1. The unsteady 20S-year-old client persists in ambulating to the bathroom alone despite being reminded to call for assistance. The nurse concludes that, according to Havighurst's developmental tasks, this behavior reflects which need of the client?

A. Adjusting to physiological changes
B. Independence
C. Industry
D. Integrity

ANSWER: B

A. Adjusting to physiological changes is a develop- mental task of middle age.
B. The client is attempting to perform self-care and to demonstrate the ability to be self- sufficient and independent from other adults.
C. Industry is one of Erikson's developmental tasks, not Havighurst's. Industry versus inferiority occurs from ages 6 to 12 years.
D. Integrity is one of Erikson's developmental tasks, not Havighurst's. Integrity versus despair occurs at 65 years and older.

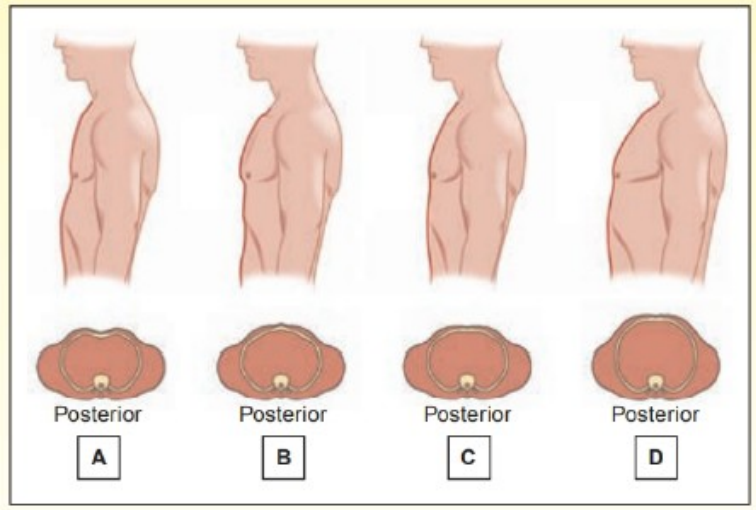
2. The nurse is completing an assessment on the 19 year - old female who participates in strenuous physical activities many hours daily. Which nursing assessment is most important?

A. Check for the presence of lordosis.
B. Look for signs of an eating disorder.
C. Examine muscles for increased mass.
D. Ask about excessive bleeding with menses.

ANSWER: B

A. Strenuous physical activity does not cause lordosis (excessive inward curvature of the spine in the lower back). Lordosis is common in children before age 5.
B. Females who participate in strenuous physical activities are at risk for eating disorders.
C. An increase in muscle mass is expected with physical activity; thus, it would not be the most important assessment.
D. Delayed menses, not excessive bleeding, would be a concern with strenuous physical activity.

3. The nurse is assessing the chest of the normally healthy adult male client without chest abnormalities. Which chest curvature illustrated should the nurse expect to observe?



A. Illustration A
B. Illustration B
C. Illustration C
D. Illustration D

ANSWER: C

A. Illustration A is pectus excavatum, or funnel chest, caused by stemal retraction.
B. Illustration B is pectus carinatum, or pigeon breast, with sternal bulging.
C. The normal adult chest has an anteroposterior - to-lateral ratio of approximately 1:2 and a costal angle less than 90 degrees. There should be no sternal or intercostal retractions or bulging at rest.
D. Illustration D is barrel chest with increased anteroposterior diameter of the chest, with near- parallel rib sloping and a costal angle greater than 90 degrees. Barrel chest occurs with COPD.

4. The nurse teaches the 18-year-old diabetic client to perform self-administration of insulin. Each time the client makes even a small mistake, the client apologizes for getting it wrong- The client also profusely apologizes when making a minimal mistake in other activities. Based on Erikson's developmental stages, the nurse concludes that the client may have an unresolved developmental task of which age period?

A. Infancy
B. Early childhood
C. School- aged childhood
D. Adolescence

ANSWER: B

A. The central task of infancy is determining trust versus mistrust. Unresolved conflict manifests itself in withdrawal, mistrust, or estrangement.
B. The behavior indicates an unresolved conflict of “autonomy versus shame and doubt” associated with the 18-month to 3-year-old age group. When parents are overly critical and controlling, the child may develop an overly critical superego. As an adult, it manifests in constantly apologizing for small mistakes.
C. The central task of the school-aged child is “industry versus inferiority.” Unresolved conflict of this stage manifests itself in Withdrawal from school and peers, loss of hope, or sense of being mediocre.
D. The central task of adolescence is “identity versus role confusion.” If unresolved, it manifests itself in indecisiveness, antisocial behavior, or feelings of confusion.

5. The 18 year-old tells the clinic nurse, “Thinking about college is stressing me out. I am used to getting A’s and B’s.” Which statement should the nurse reserve until a follow-up visit with the client?

A. “Expressing your feelings of anxiety to a friend or nurse helps you cope emotionally.”
B. “I will check with the provider about prescribing paroxetine hydrochloride.”
C. “Exercise increases the release of endorphins and can enhance your sense of well-being.”
D. “If you like drawing or painting, register for an art class during your first semester in college.”

ANSWER: B

A. Expressing feelings promotes emotion-focused coping.
B. The nurse should reserve suggesting an anti- depressant until other interventions have been tried. Antidepressants such as paroxetine hydrochloride (Paxil) influence the activity of neurotransmitters thought to play a role in anxiety disorders.
C. Physical activity promotes emotion-focused coping.
D. Art therapy promotes emotion-focused coping.

6 . The nurse is collecting information from the young adult client. Which psychosocial questions should the nurse ask during the admission assessment? Select all that apply.

A. “Do you have any pets?”
B. “How many hours of sleep do you get?”
C. “When was your last bowel movement?”
D. “How much alcohol do you drink?”
E. “Can you describe your sexual activity?”

ANSWER: A, C, D, E

A. The nurse should ask about pets. Pets can enhance mental well-being and promote responsibility.
B. The nurse should ask about sleep. Insufficient amounts of sleep and rest can decrease coping and impair the immune system.
C. Asking for the date of the last bowel movement relates to physiological functions.
D. The nurse should ask about alcohol use. Regular consumption of three or more alcoholic drinks a day increases the risk of hypertension and decreases immune competence.
E. The nurse should ask about sexual activity. Multiple sex partners and anal sex are risk factors for STIs and HIV.

7. The nurse assesses that a hospitalized 20-year-old college student is anxious and not able to concentrate when given self-care instructions. Which intervention should the nurse implement to assist the client to deal with the stress of hospitalization?

A. Have one parent stay in the room when the client is anxious
B. Encourage using a cell phone or Internet to talk with friends
C. Contact psychiatry to discuss treatments for depression
D. Reinforce multiple times how best to perform self-care

ANSWER: B

A. A young adult is not in need of constant accompaniment of a parent and may find this intrusive.
B. To enhance coping, the nurse should focus on the developmental needs of a young adult, which include interaction with peers. Finding ways to help the client communicate with friends, such as using a cell phone or the Internet, may assist in dealing with the stress of the hospitalization and trauma.
C. The client's behavior does not indicate depression.
D. Reinforcing information focuses on the injuries and self-care and not on the emotional needs of the client for stress management.

8. The nurse is obtaining nutrition information from four 20-year-old female clients. All have a BM] of 20 to 23. Which client requires the most immediate follow-up?

A. The client eats three nutritious meals a day with no snacks.
B. The client limits her intake to 2500 calories per day.
C. The client eats only fruits, vegetables, seeds, and nuts.
D. The client eats three 350-calorie meals per day.

ANSWER: D

A. The meals are nutritious and may contain enough calories whereby snacks are not required.
B. This is an appropriate caloric intake for an average young adult female.
C. The client is eating a vegetarian diet. The nurse should further assess for protein sources, but the diet would not cause immediate concern because beans and nuts contain protein.
D. By limiting meals to only 350 calories at a time, the client is only consuming 1050 calories per day. This does not meet the basic energy needs for a sedentary female. Further follow-up is required immediately.

9. The 32-year-old has been trying to get pregnant for the past 10 years- The client consults a family planning clinic after being unsuccessful with the calendar and basal body temperature methods in determining the time of ovulation. Which statement by the nurse would be most appropriate?

A. “Let me review the methods with you; maybe you have not been using them correctly.”
B. “Have you considered that you might not be ovulating and that adoption is an option?”
C. “Test kits are available that will detect an enzyme in cervical mucus that signals ovulation.”
D. “If your spouse wears restrictive underwear, this can reduce your chance of conception.”

ANSWER: C

A. Offering to review the methods is not the most appropriate response because the client has been unsuccessful for 10 years.
B. Suggesting adoption is premature because other options to test ovulation are still untried.
C. It is most appropriate for the nurse to suggest an ovulation test kit. These are available over the counter and are easy to use and considered reliable. The kit can detect the presence of guaiacol peroxidase, the enzyme in cervical mucus that signals ovulation 6 days beforehand.
D. Providing information about a male’s restrictive underwear reducing the chance of conception does not address the problem of determining the time of ovulation.

10. The nurse is caring for the 55-year-old client. Which statement by the client related to psychosocial changes should the nurse most definitely explore?

A. “I really don’t want to color my hair, even though it seems to be getting grayer every day.”
B. “I can’t see as sharp anymore. I get frustrated by the small lettering on the medicine bottles.”

C. “My husband and I have a more active sexual life now that the children are out of the house.”
D. “My house is empty; I thought I’d be happy when my children finally left, but I feel lonely.”

ANSWER: D

A. A normal physiological change in the middle years is graying hair. This is an appropriate response that does not require follow-up.
B. A change in eyesight occurs in the middle years and should he further explored, but this is a physiological and not psychosocial change.
C. Although sexual changes occur in middle age, this statement indicates that the client has a healthy sexual relationship.
D. The client’s statement suggests that the client may be experiencing empty nest syndrome. This is a psychosocial concern that the nurse should further explore with the client.

11. The nurse is assessing a healthy middle-aged adult. Which finding should the nurse expect?

A. Weight gain of 20 pounds in the past year
B. Tactile fremitus is absent at the apex of the lungs
C. Counts backward from 100 subtracting 7 each time
D. Percussion shows heart is larger than at last checkup

ANSWER: C

A. Although muscle is replaced by adipose tissue as a person ages, a weight gain of 20 lb in a year is excessive.
B. Tactile fremitus (the vibrations felt when the hand is held against the client’s chest and the client is speaking) is a normal finding; it is decreased or absent with a pneumothorax.
C. The nurse should expect that the middle-aged adult should be able to focus on a mental task such as subtraction.
D. Percussion that indicates the heart is enlarged indicates that a medical problem has occurred since the last examination. If no disease is present, the heart stays the same size during middle age.

12. The nurse is planning a health promotion program for a group of middle—aged adults. Which topic is most appropriate for the nurse to include?

A. Methods of contraception
B. Stress management skills
C. Reduction of caloric intake
D. A safe home environment

ANSWER: B

A. Methods of contraception is a more appropriate topic for young adults and not middle-aged adults who may have already experienced parenthood.
B. Stress management skills is a most important topic for middle-aged adults, who experience many stressors related to physiological changes associated with aging, earning a living, supporting a family, paying for children's educational expenses, saving for retirement, children leaving home, and, for many, caring for aging parents. Stress con- tributes to the development of stress-related diseases such as hypertension, heart attack, ulcers, and stroke.
C. Although calorie needs change with aging, a more important topic is stress management due to the cumulative effects of stress.
D. A safe home environment is a more appropriate topic for families with young children and for older adults.

13. The nurse is caring for the middle-aged client. Which client behavior should indicate to the nurse that the client may have difficulty achieving Erikson's developmental stage of generativity?

A. Talks about accomplishments that made the workplace a better place to work
B. Volunteers at the local nursing home reading to residents one day a week
C. Focuses conversation on self and displays disinterest in the activities of others
D. Shows pictures of the client's grandchildren and the client at various sports events

ANSWER: C

A. Making the workplace a better place to work suggests that the client has an interest in future generations and is in the stage of generativity.
B. Volunteering shows interest in others and in making a contribution to the community; it is in the stage of generativity.
C. Having a self—focus and displaying a disinterest in the activities of others suggest self- absorption and an inability to play a role in the development of the next generation; this can result in stagnation.
D. Pictures showing the client involved with the grandchildren demonstrate the client's interest in future generations and the stage of generativity.

14. The nurse is assessing the 50-year-old female client who is hospitalized. The nurse should assess the client for which physical changes associated with aging? Select all that apply.

A. Increased sweat gland activity
B. Decreased ability to read smaller print
C. Weight loss due to hypennetabolism
D. Increased sebaceous gland activity
E. Absence of a menstrual cycle

ANSWER: B. E

A. Sweat gland activity decreases, not increases, with aging.
B. Visual acuity declines in middle-aged adults, often by the late 405, especially near vision.
C. Weight gain, and not weight loss, occurs due to a slowing of metabolism occurring with aging.
D. Sebaeeous gland activity decreases, not increases, with aging.
E. Hormonal changes result in menopause, most commonly between ages 40 and 55 years.

15. The home health nurse is caring for the middle-aged client who is disabled due to a recent accident. The client has few interests, spends most days watching TV, and has become estranged from the family. Which of Erikson's developmental stages should the nurse conclude that the client is not meeting?

A. Industry versus inferiority
B. Initiative versus guilt
C. Generativity versus stagnation
D. Intimacy versus isolation

ANSWER: C

A. "Industry versus inferiority" is the developmental stage for the school-aged child, 6 to 12 years.
B. "Initiative versus guilt" is the developmental stage for the preschool aged child, 3 to 5 years.
C. The central task of adulthood is "generativity versus stagnation." The client has indicators of negative resolution of this developmental stage.
D. "Intimacy versus isolation" is the developmental task for young adulthood, 18 to 25 years.

16 . The nurse is caring for the hospitalized 60-year-old client of Korean American ethnicity. Which statement, if made by the client. Correctly reflects the Korean American culture and should alert the nurse that intervention is needed?

A. "Since 60 is considered old age, I retired as expected. I'm now worried about insurance."
B. "Value is on youth and beauty; so little attention is paid to problems of the elderly."
C. "Fathers are expected to continue to contribute financially even for their adult children."
D. "Grandchildren are raised by the grandparents until school age, so we have a full house."

ANSWER: A

A. In the Korean American culture, 60 is considered old age, and elders are expected to retire. At a retirement age of 60, the client does not yet qualify for Medicare insurance coverage. A social worker consult may be needed to discuss insurance options.
B. The European American and not the Korean American culture focuses on youth and beauty.
C. Giving money to adult children is not an expectation of any one culture specifically.
D. African American, and not the Korean American, grandmothers often raise grandchildren and offer economic support-

17. The 50-year-old asks the nurse how to calculate BM]. The client weighs 134 1b and is 5'3" tall. Together, the client and nurse calculate the client's BMI rounded to the nearest tenth. What is the client's BMI?

_____ (Record your answer rounded to the nearest tenth.)

ANSWER: 23.8

Formula: BMI = (705 × weight in pounds) ÷ (height in inches)²
BMI = (705 × 134) ÷ [(12 × 5) + 3] ² = 94,470 ÷ 3,969 = 23.8

18. The nurse is teaching a group of middle-aged female nurses about middle-aged moral development applicable only to women. Which point should the nurse most specifically address?

A. Gilligan's moral development theory includes responsibility and caring for self and others.
B. Kohlberg's moral development theory includes living according to universally agreed-upon principles.
C. Westerhoff's stages of faith include putting faith into personal and social action and standing up for beliefs-
D. Fowler's stages of spiritual development include becoming aware of truth from a variety of viewpoints.

ANSWER: A

A. Gilligan's theory is specific to women and pro- poses that women see morality in the integrity of relationships and caring. Women tend to consider what is right to be taking responsibility for others and caring, whereas men tend to consider what is right to be what is just.

B. Kohlberg's theory is not specific to women. Option 2 describes Kohlberg's post conventional level of moral development for middle-aged or older adults.
C. Westerhoff's stages of faith are spiritual development theories and not moral development theories. These refer in part to the individual's perceptions about the direction and meaning of life.
D. Fowler's stages of spiritual development are spiritual development theories and not moral development theories. These refer in part to the individual's perceptions about the direction and meaning of life.

19. The student nurse is discussing with the experienced nurse Lawrence Kohlberg's theory of moral development pertaining to middle-aged adults. Which statement should the experienced nurse correct?

A. "Middle-aged adults are usually concerned about basic individual rights of others."
B. "Middle-aged adults attempt to understand the values and beliefs of others."
C. "Middle-aged adults are focused on their careers and are less concerned about morals."
D. "Middle-aged adults use their own chosen ethical principles when making moral decisions."

ANSWER: C

A. Being concerned about basic individual rights of others pertains to stage 5 of Lawrence Kohlberg's theory of moral development, Social Contract and Legalistic Orientation. Kohlberg proposes that middle-aged adults are at either stage 5 or 6 of moral development.
B. Attempting to understand the values and beliefs of others pertains to stage 5 of Lawrence Kohlberg's theory of moral development, Social Contract and Legalistic Orientation. Kohlberg proposes that middle-aged adults are at either stage 5 or 6 of moral development.
C. The student nurse's statement that middle-aged adults are focused on their careers and are less concerned about morals is not associated with Kohlberg's theory of moral development. The experienced nurse should correct the student nurse's comment.
D. Using their own chosen ethical principles when making moral decisions pertains to stage 6 of Lawrence Kohlberg's theory of moral development, Universal Ethical Principle Orientation.

20. The nurse is caring for the chronically ill middle- aged adult who has had numerous hospitalizations. Which behaviors may interfere with the client's achievement of the developmental task associated with middle adulthood? Select all that apply.

A. Writes thank-you notes to friends
B. Stays at home and refuses visitors
C. Self-absorbed in own psychological needs

D. Attempts to perform own personal cares
E. Continually relays feelings of inadequacy

ANSWER: B, C, E

A. Writing thank-you notes to friends indicates that the client is trying to maintain social relation- ships, which is one of the developmental tasks of middle adulthood.
B. Stays at home and refuses visitors may interfere with maintaining social relationships, which is one of the developmental tasks of middle adulthood.
C. Self-absorption may interfere with maintaining social relationship, which is one of the developmental tasks of middle adulthood.
D. Attempting to perform self-care activities shows initiative and interest in improving one's health and will not interfere with the developmental tasks associated with middle adulthood.
E. Continually relaying feelings of inadequacy may interfere with the client's ability to improve his or her health status and to resume a career. This may interfere with achieving the developmental tasks of middle adulthood.

21. The nurse is caring for the 50-year-old client who reports having difficulty falling asleep. Which recommendations should the nurse make to this client? Select all that apply.

A. Drink a glass of wine or a beer before bedtime.
B. Avoid exercising 2 to 3 hours before bedtime.
C. Go to bed at the same time each night.
D. Watch television in bed just before bedtime.
E. Avoid eating large or spicy meals in the evening.

ANSWER: B, C, E

A. Alcohol should be avoided before bedtime. Although alcohol may initially cause drowsiness, it can cause wakefulness alter a few hours of sleep.
B. Exercising before bedtime is stimulating and can cause wakefulness. Avoidance of exercise near bedtime promotes a good sleeping habit.
C. Going to bed at the same time each night programs the body to expect to sleep at a certain time and influences circadian rhythms.
D. Watching television or using technology in bed is stimulating and makes it difficult to disengage and fall asleep. The light from these can also alter circadian rhythms.
E. Food remains in the stomach for 2 to 4 hours after eating. Lying down with a full stomach or eating spicy foods can cause indigestion, keeping a person awake. Spicy foods are also thought to increase body temperature, disturbing the nervous system and hormonal mechanisms that initiate sleep.

22. The nurse is interviewing an 80-year-old client who has urinary incontinence. The client is taking furosemide. When asked about daily fluid intake, the client states, "I drink 2 glasses of water, 1 glass of milk, and a half glass of juice. I don't drink coffee or tea." Which responses by the nurse are appropriate? Select all that apply.

A. "Your fluid intake should be 6 to 8 glasses of water, plus other fluids-"
B. "Your fluid intake is adequate and may help to reduce your incontinence."
C. "Caffeine increases urination; it is good that you avoid drinking coffee."
D. "Your fluid intake is limited; this increases your risk for dehydration."
E. "Your fluid intake is sufficient to maintain a fluid and electrolyte balance."

ANSWER: A, C, D

A. To promote a fluid and electrolyte balance and to prevent dehydration, older adults should consume 6 to 8 glasses of water, plus other fluids.
B. The client's fluid intake is inadequate, not adequate. Incontinence may increase when fluids are inadequate because concentrated urine irritates the bladder and urinary sphincter.
C. Caffeine has a diuretic effect and can cause dehydration if consumed in excess.
D. The total daily fluid intake is 3% glasses of liquids. This is insufficient and can lead to dehydration and electrolyte imbalances, especially when taking the diuretic furosemide (Lasix).
E. The client's fluid intake is inadequate (not sufficient) and can increase the client's risk for dehydration and electrolyte imbalances, especially since the client is on a diuretic, which promotes fluid excretion.

23. The nurse educator is planning teaching for other nurses after noting that some nurses need additional education on insulin types and how to use the new insulin injection pens. When planning teaching, which question by the educator best reflects consideration that the nurses are adult learners?

A. "Does anyone want to volunteer to prepare a poster board and help with handouts?"
B. "What do you need to learn about insulin, and what teaching method would you prefer?"
C. "Can you attend a presentation if I post various times during the day and evening shift?"
D. "What don't you understand about the information in the policy and procedure manual?"

ANSWER: B

A. Adults learn best by demonstration and hands-on practice. A poster board does not support adult learning styles.

B. Adults are independent learners. Before deciding what nurses do not know, the nurses them-selves should identify their specific learning needs and the methodology for learning.
C. Adults learn best by demonstration and hands-on practice. A presentation does not support adult learning styles.
D. Asking staff what they don't understand about the policy and procedure is threatening.

24. The nurse has limited time to teach the middle-aged adult client- The nurse should initially plan to take which action?

A. Provide brochures and handouts that the client can discuss with family members.
B. Make a referral to outpatient resources for the client to receive the needed teaching-
C. Establish the highest-priority learning needs and teach with each client or family contact.
D. Answer the client's questions and leave the extensive teaching for the nurse on the next shift.

ANSWER: C

A. Family members may not have the medical knowledge to answer the client's questions and clarify information. Printed educational materials should be used with other teaching strategies.
B. A referral might be an option if extensive teaching is needed, but it would not be an initial approach. Depending on the referral, there may be additional costs.
C. To make the most of limited time, the nurse and client should set priorities of the client's learning needs so that important teaching can be completed during any contact with the client or family.
D. The nurse has a professional responsibility to include client teaching. Teaching and practice can be broken into small time periods.

25. The nurse plans to teach the client progressive muscle relaxation. Prioritize the steps that the nurse should teach to correctly perform progressive muscle relaxation.

A. Relax the feet, imagining the tension flowing out with each exhalation.
B. Lie down in a quiet place where you are undisturbed.
C. Contract the muscles of your feet first as you inhale and hold the contraction briefly.
D. Relax your body, allowing it to feel heavy.
E. Lie still for a few minutes after the contraction and relaxation of all muscles.
F. Imagine the tension flowing out with each breath you take.
G. Move up the body, contracting then relaxing each muscle.

ANSWER: B, D, F, C, A, G, E

B. Lie down in a quiet place where you are undisturbed. A quiet place is needed so the client can focus on the muscle relaxation techniques.

D. Relax your body, allowing it to feel heavy. The feeling of heaviness before beginning muscle tension and relaxation helps the client to monitor the state of muscle contraction and relaxation as the steps progress.

F. Imagine the tension flowing out with each breath you take. Focusing on breathing allows for further muscle relaxation.

C. Contract the muscles of your feet first as you inhale and hold the contraction briefly. Tensing the muscles in a particular area should occur before relaxation of those muscles.

A. Relax the feet, imagining the tension flowing out with each exhalation. Relaxation should occur after muscle tension.

G. Move up the body, contracting then relaxing each muscle. Progressive muscle relaxation can occur from the feet up or the head down. In this scenario, the feet were first.

E. Lie still for a few minutes after the contraction and relaxation of all muscles. The last step is to lie still so the person can monitor what muscles feel like when they are relaxed after performing the steps.

26 . The nurse is reviewing a laboratory report for a 61—year-old client. Which finding is most important for the nurse to address with the HCP?

A. Total cholesterol 180 mg/dL ; was 140 at age 50
B. Erythrocyte sedimentation rate (ESR) increased
C. Alkaline phosphatase increased
D. AST, ALT, and serum bilirubin increased

ANSWER: D

A. Total cholesterol increases by 30 to 40 mg/dL with aging. This value is still less than 200 mg/dL.
B. ESR increases with aging for unknown reasons.
C. Alkaline phosphatase is an enzyme found throughout the body that increases with aging.
D. It is most important for the nurse to notify the HCP if liver function tests are elevated. AST, ALT, and serum bilirubin are liver function tests that are unchanged with age.

27. While attending a health fair, the 62-year-old female is found to have many risk factors for osteoporosis. The nurse at the booth recommends that she contact her HCP about scheduling a DEXA (dual-energy x-ray absorptiometry) scan. Which risk factors influenced the nurse's recommendation? Select all that apply.

A. Hyperthyroidism
B. Postmenopausal
C. Overweight
D. African American
E. 62-year-old female

ANSWER: A, B, E

A. Too much thyroid hormone can cause bone loss.
B. Estrogen levels decrease at menopause, and this decrease is one of the strongest risk factors for osteoporosis.
C. A thin body structure rather than being overweight is a risk factor for osteoporosis. Being overweight can contribute to the development of OA.
D. Major risk factors for osteoporosis include white or Asian race, not African American-
E. Advancing age and being female are both risk factors for osteoporosis.

28. The 62-year-old client is diagnosed with osteoporosis. Which medication, if taken by the client, should the nurse identify as posing a secondary risk factor for the client's osteoporosis?

A. Baby aspirin daily for past 4 years
B. Escitalopram 5 mg daily for past 7 months
C. Multivitamin for many years
D. 10-year use of budesonide nostril spray bid

ANSWER: D

A. Baby aspirin, used for its cardioprotective effect, has not been identified to cause bone loss (osteoporosis).
B. Escitalopram (Lexapro), an antidepressant, has not been identified to cause bone loss (osteoporosis).
C. The calcium and vitamin D supplement in multivitamins is helpful in preventing bone loss.
D. Long—term use of corticosteroids, such as budesonide (Pulmicort), should be identified as a risk factor for osteoporosis.

29. The 66-year—old client recently retired after working 30 years as a bank manager. Which statement to the nurse during a clinic visit best suggests that the client is achieving the developmental stage of "integrity versus despair"?

A. "Now that] have some free time, I want to treat my wife to a trip to Hawaii."

B. “I seem to be staying in bed longer and longer each day. There isn’t a reason to get up now.”
C. “I am noticing the little aches and pains more; before I was just too busy to notice them-”
D. “I get calls a few times a week for advice; my coworkers still value my suggestions.”

ANSWER: D

A. Option 1 is a statement reflecting positive resolution of generativity versus stagnation, showing concern for others-
B. Option 2 indicates that the client is experiencing difficulty achieving the developmental stage.
C. Option 3 is not reflective of any stage.
D. “Integrity versus despair” is Erikson’s stage of development from 65 years of age and older. Indicators of positive resolution include statements of acceptance of worth and uniqueness of one’s own life.

30. The nurse is assessing the 84-year-old client during a routine health examination. Which finding should the nurse investigate first?

A. Decreased force of cough
B. Impaired swallowing
C. Urine light yellow in color
D. Height decreased by ½ inch

ANSWER: B

A. Decreased force of cough is an age-related change. Although important to investigate further to rule out an underlying respiratory condition, this is not priority.
B. Gastric motility decreases with aging, but impaired swallowing can be due to other conditions and increases the client’s risk for aspiration. This should be investigated first.
C. Decreased urine concentration is an age-related change. Although important to investigate further to rule out an underlying renal condition, this is not priority.
D. Height decreases with aging. Although important to investigate further to rule out an underlying medical condition, this is not priority.

31. The 70-year-old client, hospitalized with chest pain, has been functioning independently at home. During the night, the client is found wandering in the hallway and states, “I can’t find my kitchen. I need a glass of milk.” What is the nurse’s best interpretation of the client’s behavior?

A. The client most likely had a stroke.

B. The stress of being in unfamiliar surroundings has caused the client's confusion.
C. The decline in mental status, especially at night, is a normal part of aging.
D. This is an insidious change, and it likely means the client has early dementia.

ANSWER: B

A. The client would be exhibiting other signs and symptoms if a stroke had occurred.
B. Stress of unfamiliar situations or surroundings can cause confusion in an older adult.
C. Short—term memory is often less efficient, but a decline in mental status is not a normal part of aging.
D. The confusion was an abrupt change in behavior, not insidious.

32. When the office nurse completes height measurement for the 72-year-old female, the client says that she lost half an inch. Which explanation by the nurse is most accurate?

A. "As we age, we lose muscle mass."
B. "Bone loss is due to lack of exercise."
C. "As we age, we lose knee and hip cartilage."
D. "The vertebral column shortens with aging."

ANSWER: D

A. Loss of muscle mass does not affect height.
B. Bone loss can be due to lack of exercise, but it can also result from aging. There is no indication that the client lacks exercise.
C. Although there is loss of cartilage in joints, this does not affect height.
D. With aging, there is shortening and thinning of the vertebral column due to loss of water and bone density, causing compression resulting in decreased height.

33. The 73-year-old client receiving palliative care comments to the nurse, "I am such a feeble old man. My life is such a waste, and I hate having my wife see me like this. just wish I could die now." Which statement is the nurse's best interpretation of the client's comments?

A. The client is feeling ashamed and ready to die.
B. The client is feeling anxious knowing that he is terminally ill.
C. The client is facing Havighurst's developmental tasks of later maturity.
D. The client is in Erikson's developmental state of integrity versus despair.

ANSWER: D

A. Shame would be from a sense of guilt; there is no evidence of guilt in the client's comment.
B. The client's comments do not reflect anxiety.
C. Havighurst's developmental tasks of later maturity include positive behaviors and adjustments, such as adjusting to decreasing physical strength and health. The client's comments indicate lack of adjustment.
D. Indicators of a negative resolution (despair) include contempt for self or others and a sense of loss. Indicators of positive resolution (integrity) include acceptance of worth and acceptance of death.

34. The nurse assesses the 75-year-old client and concludes that some findings are not age—related changes and require further follow-up. Which report by the client represents a non-age-related finding that requires additional investigation?

A. Reports a decreased ability to see at night
B. Reports seeing halos around lights
C. Reports difficulty distinguishing some colors
D. Reports diminished visual acuity

ANSWER: B

A. The lens increases in density and rigidity, which cause the older adult client's night vision to decrease.
B. Seeing halos is not a normal age-related vision change. Halos are classic symptoms of glaucoma.
C. The lens increases in density and rigidity, which reduce the client's ability to distinguish some colors.
D. Age-related changes include a decrease in the size of the pupil, limiting the amount of light entering the eye.

35. The experienced nurse is observing the new nurse recommend screening tests to the 80-year-old female client- Which recommendation made by the new nurse should the experienced nurse correct?

A. Hearing screen annually
B. Colonoscopy every 10 years
C. Pneurnocoecal vaccine annually
D. Mammogram every I to 2 years

ANSWER: C

A. Hearing screen should be performed annually for older adults because hearing loss occurs with aging.
B. Colonoseopy should be performed every 10 years unless the client is at high risk; there is no indication of this in the question stem.
C. Pneumocoeeal vaccine is administered at age 65 and every 10 years, not annually. An influenza vaccine should be administered annually.

D. Mammogram should be performed every 1 to 2 years to rule out the presence of a breast mass.

36 . The nurse completes teaching for the 80-year-old female client. Which statement made by the client indicates further teaching is needed?

A. "Instead of using sodium seasonings, I plan to try one with herbs and lemon."
B. "Although I find my lavender-scented hand cream relaxing, I should not use it."
C. "I should place a towel on the floor outside my shower so I don't slip when getting out."
D. "Rather than relying on laxatives, I should increase my intake of fruits and vegetables."

ANSWER: C

A. Nonsodium seasonings such as herbs, garlic, and lemon are recommended to prevent hypertension.
B. Scented lotions increase skin irritation and the risk for skin breakdown; their use should be avoided in older adult clients.
C. Placing a towel outside the shower on the floor can increase the client's risk for a fall. A slip-resistant mat should be used and the towel placed within reach without bending.
D. Older adults have decreased GI motility, and laxatives can be overused by those who are constipated; roughage from fruits and vegetables will decrease constipation and the need for laxatives.

37. The 83-year-old tells the nurse, "I'm not taking my medication because it's too expensive and I really don't need it anymore." Before responding to the client, the nurse should consider that the most common reason for older clients to discontinue their medications is which of the following?

A. Information about the medications is insufficient.
B. Medications alter the taste of foods that they enjoy.
C. Fear they will live longer than their resources will last.
D. They want the attention from others when they are sick.

ANSWER: C

A. While older adults may discontinue some medications because they lack sufficient information about them, this is not the most common reason.
B. Many medications do alter taste, but this not the most common reason for discontinuing their use.
C. Fear of future lack of resources is a common concern of many older adults and results in the failure to comply with medical treatments, including taking prescribed medications.

D. Although many older adults may be lonely, few would discontinue their medications to seek attention. Most prefer living as independently as possible.

38. A 72-year-old woman reports she is sexually active. It is most important for the nurse to follow up by asking which question?

A. "Can you tell me more about your sexual partners?"
B. "Have you tried artificial water-based lubricants?"
C. "Are any medications having any drying effects?"
D. "Do you need to use different sexual positions?"

ANSWER: A

A. It is important to assess the types of sexual relationships in which the client is engaged and whether the relationship is monogamous. The incidence of HIV and AIDS infection and other STIs is rising among older adults.
B. Water-based lubricants can decrease discomfort, but it is more important to assess the risk for transmission of STDs.
C. Some medications dry vaginal secretions, but it is more important to assess the risk for transmission of STDs.
D. Different sexual positions, aids to increase stimulation, and lubrication can all enhance sexual activity and comfort, but it is more important to assess the risk for transmission of sexually transmitted diseases.

39. The nurse is teaching an 86—year-old about glaucoma and how to administer eye drops. Which interventions should the nurse implement? Select all that apply.

A. Plan the session at a time when a support person can attend
B. Provide an environment that is private, quiet, and well lit
C. Be detailed with the explanations to ensure understanding
D. Engage as many of the client's five senses as possible
E. Give extensive written materials and a schedule to follow

ANSWER: A, C, D

A. The client's decreased vision may be a barrier to learning, so the presence of a support person may be needed.
B. A private, quiet, and well-lit environment is needed so that the client can focus on the content and procedure.
C. Providing too much information can overwhelm and confuse the client.
D. Engaging the five senses is important for retention of information through use of graphics, videos, or other teaching strategies.
E. Written materials should be concise, providing needed information and serving as a reference if questions or problems arise.

40. The 87-year-old hospitalized client is noted to have normal skin changes of senile purpura, but no other skin abnormalities. When assessing the client, which skin change illustrated should the nurse expect to find?



ANSWER: C

A. Seborrheic keratosis is a benign pigmented lesion with a waxy surface on the face and trunk.
B. Acrochordon is a small, benign polyp-growth also known as a skin tag.
C. Senile purpura is characterized by areas of ecchymosis and petechiae found on the hands, arms, and legs caused by frail capillaries and decreased collagen support. It is a common skin lesion associated with aging.
D. Urticaria is an abnormal lesion that can occur anywhere on the body from an allergic reaction.

41. The nurse overhears a person say, "I'm having a senior moment because I forgot " How should the nurse interpret this statement?

A. This phrase is a comical statement without age bias and is acceptable to others.
B. This phrase is a stereotypical reference to older adults that can be termed ageism.
C. This phrase admits that the older adult's ability to learn new information is limited.
D. This phrase recognizes that all older adults have short— and long-term memory issues.

ANSWER: B

A. The statement is biased against older adults.
B. This statement is a form of ageism, which comprises the prejudices and stereotypes that are applied to older people and perpetuate negativism against them.
C. In older adulthood, the processes of learning new information and recalling old information slow down somewhat, but the overall ability to learn and remember is not significantly affected in healthy older people.
D. Although short-term memory may decline with age, not all older adults are affected with short- and long-term memory loss.

42. The nurse is assessing the older adult. Which tool should the nurse select to identify the client's needs and care deficits?

A. Katz Index of Activities of Daily Living
B. Maslow's Hierarchy of Needs
C. Mini Mental State Exam (MMSE)
D. Erikson's Developmental Tasks

ANSWER: A

A. Katz Index of Activities of Daily Living is a widely used functional assessment tool for evaluating the client's ability to perform daily personal care activities.
B. Maslow's is a human needs theory that is pertinent to everyone.
C. The MMSE only assesses cognition.
D. Erikson's theory is a developmental theory differentiating needs of each age group.

43. After performing an assessment and determining that there are no other causes, the nurse concludes that the older adult's recent hearing loss in one ear may be from cerumen accumulation from age- related changes. The nurse's conclusion was based on which age-related changes that contribute to the cerumen accumulation?

A. Reduced sweat gland activity; thinning and drying of the skin lining the ear canal
B. Ossicular bone calcification; longer and thicker hair growth in the ear canal
C. Degenerative structural changes of the eardrum preventing cerumen passage
D. Over activity of the sweat glands contributing to the development of presbycusis

ANSWER: A

A. The reduced sweat gland activity causes drying of the wax and a prolapsed or collapsed ear canal. The buildup of wax affects the perception of sounds. Longer and thicker hair growth in the ear canal is also a contributing factor.

B. Ossicular bone calcification does not contribute to cerumen buildup, whereas longer and thicker hair growth in the ear canal does.
C. Degenerative structural changes of the eardrum do not contribute to excess buildup.
D. Presbycusis is age-related sensorineural hearing loss, mostly at higher frequencies and usually occurring bilaterally but may be at different times. This does not relate to the accumulation of cerumen.

44. The nurse is interviewing a family member of the hospitalized 90-year-old client to assess for common problems associated with an increased risk for falling. Which questions should the nurse ask? Select all that apply.

A. "Has your mother fallen within the past year?"
B. "Has your mother had her annual influenza vaccine?"
C. "When was the last time your mother took a pain pill?"
D. "Does your mother have any problems with urination?"
E. "Does your mother have difficulty falling asleep at night?"

ANSWER: A, C, D, E

A. Asking if the client has fallen in the last year will help determine if the client has a history of falls and the risk level for a fall.
B. Having an influenza vaccination is not a problem that can increase the client's risk for falling.
C. Analgesics can contribute to dizziness and increase the risk for falling.
D. Asking about elimination will help determine if the client has problems with incontinence or urgency. Needing to hurriedly use the bathroom can increase the risk for falling.
E. Asking about the client's nighttime sleep will help determine if the client has any sleep disorders that could contribute to night-time wandering and the risk for falling.

45. The nurse is teaching newly hired NAs in a long term care facility. What information about skin care for older adults should the nurse emphasize?

A. Avoid skin products purchased for the resident by family that contain alcohol
B. Apply perfumed skin lotions after the resident's bath when the skin is still moist.
C. When taking residents outdoors, apply sunscreen with. a sun protection factor of 8.
D. Apply a strong detergent to clothing with food stains before sending to laundry.

ANSWER: A

A. The nurse should emphasize avoiding skin products containing alcohol, which is drying to the skin. Age-related skin changes of the elderly include dry and fragile skin.
B. Perfume-free (not perfumed) skin lotions should be used because perfumed lotions increase skin irritation.
C. Sunscreen should have an SPF of 15 (not an SPF of 8) or greater to protect against sunburn.
D. Strong laundry detergents should be avoided (not used) because of skin irritation and the risk of skin breakdown.

46 . The nurse is evaluating the older adult client's hydration status. Which information should the nurse include? Select all that apply.

A. Urine color
B. Serum blood urea nitrogen (BUN) and creatinine
C. Serum white blood cell (WBC) and differential count
D. Urine specific gravity
E. 24-hour fluid intake and urine output

ANSWER: A, B, D, E

A. Urine color indicates the concentration of the urine and varies with specific gravity. A more concentrated urine can indicate dehydration.
B. BUN and creatinine are interpreted together and are directly proportional to renal excretory function. Overhydration tends to dilute the urine, resulting in lower levels, and dehydration tends to concentrate the urine, resulting in higher levels.
C. WBC and differential count evaluate infection, neoplasm, allergy, or immunosuppression, not hydration.
D. With overhydration, the urine is dilute and light-colored, with low specific gravity. With dehydration, the urine is concentrated and dark-colored, with high specific gravity.
E. Comparing 1&0 measurements of the client's fluids for 24 hours evaluates for actual or potential imbalances.

47. Pre- hospital admission medications for the older adult client include warfarin and atenolol. Which statement made by the client should prompt the nurse to initiate a referral to a social worker?

A. "I crush my medications and take them with applesauce because they are hard to swallow."
B. "I stopped taking my blood pressure pill; I can't afford it, and my blood pressure is normal."
C. "I feel more alert after starting to take ginkgo, but I forgot to ask my doctor if it were okay."
D. "I have my daughter set up my medications for two weeks at a time in a medication bar."

ANSWER: B

A. The client may need a referral to a dietitian if experiencing swallowing difficulties, not a social worker.
B. Responsibilities of a social worker include assisting the client with financial concerns.
C. Ginkgo can increase the effects of warfarin (Coumadin). The nurse should notify the HCP.
D. If medications and dosages will be changing, setting up medications for two weeks at a time could result in the client receiving the wrong dose or the wrong medication. The nurse should address this concern with both the client and daughter.

48. The nurse is caring for the 87-year-old hospitalized client. The nurse should assess for which age- related changes to best protect the client from friction injury?

A. Increased tissue vascularity
B. Increase in subcutaneous tissue
C. Increased rate of cellular replacement
D. Loss of skin thickness and elasticity

ANSWER: D

A. Tissue vascularity decreases, not increases, with aging because of decreased skin thickness.
B. A decrease in subcutaneous tissue, not an increase, occurs with aging.
C. The rate of cellular replacement decreases, not increases, with aging due to the loss of skin thickness and decreased tissue vascularity.
D. The replacement rate of the first epidermal layer declines by 50% as individuals age, and the dermis decreases in thickness by 20%. A thinner epidermis allows more moisture to escape, decreasing strength and increasing the risk of friction injuries and skin tears.

49. The nurse is caring for the older adult client. The nurse should identify that the client is at risk for developing skin breakdown when making which observations? Select all that apply.

A. A nursing assistant applies a perfumed lotion to the client's skin.
B. Two nursing assistants are elevating the client's heels off the bed.
C. A family member brings the client's favorite custard from home.
D. The nurse applies an alcohol-based hand wash to the client's hands.
E. The nurse is directing the client to push with the heels to move up in bed.

ANSWER: A, D, E

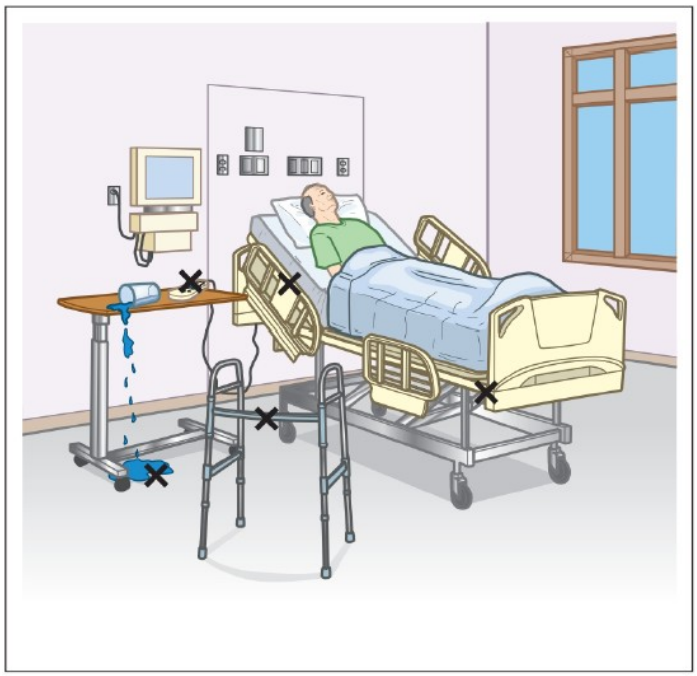
A. Perfumed lotion increases skin irritation and can lead to skin breakdown.

B. Elevating the heels off the bed will reduce pres- sure on bony prominences and skin breakdown.
C. Adequate nutrition promotes tissue repair and maintains healthy tissues.
D. Alcohol-based hand wash is drying and can increase skin irritation and lead to skin breakdown.
E. Using the heels to reposition in bed causes friction and sheer and increases the risk for skin breakdown.

50. The nurse walks into a room after the NA has helped to reposition the client (see illustration). The nurse identifies five safety concerns that increase the client's risk for a fall. Place an X on each item that poses a safety concern identified by the nurse.



1075. ANSWER:



A side rail left down, the bed left in high position, the bedside table positioned away from the client, the walker away from the client all increase the client's risk for a fall. Because the call light is out of reach, the client is unable to alert the nurse for help. Water on the floor increases the risk for slipping.

51. The nurse is assessing the older adult client experiencing problems sleeping. Which statements, if made by the client, indicate that the client may benefit from teaching? Select all that apply.

A. "I am so tired that I need to take a nap in the middle of the day."
B. "My routine includes a glass of warm chocolate milk at bedtime-"
C. "I installed room-darkening shades after my doctor advised these."
D. "I'm in my bed a lot; it is the most comfortable place in my home-"
E. "I often take my pain pill for my leg pain just before going to bed."

ANSWER: A, B, D

A. The client with sleep problems could benefit from teaching because daytime napping can result in nighttime wakefulness.
B. The client with sleep problems could benefit from teaching because chocolate milk is a caffeinated beverage that can increase alertness and cause difficulty falling asleep.
C. Reducing lighting decreases sensory stimulation and can help promote sleep.
D. The client with sleep problems could benefit from teaching about using the bedroom only for sexual activity and sleeping.

E. Taking analgesics at bedtime will prevent interruption of sleep from pain.

52. The nurse is admitting the older adult client to a nursing home. Which is the nurse's best approach when obtaining information during the admission interview?

A. Direct questions to the family member accompanying the client.
B. Speak clearly and slowly to the client using high- pitched vocal tones.
C. Take the client and family members to a private room without distractions.
D. Speak to the client loudly about familiar topics before asking questions-

ANSWER: C

A. Directing questions to the family members of the older adult client shows a lack of respect for the client.
B. Low-pitched and not high-pitched vocal tones should be used when speaking to the older adult client because the ability to hear high-pitched tones diminishes with aging-
C. Taking the client and his or her family to a private room for the interview will prevent confidential information from being overhead by others; removing distractions will allow the client to focus on the questions.
D. Some clients may be put at ease by talking about familiar topics first, but not everyone. Although hearing diminishes with aging, not all older adult clients are hard of hearing.

53. The nurse is assessing the 88-year-old client. Which finding should the nurse associate with the normal aging process?

A. Arm muscle strength 4 on a 0 to 5 scale
B. Multiple fractures to the thoracic spine
C. Ulnar deviation of the left hand fingers
D. Slight pain in the right and left heel

ANSWER: A

A. Muscle strength decreases with aging. On a 0 to 5 scale, less than 3 muscle strength for an older adult could indicate a problem or concern.
B. Fractures are not a normal part of aging.
C. Ulnar deviation of the fingers is a sign of rheumatoid arthritis, not a normal part of aging.
D. Pain at the calcaneus (heel) may be due to bone spurs and is not a normal part of aging.

54. The nurse's assessment findings of the hospitalized older adult include: BP 96/64 mm Hg, P 118 bpm, RR 20/minute, weight 110 lb with an 8-lb weight loss in the last 3 months due to severe loss of appetite from chemotherapy, and BMI of 19. The client reports fatigue so does not go out, but is able to get around the house. Though tired, the client responds appropriately and clearly to questions and denies psychological issues. What score should the nurse assign to the client when completing the Geriatric Mini Nutrition Assessment?

_____ (Record your answer as a whole number.)

Geriatric Mini Nutrition Assessment	Score
Has food intake declined over the past 3 months due to loss of appetite, digestive problems, or chewing or swallowing difficulties? 0 = severe loss of appetite 1 = moderate 2 = no loss	
Weight loss during past 3 months 0 = >3 kg 1 = unknown 2 = 1–3 kg 3 = no weight loss	
Mobility 0 = bed- or chair-bound 1 = able to get out of bed/chair but does not go out 2 = goes out	
Psychological stress or acute disease in past 3 months 0 = yes 2 = no	
Neuropsychological problems 0 = severe dementia or depression 1 = mild dementia 2 = no psychological problems	
BMI 0 = <19 1 = 19–20.9 2 = 21–22.9 3 = 23 or more	
Score (max. 14): 12 or more = normal; 11 or less = possible malnutrition, continue assessing	

ANSWER: 4

The nurse should give a score of 4 on the Geriatric Mini Nutrition Assessment. Severe loss of appetite = 0; 8-lb (3.6 kg) weight loss during last 3 months is >3 kg = 0; able to get out of bed/ chair but does not go out = 1; acute disease (cancer) in past 3 months = 0; no psychological problems = 2; and BMI 19 = l.

55. The client's family approaches the nursing supervisor with a complaint about the NA's inappropriate communication with their 89-year-old father. When evaluating the NA's communication, which statements does the nurse determine most likely caused the family's complaint? Select all that apply.

A. "Are you ready for the nurse to give you your medicine?"
B. "Would you like to go to breakfast now, Grandpa?"
C. "Would you prefer to wear the brown socks today?"
D. "Your family will be visiting today. Isn't that nice?"
E. "Honey, this is your bath day. Are you ready to go?"

ANSWER: B, D, E

A. Asking the client questions is appropriate communication.
B. "Grandpa" is a diminutive, or an inappropriate intimate term of endearment, implying a parent-child relationship.
C. Asking the client questions is appropriate communication.
D. The statement "Isn't that nice?" uses a cliché that can block the feelings and thoughts of the client. It could be interpreted as infantilizing the client.
E. "Honey" is a diminutive, or an inappropriate intimate term of endearment.

56 . The older adult client is experiencing relocation stress after being admitted to a nursing home. Which intervention is best for the nurse to implement?

A. Ask family members to explore placing the client in another nursing home.
B. Change the client's room every week until a compatible roommate is found.
C. Place the client's favorite items, such as a family picture, at the client's bedside.
D. Ask that family members avoid talking to the client about being in the nursing home.

ANSWER: C

A. Moving to another nursing home may increase the client's stress.
B. There is no indication that the client has an incompatible roommate. Changing rooms frequently can increase the client's stress.
C. Having familiar objects nearby can help to minimize the effects of relocation stress.
D. Avoiding talking about the nursing home placement may increase the client's stress.

57. The nurse observes the NA providing a stuffed animal to the hospitalized older adult client who is experiencing delirium. Which action by the nurse is most appropriate?

A. Reprimand the NA for treating the client like a child.
B. Remove the stuffed animal before anyone else sees it.
C. Report the NA's action to the unit's nurse manager.
D. Thank the NA for providing it for the client's fidgeting.

ANSWER: D

A. Providing an object to the delirious client has been shown to reduce the incidence of accidental removal of IV lines or drains by the client; the NA should not be reprimanded.
B. The stuffed animal should not be removed; it may be comforting and beneficial to the delirious client.
C. It is unnecessary to report the NA's actions to the nurse manager because providing a stuffed animal may be beneficial to the delirious client.
D. Having a stuffed animal may occupy the hands and fingers of the delirious client and prevent the client's accidental removal of lines or drains. Thanking the NA is appropriate.

58. The home health nurse suspects elder mistreatment of the 93-year-old client by the live-in caregiver. Which findings support the nurse's conclusion? Select all that apply.

A. Client has urine burns.
B. Client has wrist bruises.
C. Client states there have been some unexplained financial expenditures.
D. Client is more talkative than during previous home visits.
E. Smell of alcohol noted on live-in caregiver's breath.

ANSWER: A, B, C, E

A. Urine burns suggest caregiver neglect by not assisting the client to the toilet or changing the client if incontinent.
B. Wrist bruises suggest physical abuse that may be caused by physically restraining the client.
C. Unexplained financial expenditures suggest financial exploitation and use of funds for personal use by the caregiver.
D. The more withdrawn client, rather than the more talkative one, suggests psychological or emotional abuse.
E. Substance abuse is an abuser characteristic.

59. During a nursing home visit, the son notices multiple healing bruises on his father's arms and legs and calls a friend who is a nurse. Which initial recommendations should the nurse provide to the son? Select all that apply.

A. "Ask your father how the bruises occurred and whether he was abused."
B. "Contact Adult Protective Services immediately to report the abuse."
C. "Verify with the nursing staff whether your father is on anticoagulants."

D. “Inform the agency’s nursing supervisor that your father is being abused.”
E. “Contact the state ombudsman who can help you make an anonymous report.”

ANSWER: A, C

A. More information is needed about the healing bruises before abuse should be considered.
B. Contacting Adult Protective Services is an appropriate recommendation when abuse is suspected. More information is needed before considering if these are due to abuse.
C. The nurse should initially recommend exploring whether the client is receiving any anticoagulants such as warfarin or aspirin. Their use, frequent blood draws, and bumping of the arms and legs can cause the client to bruise easily.
D. Nurses are mandatory reporters and are required to report allegations and/or suspicions of abuse, but more information is needed before considering if these are due to abuse.
E. Although a report to the state ombudsman will be investigated, more information is needed before considering if the bruises are due to abuse.

60. The nurse is caring for the 94-year-old hospitalized client of the Muslim faith who is near death. Which nursing action is most inappropriate?

A. Spraying perfume in the client’s room
B. Placing the client supine facing Mecca
C. Offering grief counseling to family members
D. Checking records for wishes of organ donation

ANSWER: C

A. Perfuming the room is an end-of-life care ritual in the Muslim faith.
B. Positioning the client supine facing Mecca is an end-of-life care ritual in the Muslim faith.
C. Discussion of death and grief counseling are inappropriate because these are discouraged in the Muslim faith.
D. Organ donation is allowed, so it is appropriate for the nurse to check the records.