Some older people try to live in their homes despite broken plumbing, inadequate heat, and insufficient access to food. Families, health care professionals, and social service agencies may have to step in to protect the welfare of these aging individuals.

Some older people recognize the problems associated with living alone and decide to seek housing arrangements that are better matched to their needs and abilities. They may move into an apartment, condominium, senior complex, or other type of housing. As the older adult population grows, new types of housing and living arrangements are evolving (Fig. 1.6). The following Critical Thinking box should help you examine your attitudes toward housing for older adults.

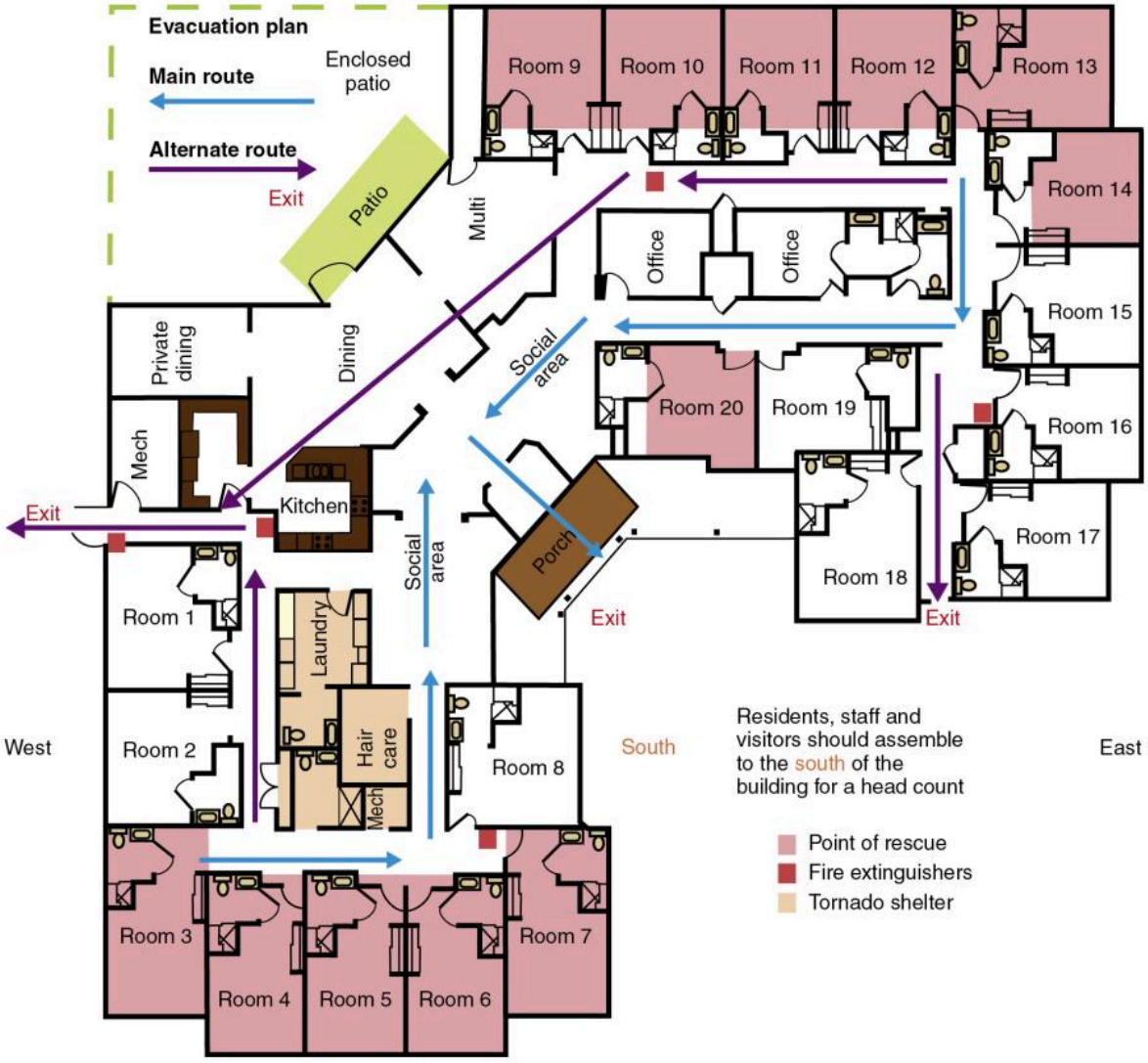

Fig. 1.6 A living plan for a community-based residential facility with evacuation plan. (Courtesy Elness Swenson Graham Architects, Inc., Minneapolis, MN.)

Critical Thinking

Your Attitudes Toward Housing for Older Adults

- Is it safe for older adults to remain indefinitely in their own homes?
- When should an older person sell their home?
- Once a home is sold, what are the best types of living accommodations for older adults?
- What kinds of alternative housing for older adults are available in your community?
- Should older adults live in housing that is separated from people in other age groups? Why? Why not?

Fig. 1.7 Dining room in an assisted living facility. (Photo courtesy Era Living, Seattle, WA.)

Independent or assisted living centers are becoming common. These centers combine privacy with easily available services. Most consist of private apartments that are either purchased or rented. For additional charges, the residents can be served meals in restaurant-style dining rooms and receive laundry and housekeeping services (Fig. 1.7). Different levels of medical, nursing, and personal care services are available. Health care services may include assistance with hygiene, routine medication administration, and even preventive health clinics. Many centers have communal activity rooms, arts-and-crafts hobby centers,

swimming pools, lounges, beauty salons, mini-grocery stores, greenhouses, and other amenities. Transportation to church, shopping, and other appointments is provided by some of these facilities. Most independent and assisted living facilities are privately operated, and costs are significant—although far cheaper than nursing home care. Some states offer subsidies to older individuals with limited resources because these living arrangements are often more cost-effective than other housing alternatives.

Did You Know?

Cruise Care

Some older adults are choosing to live on cruise ships instead of assisted living or long-term-care facilities. The ship provides a higher employee-to-resident ratio, more activities, more and better choices of food, better scenery, and more companionship for a lower price than nursing homes and a comparable price to assisted living facilities. Additionally, they have physicians and nurses on board (Bandoim, 2019). Although not appropriate for individuals suffering from dementia or immune compromise or those who require frequent medical appointments, cruise care might be an option (at least temporarily) for some adventurous seniors.

Life-lease or life-contract facilities are another housing option. For a large initial investment and substantial monthly rental and service fees, older persons or couples are guaranteed a residence for life. Independent residents occupy apartment units, but extended-care units are either attached to the apartment complex or located nearby for residents who require skilled nursing services. If one spouse needs skilled care, the other may continue to live in the apartment and can easily visit the hospitalized loved one. When the occupants die, control of the apartment reverts to the owners of the facility. The costs for this type of housing are high and may be out of the range of the average older adult. However, despite the costs, many find this option appealing because it meets their needs for independence, socialization, and services. Many find security in knowing that skilled care is easily available if needed.

Less wealthy older adults have fewer housing options. Some older adults qualify for government-subsidized housing if they meet certain financial standards and limits. Government-subsidized housing units may be simple apartments without any special services, or they may have limited services, such as access to nursing clinics and special transportation arrangements. Most communities are finding that the demand for these facilities exceeds the availability. Waiting lists with up to 2-year delays are common; some communities award the housing via lotteries. Interpretation of government regulations is causing some concern with regard to senior citizen housing. Residences originally intended for older adults may be required to accept a variety of medically disabled people regardless of age. Some of these younger residents suffer from psychiatric or drug-related problems, and the presence of these individuals may leave older adult residents feeling threatened and unsafe.

Some older adults who are not related to each other are forming group housing plans. In this type of arrangement, unrelated people share a household in which they have private bedrooms but share the common recreational and leisure areas as well as home maintenance tasks. Some communities offer services to help match people who are interested in this option. Roommates are selected so that the strengths of one individual compensate for the weaknesses of the other. In some cases, a large house may shelter 10 or more residents. Not all such arrangements are limited to older adults. In some situations, younger adults who need reasonable housing may be included. By providing services for older adult residents, the younger residents can reduce their rental costs. Both younger and older individuals who have chosen this option report benefits from the extended-family atmosphere.

A more formal type of group home, called a community-based residential facility (CBRF), is available in some communities. For a monthly fee, this type of facility provides services such as room and board, help with activities of daily living (ADLs), medication assistance, yearly medical examinations, information and referrals, leisure activities, and recreational or therapeutic programs. Fees for this type of housing may be paid by the individual or may be provided by county or state agencies. Most of these facilities provide private or semiprivate rooms with community areas for dining and socialization.

Older adults who require more extensive assistance may need placement in nursing homes or extended-care facilities. Nursing homes provide room and board, personal care, and medical and nursing services. They are licensed by individual states and regulated by federal and state laws. Three levels of care are provided by nursing homes: skilled care, intermediate care, and custodial care. Skilled care is daily nursing care, including medication administration and skilled treatments or procedures that require the expertise of licensed nurses. It also includes services performed by specially trained professionals, such as speech, physical, occupational, and respiratory therapists. Intermediate care describes professional care that is not required on a daily basis. It is a step down from skilled care. Custodial care is the next step down and refers to care that is considered nonskilled personal care, such as assistance with ADLs.

Subacute care facilities provide comprehensive inpatient care designed for individuals who have an

Critical Thinking

Nursing Home Insurance

Medicare will pay for a maximum of 100 days in a skilled care facility after a 3-day hospital stay. After that time, the cost of care is usually the responsibility of the older person or their family unless they qualify for Medicaid. In light of this, do you think that people approaching retirement should purchase nursing home insurance? Why or why not?

acute illness, injury, or exacerbation of a disease process. Subacute care falls between the traditional care provided in an acute care hospital and that provided in a skilled nursing home. For example, a ventilator-dependent patient or someone requiring frequent respiratory treatments would find appropriate care in a subacute facility.

Specialty care facilities—such as residences designed to meet the special needs of people with Alzheimer disease or other memory loss and their families—are gaining in popularity around the country. Other specialty care facilities are numerous and include inpatient hospice facilities, long-term care spinal cord injury facilities, and skilled nursing facilities that provide dialysis treatment.

HEALTH CARE PROVISIONS

Health care is a major area of concern in the United States. Everyone wants the best and most comprehensive medical care for themselves and their families. The expense of this level of care is the problem. At one time, individuals were personally responsible for the payment of physician and hospital bills. This gradually changed, and health care insurance, either individually purchased or paid for by an employer, became the norm. Insurance companies paid the bills, and the individual became less aware and involved in the rising cost of health care.

Government played a minimal role until the establishment of Medicare in 1965.

MEDICARE AND MEDICAID

Medicare is the government program that provides health care funding for older adults and disabled persons. Medicare is a popular program, and most Americans believe that it must be preserved. This has become increasingly difficult as the baby boom generation has become older; by 2030, all people in this cohort will be Medicare eligible. In 2020, Medicare provided coverage for approximately 61.2 million citizens (Kaiser Family Foundation, 2020). By 2050, this number is expected to swell to 90.7 million citizens (Kaiser Family Foundation, 2021). Most Americans older than 65 years of age qualify for Medicare.

Medicare has four distinct programs, none of which pays all of the health care costs. Medicare Part A is hospital insurance. It covers inpatient hospital care; skilled nursing care following hospitalization; some home health services, such as visiting nurses and occupational, speech, or physical therapists; and hospice services, but only after the patient pays an initial deductible and any copayments. During the 1980s, Medicare instituted the diagnosis-related group (DRG) system in an attempt to contain hospital costs. Under this system, a hospital is paid a set amount based on the patient's admitting diagnosis. If the patient is discharged in fewer days than predicted, the hospital keeps the excess money. If the patient needs to stay longer than projected, the hospital absorbs the additional costs. Although DRGs have resulted in cost reduction, they have also led to the discharge of people "quicker and sicker" than in the past. Many older people are released from the hospital before they have actually recovered from their illnesses, placing a greater health care burden on families and home health agencies.

Medicare Part B is medical insurance for outpatient care. It is optional, but most people choose this coverage. This plan covers 80% of the "customary and usual" rates charged by providers after deductibles are met. In addition to providers' fees, Medicare Part B covers medically necessary ambulance transport; physical, speech, and occupational therapy; home health services when medically necessary; mental health services; x-rays and lab tests; chiropractic care; medical supplies and equipment; and outpatient surgery or blood transfusions. The patient is responsible for the remaining 20% of the costs plus the difference between the actual fee and the government's "customary and usual" rate. The true costs of medical care often exceed the amount that the government pays. Many older adults pay for private supplemental health care insurance to cover these expenses rather than pay out of pocket.

Medicare Part C, or Medicare Advantage Plans, are optional plans offered by private companies approved by Medicare to individuals who are eligible for Part A and enrolled in Part B. These plans allow beneficiaries to receive their Medicare benefits through private insurance companies. The older adult enrolls in a private plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO). These plans are designed to cover total costs, so that supplemental insurance coverage is not necessary. They usually also include prescription drug benefits. They do, however, limit the pool of available health care providers, and premiums and rules vary depending on the plan selected.

Medicare Part D, or prescription drug coverage, is a voluntary plan available to anyone enrolled in Part A or B of Medicare. It includes both stand-alone prescription plans and Medicare Advantage drug plans.

Under Part D, prescription drugs are distributed through local pharmacies and administered by a wide variety of private insurance plans. In many plans, there is a significant gap between the cost of the drugs and the benefits provided. After meeting a deductible, recipients of Medicare Part D pay 25% of their prescription costs until they reach the out-of-pocket spending limit and qualify for catastrophic coverage; in 2020, this spending limit was $6350 (Medicare Interactive, 2021).

Supplemental Medicaid (Title 19) assistance may be available for those older adults who meet certain financial need requirements. Many of those who have assets do not qualify; they are left with a Medicare gap (or "medigap") that they must fill (pay for) themselves. Many older people buy private medical insurance—often at unreasonable prices—to pay medical bills that are not covered by Medicare. The Affordable Care Act mandated states to expand Medicaid coverage; however, not all states have expanded coverage at this time.

Critical Thinking

Medicaid and Personal Assets

Do you think that people should qualify for Medicaid if they hold valuable assets—that is, if they own a home or expensive cars? Or do you think they should liquidate their assets (i.e., sell the home and cars) before receiving Medicaid? Why or why not?

RISING COSTS AND LEGISLATIVE ACTIVITY

The costs of health care have increased dramatically in recent years. The United States spends more money on health care than any other country in the world, yet such care is not provided for all U.S. citizens. Many other nations do a better job of meeting their citizens' health care needs.

The Centers for Medicare & Medicaid Services (2020) reported that the United States spent approximately $3.8 trillion on health care in 2019. This accounts for 17.7% of our gross domestic product. A significant proportion of health care spending is spent on the older adult population. These costs are staggering, especially considering the expanding population of older adults. There has been an upsurge in initiatives to contain health care costs, such as managed care and insurance reform. If we expect to continue to provide adequate health care in the future, we can expect to see more changes in the way health care is financed and delivered. This is a major and often divisive political issue.

The cost of Medicare alone has grown dramatically from $3 billion in 1967, the first year of funding, to $55.5 billion in 1983; $297 billion in 2004; $551 billion in 2012; and $799 billion in 2019. The Congressional Budget Office (CBO) (2019) projects that it will surpass $1 trillion in 2023 and hit $1.5 trillion ($1500 billion) in 2029 (Fig. 1.8). The recipients of Medicare, however, pay quite a bit in out-of-pocket expenses: some 50% of typical Medicare recipients pay approximately 16% of their income on health care and premium costs (Noel-Miller, 2020).

The Patient Protection and Affordable Care Act (PPACA) was signed into law in 2010. It includes numerous health-related provisions designed to take effect over several years. This legislative initiative includes major changes in health insurance, health care funding, student loans, and a wide range of spending considerations. The costs of these provisions are to be offset by a variety of taxes, fees, and cost-saving measures.

There is a great deal of controversy regarding the PPACA because its long-term effects are still unknown. Those in favor of the legislation cite expanded coverage, greater competition among insurance companies, coverage of people with preexisting medical conditions, and closure of the donut hole affecting senior citizens (a large funding gap that placed a burden on older adults for medication payment; the donut hole "closed" in 2020) . Those opposed to the legislation cite cuts in Medicare funding, cuts in the Medicare Advantage program, increases in the Medicare tax, and expansion of Medicaid. They fear increased costs of health care, more taxes, and decreased incentives to primary care providers.

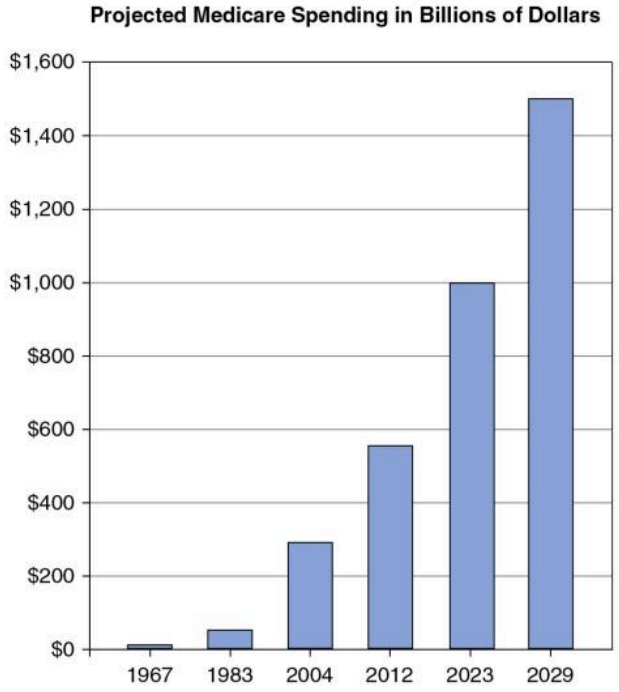

Fig. 1.8 Projected Medicare spending in billions of dollars. (Data from Congressional Budget Office, 2019, Medicare—CBO's May 2019 Baseline. https://www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf and Congressional Budget Office, 2020, 10-Year Budget Projections and Historical Budget Data. https://www.cbo.gov/about/products/budget-economic-data#2)

Legal challenges regarding the constitutionality of this bill were raised by several states, yet it was ruled constitutional by the U.S. Supreme Court in June of 2012. In writing the majority opinion, however, Justice John Roberts stated that the program is a tax—which may pave the way for different legal challenges. Efforts are now under way to strike down the entire PPACA, which would result in 21 million people becoming uninsured and millions more being denied health insurance due to preexisting conditions (Center on Budget and Policy Priorities, 2020b). Health care providers should pay attention, because this legislation is likely to have an impact on how health care is provided and funded. Other aspects of the law continue to be challenged in court.

COSTS AND END-OF-LIFE CARE

Not all older people use the available health care resources equally. Most health care services are consumed by the very ill or terminally ill minority, many of whom happen to be older adults. It is estimated that between 13% and 25% of all Medicare dollars spent on those 65 years of age or older was spent on beneficiaries in their last year of life (Duncan et al., 2019). Despite this, those patients' personal assets are quite often depleted. Serious questions are being raised about the appropriateness of using intensive, expensive interventions to extend the lives of terminally ill older people.

Financial concerns are forcing health care providers and society to face ethical dilemmas regarding the allocation of limited health care resources. This is a highly emotional issue with no easy answers. Many people are alive today because of advances in medical technology. Some of those who benefit are young, whereas others are old. Some go on to lead lives of high quality; others never lead normal lives again. By virtue of their training, physicians are inclined to try to cure everyone. Most doctors do not feel comfortable allowing a patient to die, regardless of the person's age, and will use all available technology to save a life. Talking about death is not easy for anyone, including medical providers. It is easier to avoid end-of-life issues than to take the time to consider this difficult discussion. Care providers need to take the time needed to have honest discussions with patients while the patients are competent to understand and make informed decisions about how they would like to spend their final days.

Reputable authorities, ethicists, and politicians have widely differing points of view on this issue. Some believe that health care restrictions on older adults are the ultimate in age discrimination. Others argue that the benefits gained, which can usually be measured in months, do not outweigh the costs. Private citizens examining this dilemma are equally confused. Even those who believe that health care costs are excessive frequently want everything possible done to save their lives or those of their loved ones. This moral, ethical, and legal dilemma has no simple solution. Part of the debate regarding health care reform involves differing viewpoints regarding end-of-life care. Perhaps this issue will encourage an honest national discussion among spouses, families, spiritual advisors, physicians, and other health care providers.

The following Critical Thinking box is designed to increase your awareness of and insight into these problems.

Critical Thinking

Your Understanding of the Health Care Dilemma

- Should an 80-year-old person have coronary bypass surgery at a cost of approximately $123,000? A cardiac transplant at a cost of approximately $1.3 million?
- Should dialysis be provided to individuals older than 65 years of age? Older than 75? Older than 85?
- Should people older than age 65 receive organ transplants?
- Should a ventilator be used on a terminally ill patient?
- Are feeding tubes a part of basic physical care or are they extraordinary means?
- Should the individual, family, or primary care provider decide on the type and amount of medical intervention necessary?
- What should be the role of the government in health care?

ADVANCE DIRECTIVES AND PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

All adults who are 18 years of age or older and of sound mind have the right to make decisions regarding the amount and type of health care they desire. Because older adults are more likely to experience significant health problems, the question of what and how much medical care to administer must be addressed. Such important decisions are best made during a stress-free time when the individual is alert and experiencing no acute health problems. A person's wishes can best be communicated using advance directives, which are legally recognized documents that specify the types of care and treatment that individuals desire when they cannot speak for themselves. Typically included in advance directives are: (1) do not resuscitate/do not attempt to resuscitate (DNR/DNAR) and allow natural death (AND) orders, (2) directives related to mechanical ventilation, and (3) directives related to artificial nutrition and hydration.

Two formal types of advance directives are recognized in most states: (1) the durable power of attorney for health care and (2) the living will. Information about both of these is typically provided when someone enters the hospital. Each patient is expected to make a decision about the type and extent of care to be administered if their condition becomes terminal.

These documents are designed to help guide the family and medical professionals in planning care. The family is often relieved to have this information when they are making difficult decisions during a stressful time. Advance directives are generally recognized and respected, but various agencies or health care providers may have beliefs or policies that prohibit them from honoring certain advance directives. Individuals should discuss their wishes with their health care providers when these documents are written. If there are irreconcilable differences between an individual and the care provider, changes in either the document or the care provider must be considered.

A durable power of attorney for health care transfers the authority to make health care decisions to another person, called the *health care agent*. The agent may act only in situations in which the persons involved are unable to make such decisions for themselves. Because the health care agent must be trusted to follow through with the older person's wishes, the agent specified in the document is usually a family member or friend. These wishes are specified in writing and usually witnessed by unrelated individuals so as to reduce the possibility of undue influence. Standardized legal forms are available to initiate a power of attorney for health care.

A living will informs the physician that the individual wishes to die naturally if a terminal illness develops or if the person receives an injury that cannot be cured. Living wills prohibit the use of life-prolonging measures and equipment when the individual is near death or in a persistent vegetative state. Living wills go into effect only when two physicians agree in writing that the necessary criteria have been met.

Usually, either of these documents is adequate to communicate a person's wishes; both are not needed. Those who choose to initiate both documents should ensure that there is no conflict between the directions provided in each document. Either document can be revoked at any time. An advance directive should be stored in a safe place where it can be located easily when needed. A safe deposit box is not recommended for this purpose. Family members and the family lawyer should know the content of the document and its location. An advance directive should be provided to the primary care provider so that it becomes part of the patient's permanent medical record. These documents are often required and kept available for emergency situations when an individual resides in an institutional setting such as an independent or assisted-living apartment, community-based residential facility, or nursing home.

Laws and specifics differ from state to state. Nurses should be aware of the legal standing of such documents in the particular state where they practice and should understand any legal ramifications engendered by these documents. Physician orders for life-sustaining treatment (POLST) is a legal document that has been adopted by almost every state and takes the person's wishes further by creating actual doctor's orders to be carried out by emergency personnel. The POLST contains three or four sections, depending on the state, including specifics about cardiopulmonary resuscitation (CPR) (whether to attempt resuscitation or allow natural death), medical interventions (comfort care, limited interventions, or full treatment including when to transfer to hospital), antibiotics (use freely, use for comfort, or do not use at all), and artificial nutrition (no tube feeding, trial of tube feeding, or long-term tube feeding). The POLST is printed on bright paper, the color of which is determined by the state, and signed by the physician and patient. Sample POLST forms are freely available on the internet.

Critical Thinking

Advance Directives and Physician Orders for Life-Sustaining Treatment (POLST)

- How would you as a nurse approach a patient regarding the initiation of an advance directive?
- Can a person who is diagnosed with Alzheimer disease initiate a living will or durable power of attorney?
- Does your state have POLST?
- How do hospitals and extended-care facilities identify a patient's advance directive?

IMPACT OF AGING MEMBERS OF THE FAMILY

The family is undergoing significant change in our society. Many factors—including increasing divorce rates, single parenting, coparenting, and a mobile population—are creating a less stable, less predictable family structure. Blended families, extended families, and separated families all present challenges. In addition to these societal changes, the demographic changes discussed previously are having and will continue to have repercussions that we can only begin to appreciate (Box 1.4).

Families today face historically unprecedented situations. Because of the lifespan extension, it is not

Box 1.4 Demographic Changes Affecting the Family

- Because of extended lifespans, the number of family members over age 65 is growing.
- More people are living with chronic conditions and need some degree of care or assistance.
- The number of people in the younger generations is decreasing in proportion to the number of older members.
- There is a growing number of widows who may be unprepared to provide for their own needs and will need assistance.
- The role of women is changing. As women increasingly must work outside the home, many are attempting to meet the demands of their parents as well as their homes, children, and workplaces.

Fig. 1.9 Fun—quality time with granddaughter.

uncommon for 4 or 5 generations of a family to be alive at one time (Fig. 1.9). Until recently, this was unheard of. Using 20 years as a typical generation, a family might resemble the one described in Table 1.3. If the generation time is less than 20 years, even more generations might be alive at the same time.

REFLECTION BY A NURSING PROFESSOR

Some years ago, as death was approaching for a 91-year-old gentleman, his family gathered at the hospital. His wife of 69 years asked that "the children" come into the room. This sounded rather strange because "the children" were all in their 60s, the grandchildren were all mature adults, and the great-grandchildren were fast approaching adulthood. It sounded even stranger to me, because this older man was my grandfather, and my father was "the baby" of the family.

Gloria Wold

Many older adults who need care will receive assistance, both economic and physical, from their families. The problems encountered in such situations can differ widely, depending on the respective ages of the family members. In some families, the "children" who are attempting to provide care for the oldest members are likely to be past age 65 themselves. They may have health problems of their own that make caregiving difficult or impractical. They may also have financial obligations to their own children, such as paying for education.

Table 1.3 The Family

AGE (YEARS)	GENERATION
80+	Parents
60+	Children
40+	Grandchildren
20+	Great-grandchildren
Less than 20	Great-great-grandchildren

Middle-aged family members often become the caregivers. The generation in their 40s and early 50s is sometimes called the *sandwich* generation because its members are caught in the middle—trying to work, to raise their own children, and perhaps provide assistance to one or two generations of aging family members. Sometimes they are also trying to help raise grandchildren by giving financial or physical assistance.

Although the financial, psychologic, and physical demands of assisting aging relatives affect all family members, women are likely to be the most affected. It is estimated that 75% of the caregivers in the United States are female (Box 1.5). Typically, sons contribute financially, but the brunt of the burden of emotional and physical care falls on the daughters. It is estimated that as the population ages, women will spend more time caring for their parents than they did caring for their children.

Families try to help aging family members in many ways. If the older adult is able to live alone, families may assist by visiting frequently and helping with transportation to shopping and medical appointments. Some prepare meals, help with housecleaning, and make major home repairs. Running between two households and trying to maintain both can be mentally and physically exhausting, but many are willing to help their loved ones in any way they can.

A family crisis may occur when the aging person is no longer able to live alone. Important decisions must be made. Most families find that there is no perfect solution. The two most common options are bringing the aging parent into the home of one of the children or placing the parent in an assisted living or long-term care facility. There are problems and concerns with any option that requires a major change in living arrangements. It is essential that the family making this difficult decision consider many factors. The amount of care needed by the parent; the availability of a willing and able family member; the amount of available space in the child's home; the added financial and emotional burden of an additional household member;

Box 1.5 Caregivers in the United States

Data from Family Caregiver Alliance: *Caregiver Statistics: Demographics* https://www.caregiver.org/caregiver-statistics-demographics

- The average caregiver age is 49 years.
- About 49% of caregivers are caring for a parent or parent-in-law.
- Some 75% of caregivers are female, and female caregivers typically spend more time providing care and performing personal care tasks.
- Family caregivers spend an average of 24.4 hours per week in giving care.
- The average duration of caregiving for a family caregiver is 4 years.

the wishes of the parent, the child, and the child's family; and the interpersonal dynamics within the family must all be considered before a decision is made.

Children may take older parents into their homes when the older parents can no longer maintain their own homes. Although this arrangement works well in some families, in others it is problematic for everyone involved. The familiar roles and responsibilities are often reversed when children step in and attempt to take care of their parents. This places the aging person into the role of the child, which they usually resent strongly. "Don't tell your mother what to do!" or "I'm still your father!" is often heard in such parent-child interactions.

Loss of independence is probably the most significant issue that aging parents and their children must face. The aging family members have spent decades making their own decisions. As independent adults, they made their own choices about where to live, what to do, and when to do it. They chose what to eat, obtained their food, and prepared it without interference. They went to bed when and where they chose. They went where they wanted to go without asking permission. They had control of their lives. Most independent adults do not want to ask anyone for help.

As physical changes or diseases affect older adults, some or all of their independent function may be lost. Aging people find it difficult to accept that they can no longer do the things they once did. It is also distressing for the family to watch their loved ones change. While the aging person tries to cope with these changes, the family tries to determine how to respond. If "the right thing to do" is not obvious, family members begin to experience mixed feelings and confusion. Feelings of grief, anger, frustration, and loss are common in all affected individuals.

When an older adult moves in with a child's family, the dynamics within the home are unavoidably changed. The ability of the family to adapt and cope with an additional member of the household varies greatly from situation to situation. If all parties are agreeable to the move and if the older adult can be given enough privacy to maintain independence, the blending of the older person into the child's home may be successful. Some families feel that having a resident grandparent can be rewarding and enriching. However, if the presence of the older person intrudes excessively on the family unit, the situation may be unpleasant for both the family and the older person.

If the older family member requires a substantial amount of physical care, the demands on family members can be intense. Nevertheless, many children feel duty bound to care for their aging parents. This sense of obligation may be based on cultural, religious, or personal beliefs. If the children determine that they are unable to care for their parent and instead opt for nursing home placement, the children often feel that they have failed in their responsibilities. This can lead to intense feelings of guilt even if nursing home placement is the most realistic and reasonable option.

THE NURSE AND FAMILY INTERACTIONS

When we as nurses care for older adults, particularly in hospital or nursing home settings, we see the person only as they are now. We often forget that these people have not always been old. They lived, loved, worked, argued, and wept as we all do. Often, the older adults we care for are very ill or infirm and, as nurses, we tend to focus on their physical needs, cares, and treatments. In our preoccupation with our duties, we can easily lose our perspective of the older patient as both a person and a member of a family.

In hospitals and nursing homes, family members come and go. Some families show a great deal of interest and concern for their aging members, visit regularly, and interact with the patient and staff. This allows us to increase our understanding and appreciation of our patients as people. Other older individuals may never have family members visit them. They seem to be alone in the world, even though the medical record lists children and their telephone numbers for emergencies. Even in home settings, family attention and interaction vary greatly. In some households, a great deal of interest is given to each family member; in others, little or none is shown. Why do we see such a wide variation of family attention?

The answer often lies in family dynamics and processes that began long ago when the older adult was a young spouse and parent. Some families are very stable and cohesive. They are together often and share close, loving bonds. They have developed healthy methods for interacting, responding, and meeting each other's needs. Because of the strong bonds that have developed over many years, these families remain interested in and supportive of their aging members.

Other families never develop the closeness that is ideal in a family. The family unit may have been disrupted by divorce, mental illness, or other serious problems. There may have been problems with abuse, alcohol use disorder, or drugs. Long-term problems that have developed over time do not go away when a person gets old. When the family unit is weak, supportive behavior from family members is unlikely.

Most families we interact with fall somewhere between these extremes. Few families are perfect and few are terrible. Families are made up of human beings who respond to stress in many different ways. Coping with the stresses related to aging is difficult for both the older adult and the family. The behavior we see at any given time is the best that the person is capable of at that moment. That does not mean that it is the best that they will be capable of at some other time. We as nurses need to examine the stresses affecting the family so that we can best respond to the needs of all family members. The following Critical Thinking box should help you determine your stress factors.

Critical Thinking

You and Your Family

Complete the following:

When my parents are unable to care for themselves, I will _____.

If both my parents and grandparents were alive and in need of assistance, I would _____.

If both my children and my parents needed help from me, I would _____.

If my parents were in a nursing home, I would want the nurses to _____.

When I grow old, I want my family to _____.

SELF-NEGLECT

Abuse and **neglect** usually involve something done to someone, but, unfortunately, self-neglect is a common problem in the older adult population. Self-neglect is more likely to be seen when an older person has few or no close family or friends, but it can occur despite their presence. Because our society has laws to protect the rights of adults, it may be difficult for concerned parties to intervene until a situation has reached critical or even life-threatening proportions.

Self-neglect is defined as the failure to provide for the self because of a lack of ability or lack of awareness. Indicators of self-neglect include:

1. The inability to maintain ADLs, such as personal care, shopping, meal preparation, or other household tasks
2. The inability to obtain adequate food and fluid, as indicated by malnutrition or dehydration
3. Poor hygiene practices, as indicated by body odor, lesions, rashes, or inadequate or soiled clothing
4. Changes in mental function, such as confusion, inappropriate responses, disorientation, or incoherence
5. The inability to manage personal finances, as indicated by the failure to pay bills or by hoarding, squandering, or giving away money inappropriately
6. Failure to keep important business or medical appointments
7. Life-threatening or suicidal acts, such as wandering, isolation, or substance abuse

Self-neglect in the community is most likely to be recognized by neighbors and reported to the police, public health nurses, or social workers. It may also be suspected by emergency department nurses who see these individuals after they are found injured on the street, after a fire, or in some other state of distress.

Self-neglect is often connected with some form of mental illness or dementia. Once the problem is recognized, legal action through the courts may be needed to place the person in the custody of a family member or adult protective services.

ABUSE OR NEGLECT BY THE FAMILY

Many older adults will need some form of long-term care in the home. Attempts to meet these demands may be accompanied by high levels of stress for the caregivers. The National Council on Aging (2021) estimates as many as 5 million older Americans are the victims of abuse or neglect every year, and that 10% of people over age 65 have experienced some form of abuse. Increased demands on limited resources, physical exhaustion, or mental fatigue can result in deviant behaviors on the part of the caregiver. Inappropriate behavioral responses include abuse and neglect of the older family members. Intentional abuse occurs when any person deliberately plans to mistreat or harm another person. Abusive behavior cannot be justified at any time or in any way. Intentional abuse is most likely to occur in families with preexisting behavioral or social problems. High-risk families include those that have a history of family conflict, those with a history of violence or substance abuse, those with mental impairment of either the dependent person or caregiver, and those with severe financial problems or that are experiencing unemployment.

Not all forms of abuse are intentional, but even unintentional abuse is devastating to older adults. Unintentional abuse or neglect is most likely to occur when the caregiver lacks the knowledge, stamina, or resources needed to care for an older loved one. Often, the caregiver is an older spouse or an aging child who physically cannot meet the high-level demands of care. Situations that trigger abuse are more likely to arise when the older person requiring care is confused or needs continual care.

Continuous demands on caregivers can make them virtual prisoners within their own homes. Stress builds, leaving the caregiver feeling trapped, frustrated, or angry. Unable to cope with the stress of the continual demands, caregivers may strike out at older adults, lock them in a room, restrain them in a chair, or leave them unattended. When the stress is high and the caregivers' coping abilities are low, they may not be able to identify any better options. They may not intend to hurt the older person or may rationalize that they are doing it to only "keep Dad from hurting himself," but the end result is still abuse.

Abuse can be physical, financial, psychological, or emotional. Neglect and abandonment also constitute forms of abuse.

PHYSICAL ABUSE

There are many types of physical abuse. It involves any action that causes physical pain or injury. Abuse may occur in the form of physical attacks on frail older adults who are unable to defend themselves against younger, stronger family members. Older people may be locked in bedrooms, closets, or basements. Older women may be sexually abused or raped by caregivers

or family members. Some older people are starved by family members or given food that is unsuitable or unfit for human consumption. Failure to provide adequate food or fluids also constitutes physical abuse. The inappropriate use of drugs, force-feeding, and the use of physical restraints or punishment of any kind are examples of physical abuse. Warning signs of physical abuse include bruising, lacerations, broken teeth, broken glasses, sprains, fractures, burn marks, wounds in various stages of healing, unexplained injuries, torn or bloody underwear, signs of vaginal trauma, delay in seeking medical treatment or a history of "doctor shopping," and refusal by the caregiver to let visitors see the older adult.

NEGLECT

Physical abuse involves one or more actions that cause harm. Neglect is a passive form of abuse in which caregivers fail to provide for the needs of older persons under their care. Neglect, whether intentional on unintentional, accounts for almost half of the verified cases of elder abuse. Neglect includes situations in which caregivers fail to meet the hygiene or safety needs of the older adult. Examples include situations in which a bedridden person is left wet and soiled with body wastes without care or in which an older person suffers from exposure because of lack of adequate clothing. Failure to provide necessary medical care may constitute neglect because, with no means of accessing care, the older person may suffer or die. However, this is not considered neglect if the older person is mentally competent and refuses treatment. Neglect may be deliberate on the part of the caregiver, or it may result from lack of knowledge, inadequate financial resources, or an insufficient support system. Neglect is not uncommon in situations where one older spouse cares for the other. In spite of the best intentions, the caregiving spouse may be unable to provide adequately for the needs of their more dependent partner. It is not uncommon for an older couple to hide these deficits from family members out of fear of losing their independence.

EMOTIONAL ABUSE

Even when physical abuse is absent and adequate physical care is provided, emotional abuse may occur. Emotional abuse is the most subtle and difficult to recognize type of abuse. It often includes behaviors such as isolating, ignoring, or depersonalizing an older adult. Emotional abusers may forbid people from visiting and isolate the older person from more responsible and sympathetic friends or family members. They may prohibit the use of the telephone or interfere with communication by mail or email.

Emotional abusers can use verbal or nonverbal means to inflict their damage. Verbal abuse includes shouting or voicing threats of punishment or confinement. Emotional abusers often threaten older adults with all manners of horrors if they tell anyone about their plight. Displeasure, disgust, frustration, or anger can be communicated nonverbally through sighing, head shaking, door slamming, or other negative body language. Repeatedly ignoring what the older person has to say and avoiding social interaction with the individual are subtle forms of emotional abuse. Signs of emotional abuse may include the lack of eye contact, trembling, agitation, evasiveness, or hypervigilance on the part of the victim.

Negative communications are devastating because they can attack the older person's mind and emotions. These messages can be so subtle and routine that they may not even be recognized as abusive. Emotional abuse is insidious in that it can damage the older adult's sense of self-esteem and can even destroy the victim's will to live without leaving any obvious signs.

FINANCIAL ABUSE

Financial abuse exists when the resources of an older adult are stolen or misused by a person who is trusted by the older adult. Children and grandchildren may take money from the older adult, rationalizing that the money is owed to them for providing care or that it will eventually be theirs anyway. People who expect to benefit from the older person's estate may be afraid that the needs of the older adult will consume all of the money and leave them with nothing; therefore they decide to take it while they can. Regardless of the caregivers' rationalizations in these situations, it is financial abuse if the older person's money is taken and spent by others for their own purposes. On the other hand, it is not abusive to use the older adult's resources to provide for the personal needs of that older adult.

Many older adults are overly trusting of family members, refusing to believe that their children would steal from them. This denial often continues despite clear evidence to the contrary. Often, all of the savings have been spent, the home has been sold, and any objects of value have disappeared before the older person will accept the truth. Even then, some older adults make excuses to try to cope with the harsh reality. Abusive caregivers often abandon older people once all of their assets are gone. In such cases, older adults are left homeless, penniless, and in despair. Signs of financial abuse include unusual banking activity, such as large or frequent withdrawals, missing bank statements, missing personal belongings of value, and signatures on checks or documents that do not match the signature of the older adult.

Some actions that older adults can take to protect their financial assets include (1) arranging for the direct deposit of Social Security, pension, and other benefit checks; (2) taking great care in the selection of anyone appointed to hold the power of attorney or give advice regarding a will; (3) keeping ATM pin numbers and online passwords secure—not writing

them in a location where others could see them and not giving the number to anyone; (4) having written agreements regarding expectations and fees for services; (5) keeping valuables in a secure location, such as a safe deposit box; and (6) remembering that home helpers or attendants are employees, not friends: paying a fair and agreed-upon wage and reserving tips and gifts for special occasions.

ABANDONMENT

Abandonment occurs when dependent older persons are deserted by the person or persons responsible for their custody or care under circumstances in which a reasonable person would continue to provide care. Abandonment usually leaves the older person physically, emotionally, and financially defenseless. Older adults who have been abandoned by their families usually become wards of the state.

RESPONSES TO ABUSE

It is natural to think that an older person suffering from one or more forms of abuse would complain, but this is rarely the case. Fear of being treated even worse or fear of being institutionalized or abandoned may prevent the victim from seeking help.

Clinical Situation

Trends and Issues

An 84-year-old woman was admitted to the hospital for dehydration and malnutrition. Six months earlier, she had suffered a mild stroke. Since then, her 86-year-old husband had been caring for her at home. On admission, the woman weighed 91 pounds. Stage 2 pressure injuries were present on both buttocks. Her clothing and undergarments were soiled, and she was in serious need of a bath. She reported episodes of incontinence of bladder and bowel. She said that her only activity consisted of sitting in a lounge chair watching TV. She was wearing a wig, which covered hair that was matted tightly against her scalp. After several days of carefully combing out the snarls, the nurse realized that the woman's shoulder-length hair had not been washed in months. The patient's husband explained, "I tried to do my best, but since she had always looked after this herself, I didn't know what to do." He made sure that she took her prescribed medicines and tried to see to it that she had enough to eat and drink, but he said that she was "picky." He also stated that he was unsure just how to take care of his wife's hygiene needs: "I tried to wash her up, but she said she wanted to be left alone." He explained that he shopped for groceries when she was asleep. He was afraid that if he called anyone for help, they would place his wife in an institution, and he could not cope with this idea. She had not complained to anyone for the same reason. Their children all lived out of state and had not visited since the patient had the stroke. She and her husband had assured their children by phone that everything was all right. It was only when the patient complained of chest pain that they sought medical attention.

Older people who manifest signs of abuse must be assessed carefully (Box 1.6). They may try to protect and defend the abuser, deny that abuse is occurring, or seem resigned to the situation, believing that there is no better alternative.

Nurse Alert

Assessing for Abuse

All questioning about and assessment of abuse must be done with great tact and sensitivity. It is best to question older adults alone, so that they can speak freely and without intimidation from a potential abuser.

When one is questioning or assessing for abuse, the right of older people to determine their own affairs to the full extent of their abilities must be respected. Information obtained must be kept confidential and shared only with agencies that have been authorized by the patient or necessitated by law. All observations, both objective and subjective, must be carefully documented in case legal action is required. Detailed records should be kept regardless of whether legal action is anticipated. Data may become significant only at a later date, when they would be impossible to reconstruct if they were not appropriately recorded. Photographs may be necessary to provide proof of neglect or abuse. These may include pictures of wounds, injuries, or living conditions. It is wise to avoid using the term *abuse* when one is working with older adults because they may become defensive and will probably deny it. Using words such as *problems* or *concerns* is more likely to yield truthful information.

When there is any question of abuse, an experienced professional who is skilled in dealing with elder abuse should oversee the case. Physical abuse and

Box 1.6 Signs That an Older Person May Be Experiencing Abuse

- Excessive agreement or compliance with the caregiver
- Signs of poor hygiene, such as body odor, uncleanliness, or soiled clothing or undergarments
- Malnutrition or dehydration
- Burns or pressure injuries
- Bruises, particularly clustered on the trunk or upper arms
- Bruises in various stages of healing, which may indicate repeated injury
- Inadequate clothing or footwear
- Inadequate medical attention
- Lack of food, medication, or care
- Verbalization of being left alone or isolated
- Verbalization of fear of the caregiver
- Verbalization of a lack of control in personal activities or finances

financial abuse are criminal offenses. Nurses have a moral, legal, and ethical responsibility to report any suspected cases of abuse (see Critical Thinking box). Nurses who provide care to at-risk groups, particularly the young and the older adult population, must be aware of their legal obligations with regard to suspected abuse. Nurses must know the state laws pertaining to abuse, the proper authorities to contact, and how to contact them. Once the responsible authorities have been notified, they are obligated by law to investigate and pursue any legal action necessary to ensure the safety of the abused and to protect them from further harm.

Critical Thinking

Your Knowledge of Elder Abuse

- Is elder abuse increasing today? If so, why?
- What would you do if you thought a close friend or relative was an elder abuser?
- What do you think is the best way to reduce the incidence of elder abuse? Why?
- What would you do if you suspected that a nursing assistant was abusing patients?
- What can you as a student nurse do to prevent elder abuse?
- What resources are available in your community to help prevent elder abuse?

ABUSE BY UNRELATED CAREGIVERS

Understandably, we would like to think that all persons seeking employment as caregivers to older adults were responsible, caring individuals, but, unfortunately, this is not the case. People who are hired to provide for the safety and well-being of older adults can sometimes become their greatest threat. The increasing use of unrelated caregivers exposes older adults to additional risks.

As the older population grows and more frail older adults remain in their homes, the demand for nursing assistants, home health aides, and housekeepers increases. Most people who work as nursing assistants or housekeepers are decent, caring individuals who provide difficult services for little reward. The salaries paid to nursing assistants and housekeepers are low, the hours are long, and the work is emotionally and physically demanding. It can be difficult to find caring, responsible people who are willing to provide this service. When the demand for caregivers exceeds the supply of desirable workers, employers may be forced to hire people who are willing to take these jobs only because they cannot find other employment.

Specific federal and state laws designed to prevent undesirable persons from contact with vulnerable people, such as the young and the older adult population, are in force today; however, sometimes people with criminal records, inadequate training, or other serious shortcomings manage to gain employment despite safeguards such as state registries, employment histories, and reference checks. Undesirable individuals may unwittingly be hired to provide care for older adults by families, home health agencies, and even health care institutions.

In home settings, unscrupulous caregivers have been known to take money and personal belongings from defenseless older people under their care. They may physically abuse older persons and threaten them with physical harm if the abuse is reported. They may threaten to quit, leaving the older person in fear of being placed in an institution. Using threats enables these individuals to remain undetected until they have caused serious harm. When they are discovered, they often disappear, only to reappear somewhere else and repeat their pattern of abuse.

QSEN Considerations: Teamwork and Collaboration

Elder Abuse in Institutions

Abuse in institutional settings is most likely to occur when the nursing assistants are forced to work under stressful conditions and have little ability to deal with that stress. The risk for abuse increases when caregivers perceive that they are not valued, supported, or acknowledged.

The following are ways that may help decrease stress and the likelihood of abuse:

- Create a positive team environment with full staffing levels; convey true respect and appreciation for the work every team member does.
- Encourage staff to take breaks on time and to rest and reenergize with healthy snacks. Provide a staff member responsible for "break relief" so that care may continue during breaks.
- Rotate any "difficult" assignments, to avoid overwhelming any one team member.
- Improve staff training to identify and defuse potential abuse situations.
- Initiate a stress-reduction program, including staff support groups and exercise options.
- Recognize the value of nursing assistants to the team's effort by involving them in care planning and consulting them regarding potential problems and possible solutions.
- Increase the recognition of good, compassionate caregiving through verbal praise, employee-of-the-month recognition, bonuses, and other rewards.
- Institute a "get to know the resident" program, whereby one resident is featured on a monthly basis, noting his or her past accomplishments. Team members may be surprised to learn that the dependent older adult they now care for once served as an elite military Special Forces member, raised 12 children, volunteered as a docent at the local aquarium, or played in a rock band.
- Provide an institutional mechanism for dealing with nursing assistants' complaints and concerns in a proactive rather than punitive manner.

Even health care institutions are not immune to problems of elder abuse. Most people assume that because hospitals and nursing homes are licensed and regulated, this type of behavior does not occur. Unfortunately, this is wishful thinking. Many institutions have difficulty hiring enough people to meet the required staffing levels. Although most health care institutions and agencies screen applicants in an attempt to find the most qualified individuals and to avoid hiring anyone with a history of abusive or criminal behavior, some unscrupulous people manage to avoid detection and are employed as caregivers to older adults. These unsuitable caregivers may victimize older adults before their behavior can be detected. Nurses who supervise other caregivers must constantly be on the lookout for abusive behaviors (Box 1.7). Nurses are **mandated reporters** of elder abuse, which means that if you suspect elder abuse and do not report it, you are breaking the law. You must know and follow the reporting laws in your state. If you suspect it, report any indication of abuse as soon as possible so that appropriate action can be taken and the abusive person removed.

A wide variety of services to reduce abuse and meet the emotional and physical needs of older adults and their caregivers are available. The availability and type of services vary from area to area. Nurses who work with older adults should become knowledgeable about the services available in their communities. Resources may include education programs designed to improve the awareness of elder abuse, support groups for caregivers, **respite** care programs, and senior day care centers. Many hospitals and health care agencies provide education in nutrition, medication administration, bedside care, and other aspects of elder care. The need for these programs is growing as the older adult population increases.

Box 1.7 Abusive Behaviors in Health Care Settings

- Use of sedative or hypnotic drugs that are not medically necessary
- Use of protective devices when they are not medically indicated
- Use of derogatory language, angry verbal interactions, or ethnic slurs
- Withholding of privileges, such as snacks or cigarettes
- Excessive roughness in handling during care or transfers
- Delay in taking a resident to the bathroom or allowing a resident to lie in body waste
- Consumption of a resident's food
- Theft of a resident's money or personal belongings
- Physical striking or any other assaultive behavior toward a resident
- Violation of a resident's right to make decisions
- Failure to provide privacy

SUPPORT GROUPS

Caregivers of older adults are often isolated from other people. The demands of providing care prevent caregivers from getting the rest, encouragement, and support they need. Caregivers who want or need to share their experiences and frustrations have started to form support groups to help one another cope with stress. These groups may be specialized (e.g., for caregivers of people with Alzheimer disease) or more general nature. Support groups allow caregivers to share their feelings and learn new strategies to improve coping skills. Some groups schedule speakers to discuss topics of common interest or offer social activities to promote stress reduction.

RESPITE CARE

Respite care allows the primary caregiver to have time away from the demands of caregiving, thereby decreasing stress and the risk for abuse. Many caregivers are unable to lead normal lives because they cannot leave their responsibilities for very long without fear of some disaster occurring. Respite care gives the primary caregiver the opportunity to attend church, go shopping, conduct personal business, obtain medical care, or simply participate in leisure activities. Respite care may be provided by family members, volunteers, or one of the many service agencies that have proliferated within the past few years. The Veterans Administration (VA) offers respite care for enrolled members of the VA health care system. Caregivers may be reluctant to use respite care out of guilt, fear, or other misguided emotions. Nurses should encourage caregivers to protect their own health and well-being by regularly taking advantage of respite care.

Get Ready for the Next-Generation NCLEX® Examination!

Key Points

- Chronologic age is not always the most reliable way to measure aging because the number of years a person has lived provides little information about his or her physiologic or functional ability.
- Many aging people today live more dynamic, positive lives than ever before.
- Stereotyping and negative perceptions of aging and older adults appear to be on the decline, yet subtle forms of ageism still exist and must be addressed.
- The United States will face significant challenges to meet the costs of providing adequate health care to its aging population.
- Because older adults represent a growing segment of the population, they are having a significant impact on politics, economics, housing, and social family dynamics.
- Providing quality care for an increasingly large aging population places increased demands on both family and professional caregivers.
- Although many positive changes have occurred, the frailest older adults remain vulnerable to physical, emotional, and financial abuse.

Additional Learning Resources

SG Go to your Evolve website at http://evolve.elsevier.com/Williams/geriatric for the additional online resources.

Online Resources

- Official geriatric nursing website of the American Nurses Association (ANA): Geronurse-online.org

Review Questions for the Next-Generation NCLEX® Examination

1. **Which statements are true regarding older adults? *Select all that apply.***
   - **a.** Most older adults live independently.
   - **b.** Older adults typically remain sexually active.
   - **c.** Older adults are a very diverse group of people.
   - **d.** Most older adults experience significant personality changes.
   - **e.** Older adults suffer from depression more than younger adults.

2. **Which is/are true of the baby boom generation?**
   - **a.** Its members were born between 1946 and 1964.
   - **b.** Its members will all be age 65 or older by 2020.
   - **c.** They outnumber the millennials.
   - **d.** It comprises about one-third of the population today.

3. **When was Medicare legislation established?**
   - **a.** 1940s
   - **b.** 1950s
   - **c.** 1960s
   - **d.** 1970s

4. **What is the overall percentage of adults over age 75 who live in an institutional setting?**
   - **a.** Approximately 1%
   - **b.** Approximately 3%
   - **c.** Approximately 11%
   - **d.** Approximately 17%

5. **What does a durable power of attorney for health care enable the health care agent to do?**
   - **a.** Decide whether the older adult should be resuscitated
   - **b.** Act only when the older adult is unable to act for themself
   - **c.** Determine when the older adult should be hospitalized
   - **d.** Change care decisions if that appears to be of benefit to the older adult

6. **What is probably the most significant issue to affect the older adult and their family?**
   - **a.** Loss of independence
   - **b.** Change in physical appearance
   - **c.** Decreased financial resources
   - **d.** Sensory and cognitive decline

7. **A nurse is assessing an older adult who was admitted to the emergency room accompanied by their daughter, with whom they reside. What observation might arouse suspicion of elder abuse? *Select all that apply.***
   - **a.** Bruises are observed on the older adult's arms and upper body.
   - **b.** The daughter answers all questions for her parent.
   - **c.** The older adult has a body odor and soiled clothing.
   - **d.** The older adult's skin is intact, with good turgor.
   - **e.** The daughter states that her parent does not get along with her grandchildren.

8. **Which are true statements regarding the economic security of older adults? *Select all that apply.***
   - **a.** Securing a reverse mortgage is the best way to ensure economic security for the older adult.
   - **b.** Fewer older adults will be receiving pensions in the years to come.
   - **c.** Most older adults qualify for government income programs.
   - **d.** The typical older adult lives below the poverty level.
   - **e.** Social Security income accounts for approximately one-third of the income of people aged 65 and older.

9. **Which type of document indicates someone's wishes by creating physician orders to be followed at home?**
   - **a.** Advance directive
   - **b.** Living will
   - **c.** Durable power of attorney for health care
   - **d.** POLST

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