

Donna J. Bowles



GERONTOLOGY NURSING CASE STUDIES

Second Edition

100+ Narratives for Learning



Gerontology Nursing Case Studies

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This one is for you, Mom . . .
JoAnn Elliott Nichols
(January 7, 1933 to March 8, 2014)

Contents

<i>Foreword</i>	Barbara Resnick, PhD, CRNP, FAAN, FAANP	<i>xiii</i>
<i>Preface</i>		<i>xvii</i>
Chapter 1. Political, Ethical, and Legal Issues of Older Adults		1
Case 1.1	Advance Directives	1
Case 1.2	Health Care Decision Making	3
Case 1.3	Physical Restraints	6
Case 1.4	Patient's Bill of Rights (Long-Term Care)	8
Case 1.5	The Older Driver	10
Case 1.6	Iatrogenesis and the Elderly	13
Chapter 2. Loss and End-of-Life Issues		17
Case 2.1	Death of a Spouse	17
Case 2.2	Prolonged Grief	19
Case 2.3	Death With Dignity	21
Chapter 3. Mistreatment of Older Adults		25
Case 3.1	Physical Abuse	25
Case 3.2	Physical Neglect	27
Case 3.3	Consumer Fraud and the Elderly	29
Case 3.4	Financial Mistreatment	32
Case 3.5	Health Care Disparities and the Elderly	34
Chapter 4. Depression, Addiction, and Suicide		37
Case 4.1	Alcoholism	37
Case 4.2	Prescription Pain Medication Misuse	39
Case 4.3	Depression	41
Case 4.4	Gambling Disorder	43
Case 4.5	Risk for Suicide	46

Chapter 5. Assessment and Management of Individual Issues	49
Case 5.1 Spirituality and Aging	49
Case 5.2 Frailty	51
Case 5.3 Functional Decline in the Hospitalized Elderly	53
Case 5.4 Aging in Place	56
Case 5.5 Hoarding Behavior	58
Case 5.6 Health Promotion for the Elderly Client	61
Case 5.7 Overview of Medicare Services	63
Chapter 6. Sexuality	65
Case 6.1 Erectile Dysfunction	65
Case 6.2 Vaginal Dryness and Dyspareunia	67
Case 6.3 Sexual Problems Due to Physical Limitations	69
Case 6.4 Sexual Expression for Institutionalized Older Adults	71
Chapter 7. The Aging Sensory System	73
Case 7.1 Gustatory and Olfactory Disturbance	73
Case 7.2 Hearing Loss	75
Case 7.3 Somatosensory Disturbance	77
Case 7.4 Macular Degeneration	79
Case 7.5 Visual Alterations	81
Chapter 8. Integumentary Disorders and Infectious Diseases of the Elderly	85
Case 8.1 Venous Insufficiency in a Homebound Elder	85
Case 8.2 Pressure Ulcer in an Acute Care Setting	87
Case 8.3 Burns and the Elderly	89
Case 8.4 Dermatologic Drug Reaction	93
Case 8.5 Postoperative Infection (<i>Clostridium difficile</i>)	95
Case 8.6 Herpes Zoster (Shingles)	97
Chapter 9. The Aging Musculoskeletal System	99
Case 9.1 Osteoarthritis	99
Case 9.2 Hip Fracture	101
Case 9.3 Falls: Home Environment	103
Case 9.4 Fall Prevention in a Hospital Setting	106
Case 9.5 Immobility	108
Case 9.6 Osteoporosis	110
Case 9.7 Foot Problems in the Elderly	112

Chapter 10. The Aging Neurologic System	115
Case 10.1 Cerebrovascular Accident (CVA) (Acute Phase)	115
Case 10.2 CVA Rehabilitation Phase	117
Case 10.3 Parkinson's Disease	119
Case 10.4 Alzheimer's Disease	121
Case 10.5 Dizziness/Vertigo	123
Chapter 11. The Aging Cardiovascular System	127
Case 11.1 Coronary Artery Disease: Living With Chronic Stable Angina	127
Case 11.2 Congestive Heart Failure	128
Case 11.3 Chronic Atrial Fibrillation	131
Case 11.4 Peripheral Vascular Disease	133
Case 11.5 Hyperlipidemia	135
Case 11.6 Abdominal Aortic Aneurysm	137
Case 11.7 Anemia	140
Case 11.8 Pacemaker Implantation	143
Chapter 12. The Aging Pulmonary System	147
Case 12.1 Pneumonia	147
Case 12.2 Lung Cancer	149
Case 12.3 Chronic Obstructive Pulmonary Disease	152
Case 12.4 Tuberculosis	154
Case 12.5 Pulmonary Embolism	156
Case 12.6 Influenza Prevention in the Elderly	159
Chapter 13. The Aging Endocrine System	161
Case 13.1 Diabetes Mellitus (Screening)	161
Case 13.2 Diabetes Mellitus and Medication	163
Case 13.3 Diabetes Mellitus and Nutrition	164
Chapter 14. The Aging Genitourinary System	167
Case 14.1 Transient Urinary Incontinence	167
Case 14.2 Benign Prostatic Hypertrophy	169
Case 14.3 Functional Incontinence	171
Case 14.4 Acute Renal Insufficiency	173
Case 14.5 Pelvic Organ Prolapse	175
Case 14.6 Catheter-Associated Urinary Tract Infections	177

Chapter 15. Nutrition and the Aging Gastrointestinal System	181
Case 15.1 Mealtime Difficulties	181
Case 15.2 Oral Health	183
Case 15.3 Diverticular Disease	185
Case 15.4 Chronic Constipation	187
Case 15.5 Hiatal Hernia	189
Case 15.6 Hydration Management	191
Chapter 16. Cancer in the Older Adult	195
Case 16.1 Chemotherapy and the Aged	195
Case 16.2 Colorectal Cancer	197
Case 16.3 HIV/AIDS	199
Case 16.4 Hospice Care	202
Chapter 17. Cognitive Impairment in the Older Adult	205
Case 17.1 Acute Confusion (Delirium)	205
Case 17.2 Early Dementia	207
Case 17.3 Dementia (Late Stage)	209
Case 17.4 Wandering/Need for Movement	211
Case 17.5 Agitation and Aggression	213
Chapter 18. Cultural Diversity	217
Case 18.1 Culturally Specific Care—Part I	217
Case 18.2 Culturally Specific Care—Part II	220
Case 18.3 The Homeless Aging	223
Case 18.4 The Baby Boomer Culture	225
Chapter 19. Pain Management in the Older Adult	227
Case 19.1 Undertreatment of Pain	227
Case 19.2 Side Effects of Opioids	229
Case 19.3 Adjuvants for Pain Control	230
Case 19.4 Noninvasive Interventions for Pain	232
Chapter 20. Sleep Disturbances in the Older Adult	235
Case 20.1 Restless Legs Syndrome	235
Case 20.2 Insomnia	238
Case 20.3 Hypersomnia	242

Chapter 21. Aging Issues Affecting the Family	245
Case 21.1 Caregiver Burden	245
Case 21.2 Ineffective Family Coping	248
Case 21.3 Emergency Preparedness for the Elderly and Their Families	250
Case 21.4 Leaving the Homestead: Challenges and Solutions	253
Case 21.5 Long-Distance Caregiving	257
Case 21.6 Relationships and Aging	259
Case 21.7 Geriatric Specialists for the Family	260
<i>Index</i>	263

Foreword

The book *Gerontology Nursing Case Studies: 100+ Narratives for Learning, Second Edition*, by Donna J. Bowles, is a creative and informative compilation of everything that nursing students and new nurses need to know about care of the older adult. Kudos go to Donna Bowles for conceptualizing this and for the creative way in which she has used cases to capture the interest of students and motivate them to learn new information to help manage the cases in the chapters and the real-world patients they will encounter. It is written in an easy-to-read style. In fact, it is a book one could curl up with on a rainy day and enjoy! Each case's narrative section within the chapter provides numerous Internet references useful for the student to obtain additional information to answer the questions posed. The book is rather practical in the way in which it outlines content and topics. Rather than using a more traditional systems-based approach (head, chest, etc.) or disease-based approach (e.g., Alzheimer's disease, hypertension), material is organized in ways in which it would likely be used or experienced in the clinical setting. For example, the section on HIV is placed in the chapter that also includes management of cancer, chemotherapy, and hospice care. Likewise, anemia is placed in the chapter with cardiovascular disease because of the impact of anemia on cardiac function.

Overall, the new edition includes 21 chapters, although within each chapter there are three to eight case narrative sections that address different aspects of the topic. Chapter 1 starts with the critically important policies that every nurse should know when working with older adults. Such things as advance directives, health care decision making, use of restraints, issues about driving, and iatrogenesis are all reviewed. Essentially, this chapter presents the basics of providing legally competent and safe patient care. Chapter 2 focuses on the many losses that commonly occur with aging, such as the death of a spouse and the subsequent prolonged grief that can occur. The last case in this chapter on loss addresses death with dignity and provides the story, as told by a nurse, of a patient under the care of hospice who dies with the dignity that one would hope for for all patients. Chapter 3 covers the issues of neglect and abuse, both physical and financial, and provides guidance to new nurses caring for older adults as to how they can recognize abusive situations. Chapter 4 identifies and focuses on the most challenging psychosocial issues we encounter in geriatrics: depression and participation in risky behaviors, such as gaming and alcohol abuse. The next chapter, Chapter 5, is a terrific review of the individual and family dynamics affecting older adults, addressing such important issues as frailty, hoarding behavior, and health promotion for the elderly client. Chapter 6 addresses sexuality, presenting male and female issues in different narratives.

Chapters 7 through 14 review more traditional clinical problems and cover the sensory, dermatologic, musculoskeletal, neurologic, cardiovascular, pulmonary, endocrine,

and genitourinary systems and the changes that occur with aging. Within each section, the most common problems we encounter are addressed with a case and management principles and resources. For example, the chapter on musculoskeletal disorders presents patient narratives that focus on degenerative joint disease, hip fractures, falls, immobility, osteoporosis, and foot problems.

Chapter 15 returns the reader to clinical issues and health and the topic of nutrition. This is not a simple regurgitation of nutritional guidelines. Rather, each case narrative poses the challenges related to achieving nutritional homeostasis in older adults due to mealtime issues, oral health, and gastrointestinal problems such as constipation or diverticulosis. Chapter 16 provides some general tips on chemotherapy, using the case of a woman with breast cancer, and then provides additional case narratives on colorectal cancer, as it is so prevalent in older adults. As noted earlier, this section also includes an overview of HIV and hospice. The five case narratives in Chapter 17, addressing cognitive impairment in the elderly, present realistic situations with regard to the common issues nurses encounter daily. Questions within the cases assist the reader to focus on evidence-based practice in order to assist those with the need for movement and wandering, who experience acute confusion and agitation or aggression. Dementia is compared and contrasted by cases that review early- and late-stage symptoms and approaches for nursing care.

Chapter 18 is a must-read for all health care providers as it gives an overview of cultural sensitivity in the first section and then an example of how to optimally manage a Hispanic patient. The information provided is practical and realistic and can be applied across settings.

Chapters 19 and 20 address common geriatric syndromes including pain and sleep disorders. The chapter on pain covers undertreatment of pain and how to recognize and manage this, pharmacological management of pain with opioids, a case narrative that reviews different types of pain (e.g., neuropathic) and use of adjuvant medications, and, lastly, a case narrative on noninvasive or behavioral interventions and prevention of pain. Chapter 20 addresses some prevalent sleep-related issues including restless legs syndrome and insomnia, as well as the much less commonly recognized hypersomnia experienced by some older adults.

This revised edition adds a wonderful new component with an entirely new Chapter 21, "Aging Issues Affecting the Family," and the incorporation throughout the text of 10 new case examples or focused topical areas on practical aspects of geriatrics, gerontology, and care of older adults. The new cases address such topics as health care disparities and the elderly, spirituality and aging, functional decline in the hospitalized aging, aging in place, health promotion for the elderly adult, challenges and solutions of leaving the homestead, long-distance caregiving, an overview of Medicare, catheter-associated urinary tract infections, and the cultural issues associated with generational aging as we face the aging of a large cohort of baby boomers. These cases are a wonderful source of information, with useful web pages and recommended resources, and provide practical information about how to best address these common aging issues and improve the lives of older adults.

In sum, this is a terrific text that provides nurses, and other health care providers, good basic information about clinical problems and challenges faced in providing care to older adults. It should be considered required reading in all undergraduate

programs. While provided in a text format, the material is easy to read, thus, it will meet the needs of today's students who are used to accessing information quickly and easily on the Internet.

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Professor
University of Maryland School of Nursing
Sonya Ziporkin Gershowitz Chair in Gerontology

Preface

The Process

Twenty contributors were recruited to assist with the first edition of this book. Combining the collective years of nursing practice of this group resulted in over several centuries' worth of expertise. The plethora of case study topics offered is highly unusual for a health care-associated text. In particular, psychosocial issues common in today's society such as gambling addiction, hoarding behavior, emergency preparedness, long-distance caregiving, and others, represent a holistic approach to geriatric nursing care. Many of the case studies reflect true events that have been transferred into a quality learning experience. The various roles and working environments inherent in the nursing profession are well represented, which came about rather serendipitously. These include encounters with the geriatric client in the home, hospital, long-term care, or rehabilitation facility, from a public health contact, a clinic, a hospice organization, as a neighbor, or through parish nursing. In addition, the health care provider may be a student, member of a nursing staff, advanced practitioner, or administrator.

The geriatric clients in the stories range in age from 65 to 91 years. Many are living predominantly healthy, productive lives with stable support systems. Considering the unfortunate ageism that exists in our country, this approach was purposeful in relation to countering myths and attitudes about getting older that undergraduate students may believe.

The Outcome

A comprehensive approach to addressing the physical, mental, and psychosocial needs and issues of the older adult are offered across the 100+ case studies in this text. Expected age-related changes, safety concerns, cultural awareness, and evidence-based practice pertaining to geriatric nursing are pervasive throughout the text. Ethical

dilemmas are presented to encourage students to reflect on the “right thing to do” when planning or providing care. Each case provides 8 to 12 questions for the learner to address. Unlike electronic, “interactive” case studies available, students do not click response boxes of solely multiple-choice questions. Rather, they are often asked to use critical thinking skills; giving an opinion, conveying an experience, formulating a response, developing a plan, comparing and contrasting, and so on.

Gerontology Nursing Case Studies: 100+ Narratives for Learning, Second Edition has a multifaceted use for undergraduate students. The text can easily be integrated across the curriculum, or serve as an assessment piece in a stand-alone gerontology course. **A fully updated answer guide is available to professors who adopt the book from Springer Publishing Company by emailing textbook@springerpub.com.** The cases can be assigned as an out-of-class learning experience, stimulate a small group discussion, or be presented by the instructor to introduce or reinforce a specific lecture topic. The text design allows for heavy use of the Internet to explore answers and develop solutions to the various client situations.

These stories are highly varied with regard to the problem at hand, the role of the nurse, and unexpected events that occasionally surface. For example, a client with a postoperative pulmonary embolism placed on heparin therapy requires frequent lab work in order to receive safe care; a routine event for sure. However, she has a severe needle phobia. Or, a client who cannot afford medical services substitutes a beautiful hand-made quilt as payment. Should the nurse accept this gift?

This second edition has been revised fully, with updated links to relevant guides and resources. New case studies have been added, which cover topics such as aging in place, health care disparities, and the baby boomer culture. A new chapter on aging and the family delves into the roles of family caregivers, coping, and relationships.

It is with sincere intention that these stories were created to provide engagement of learning, encourage thoughtful discussion, and present students with a better understanding of the special needs of older people. Bridging the gap between theory and practice is a phrase many of us seasoned nurse educators have heard for years; this project was completed as a means to fill that gap. Enjoy.

Donna J. Bowles

Suggested Resources

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass.

Faculty Tool Kit. (2009). *The essentials of baccalaureate education for professional nursing practice*. American Association of Colleges of Nursing. Retrieved from www.aacn.nche.edu/education/bacessn.htm

1

Political, Ethical, and Legal Issues of Older Adults

Case 1.1 ■ Advance Directives

Melanie Hughes, RN, GNP, has two appointments this morning in regard to advance directives (ADs). She has been employed with a hospice facility for nearly a decade in the role of a nurse practitioner specializing in end-of-life care. The majority of her clients are elderly, and today she will meet with Tom Barker, an 80-year-old male diagnosed with colon cancer, and Margarita Ruiz, a 72-year-old with end-stage chronic obstructive pulmonary disease (COPD). Both individuals were recently hospitalized and were asked about the presence of an AD; neither has made formal arrangements although they both have opinions on the topic.

- 1. What federal law enacted in 1991 requires agencies and institutions receiving Medicare or Medicaid reimbursement to inform clients of their right to make health care decisions including completing an AD?***

Melanie generally begins a session with an unfamiliar client by assessing for any visual or hearing deficits and language barriers. She attempts to explore what quality of life means to the individual, along with how the client's illness and death will affect others insofar as emotional or financial impact. Melanie also asks the client what inspired him or her to seek assistance and assesses what is known about an AD. She provides written material and explains the details carefully. Reviewing terms and definitions is generally the first step in the process. Use the Hartford Institute for Geriatric Nursing website as a resource for the following two questions pertaining to an AD (Mitty, 2012) at http://consultgerirn.org/topics/advance_directives/want_to_know_more.

- 2. The authors of the evidence-based guideline point out less than 20% of Americans have an AD. What do you think may be contributing factors for this rate?***
- 3. What are the two types of ADs?***

Mr. Barker is the first appointment this morning. He has arrived with a document for his AD and explains to Melanie, "I may not have much time left on earth and want to make everything as easy for my daughter as possible." Mr. Barker was diagnosed with Stage IV colon cancer 8 months ago. He had surgery to remove a large section of malignancy; however, it was discovered metastases had spread to his peritoneum and spine. Hospice has been following him weekly for pain management; no palliative treatment such as chemotherapy or radiation was chosen by his request.

The client explains that his proxy will be his daughter and he needs assistance with several questions. He has determined, with his physician's awareness, if hospitalized, he does not want any form of resuscitation. When Melanie asks for him to clarify what treatments he chooses to forego, his response is, "I guess the cardiopulmonary resuscitation (CPR) part, what else is there?"

The National Cancer Institute Fact Sheet on Advance Directives (2013) may serve as a resource for the following questions. It is located at www.cancer.gov/cancertopics/factsheet/support/advance-directives.

4. As a nurse, what other medical directives would you review with a client?

Mr. Barker also asks Melanie about an AD being honored from one state to another. His daughter lives in a town only 10 miles away, but it is in a different state from his residency. He goes on to explain that if his health allows, he hopes to visit her for a few hours on the weekends for family meals and a change of scenery. Yet, he is concerned of the outcome, should he be hospitalized during a visit.

5. Is there reciprocity among states for an AD?

Finally, Mr. Barker tells Melanie that his daughter is also considering having an AD initiated. He states, "She's only 54 years old, what if medical technology advances and there are better options for her life when she's my age?"

6. Is an AD document permanent once it's signed?

Ms. Ruiz is accompanied by her long-term "boyfriend" when she visits the hospice facility. Her chronic lung condition requires continuous oxygen, multiple inhalers, and predominant bed rest. She had a physician visit in the same building this morning and asked to be seen in person although the offer for a home appointment was given. She stated over the phone that privacy was necessary and that was not possible in her house.

Ms. Ruiz presents Melanie with a document and asks for her opinion on the effectiveness of it. The document is known as "Five Wishes," originally disseminated from a grant by the Robert Wood Johnson Foundation in 1997. This document serves as a form of an AD, which does not require an attorney or notarization in order to be honored.

Ms. Ruiz goes on to explain that her immediate family, which consists of four adults and three teenagers all living in her home, has not accepted her condition as terminal. They were present when she had a hospice consult but refuse to believe she will likely decline physically to the point of death. Therefore, she has designated her boyfriend to keep a copy of her wishes and provide it when hospitalized. This event is purposely being kept "secret" from her family.

- 7. Find a copy of the “Five Wishes” document and review it using the following link: www.agingwithdignity.org/five-wishes.php (Aging with Dignity, 2015). What are the actual five issues addressed?**
- 8. From the information provided, can Ms. Ruiz name her boyfriend as a health care agent on this form?**
- 9. Melanie has witnessed numerous family conflicts through the years as a hospice nurse pertaining to family thoughts on end-of-life care differing from the patient. Do you believe she should keep the “secret” of the “Five Wishes” document? Explain your rationale for this ethical dilemma.**

Ms. Ruiz was born in Mexico City and lived there until coming to the United States at the age of 40. She has a high level of acculturation, including reading, and speaking English fluently.

For an individual who may have cultural-based challenges with an AD, it is a nursing responsibility to be knowledgeable and sensitive toward the specific needs. The document in the following website, www.greaterniagarachamber.com/LinkClick.aspx?fileticket=F6VVHObjQWk%3D&tabid=203, offers numerous tips for effective communication with culturally diverse clients (Niagra Immigrant Connections Initiative, n.d.).

- 10. Review the document and comment on a suggestion you found helpful, or new information that could be beneficial in your future practice.**

Suggested Resources

- Aging With Dignity. (2015). *Five wishes*. Retrieved from <http://www.agingwithdignity.org/five-wishes.php>
- Mitty, E. L. (2012). *Geriatric nursing standard of practice: Advance directives protocol*. Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/topics/advance_directives/want_to_know_more
- National Cancer Institute. U.S. National Institutes of Health. (2013). *Advance directives*. Retrieved from <http://www.cancer.gov/cancertopics/factsheet/support/advance-directives>

Case 1.2 ■ Health Care Decision Making

Colby Hines sought employment in a large outpatient surgical center following 2 years of working on a medical–surgical floor after he became an RN. In this role, he rotates through all phases of the surgical experience; pre-, intra-, and postoperative

patient care. Colby has been exposed to a variety of situations in his short career involving health care decision making and fully realizes the importance of this topic, in particular with older clients.

During his orientation period, two members of the Hospital Ethics Committee spoke to the new hires about the role and importance of this service. The speakers started their presentation reviewing the four core ethical principles, which set the foundation for the health care decision making process.

1. Respect for autonomy
2. Beneficence
3. Nonmaleficence
4. Distributive justice

1. Choose any two of the principles and create an example using a geriatric client to demonstrate understanding of the meaning of the terms.

In addition, the Hospital Ethics Committee representatives emphasized repeatedly that individuals' right for self-determination includes not only the right to agree with a particular treatment but also the right to refuse. Colby witnessed a number of older people on the medical-surgical floor choose not to undergo a particular procedure, treatment, or modality that was presented by a physician.

One case involved a 90-year-old gentleman who was admitted for dehydration and weight loss. He became a widower 5 months prior, after being married for over seven decades; the couple had no children. His treatment plan called for insertion of a gastrostomy tube for feeding. It was explained to him that this could be a temporary measure, sustaining him nutritionally until he was able to take in sufficient calories again. The patient consistently refused consent each time he was asked. Colby reported that he believed it was disrespectful of this patient to be asked on four different occasions to give consent.

2. If this client asked you for your opinion on his decision, how might you respond?

Colby is aware of the components involved with informed consent. There are several copies of the guidelines posted at the surgical center.

3. What requirements are to be included by the physician seeking consent for a treatment? Use the link, <http://depts.washington.edu/bioethx/topics/consent.html> (De Bord, 2014), to assist.

4. Which of the following represents the RN's role with informed consent?

- a. Reviewing the anticipated postoperative discharge orders***
- b. Providing literature on alternate treatments***
- c. Developing a list of questions the client should ask the physician***
- d. Witnessing the client's signature on the consent form***

Use the Hartford Institute for Geriatric Nursing website for evidence-based guidelines on health care decision making (Mitty & Post, 2012) found at http://consultgerirn.org/topics/treatment_decision_making/want_to_know_more to answer the remaining questions.

The determination of decision-making authority represents a significant event in the health care environment. Some patients purposefully choose to include others with this course of action and therefore use “assisted, supported, or delegated” autonomy with the decision-making process (Mitty & Post, 2012, p. 563). Assessment of an individual’s capability for making decisions is often necessary.

5. Compare and contrast the terms “capacity” and “competence” in relation to decision making.

Colby distinctly remembers his time and contact with the elderly patient who refused a gastrostomy tube insertion. The gentleman had several co-morbid conditions, was very hard of hearing, and slept up to 15 hours of every 24-hour period. Yet, he possessed all elements of decisional capacity.

6. Identify the five essential elements.

During his 4 years of employment, Colby has worked multiple times with an advanced geriatric mental health nurse practitioner, Dr. Eads. Colby has great respect for Dr. Eads’s clinical knowledge and communication skills after witnessing her interactions with families in the surgical center. In one case, an older client had a myocardial infarction preoperatively and died; another client experienced significant stroke activity postoperatively. In these events, Dr. Eads came to the clinical area with the hospital chaplain and provided emotional support during the crises.

In both cases, Dr. Eads assisted preoperatively in assessing the decision-making capacity for these two elderly patients. Colby attended these sessions and found them to be quite informative. Dr. Eads used an assessment tool, Screening Older Adults for Executive Dysfunction (Kennedy & Smyth, 2015), in both cases, which is located at www.nursingcenter.com/prodev/ce_article.asp?tid=828679.

7. What are the three instruments used to test for executive function representing best practice?

8. One of Colby’s patients experienced a mild stage of dementia, the other was diagnosed with moderate mental retardation as a child. How does this affect their decision-making capacity?

In the past, Dr. Eads had shared a document with Colby from the *Best Practices in Older Adults: Dementia* (Mitty, 2012). Colby found the section on process guidelines particularly informative and uses the suggestions recommended in his practice frequently.

9. After review, what new information pertaining to decision making for clients with dementia was helpful to you?

Suggested Resources

De Bord, J. (2014). *Informed consent*. University of Washington School of Medicine, Ethics in Medicine. Retrieved from <https://depts.washington.edu/bioethx/topics/consent.html>

- Kennedy, G. J., & Smyth, C. A. (2015). How to try this: Screening older adults for executive dysfunction. *American Journal of Nursing*. Retrieved from http://www.nursingcenter.com/prodev/ce_article.asp?tid=828679
- Mitty, E. L. (2012). Geriatric nursing protocol: Advance directives. Hartford Institute for Geriatric Nursing and Alzheimer's Association. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_d9.pdf
- Mitty, E. L., & Post, L. F. (2011). Health care decision making. In B. Boltz, E. Capezuti, T. T. Fulmer, & D. Zwicker (Eds.), *Evidence-based geriatric nursing protocols for best practice* (4th ed., pp. 562–578). New York, NY: Springer Publishing Company.
- Mitty, E. L., & Post, L. F. (2012). *Nursing standard of practice protocol: Health care decision making*. Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/topics/treatment_decision_making/want_to_know_more

Case 1.3 ■ Physical Restraints

Joseph Deikel is a 78-year-old male admitted to a medical–surgical floor in an acute care facility. Three days before, he had visited his internist for nausea, vomiting, and a low-grade fever. At that time, he was provided with a prescription for promethazine (Phenergan) suppositories and returned home. Mr. Deikel has a strong aversion to any medications taken rectally and did not use the suppositories. The vomiting continued for another 48 hours and was followed by dry heaves. He barely was able to get out of bed at this point and had to hold onto furniture for support. His son found him lying on the bathroom floor, and he was transported to the local emergency department (ED).

Abnormal findings in the ED include Mr. Deikel's BP of 88/50, heart rate 114, temperature 100.1°F, oriented to person only, serum Na⁺ 128, blood urea nitrogen (BUN) 44, and creatinine 2.1. Intravenous fluids (IVF) of sodium chloride 0.9% were initiated at 140 mL/hr along with orders for multiple cultures.

On the medical–surgical unit, Mr. Deikel felt the need to urinate and attempted to get out of bed to go to the bathroom, and fell (no urinal had been provided). His son left, and he was put into a posey vest restraint. When given a dose of intravenous (IV) antibiotics shortly thereafter, he yelled out in pain as his entire arm with the IVFs had a tremendous burning sensation, so as a means of “self-preservation” he pulled the angiocath and tubing out. He now found himself with both wrists restrained.

Reviewing the events, it is apparent that Mr. Deikel, an elderly gentleman, was dehydrated by several days of fluid loss, as evidenced by abnormal vital signs and lab work, and thus became confused. The use of physical restraints described in this scenario was unfortunately not uncommon in years past. Hopefully, this will remain just that: a practice of the past. Use a document provided by the U.S. Food and Drug Administration (2014) at www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/ucm123676.htm to assist with the following questions.

- 1. When are full bedrails (aka, siderails) considered a form of physical restraint? What can be a negative outcome of having full bedrails up, surrounding a patient?***
- 2. What psychological effects do you believe physical restraints can have on a patient?***

For Questions 3 to 7, use the Hartford Institute for Geriatric Nursing website at http://consultgerirn.org/topics/physical_restraints/want_to_know_more (Bradas, Sandhu, & Mion, 2012).

- 3. What, if any, items listed under the definition of physical restraints were unfamiliar to you?***
- 4. After reviewing the section “Morbidity and Mortality Risks Associated With Physical Restraints,” choose any two items and discuss how physical restraints could lead to the specific problem.***

A thorough assessment of a client is the first step in planning an alternative to physical restraints of a patient in order to know whether physical or cognitive impairment exists, as well as risks for injury, such as falling. In addition, presence of medical devices in cognitively impaired patients can represent a risk factor, such as a urinary catheter, nasogastric tube, peripheral/central IV access device, and other invasive items. Finally, a diagnosis or presence of a psychiatric disorder such as drug withdrawal, posttraumatic stress disorder, panic attacks, and so forth should be known.

- 5. Provide the name of the assessment tools and their primary purpose in the “Try This Series” listing.***
- 6. If physical restraints must be used, which of the following must be implemented? Select all that apply.***
 - a. Choose the least restrictive device***
 - b. Ensure proper sizing and fit of restraint***
 - c. Reassess the patient's response at least every 4 hours***
 - d. Release the restraint at a minimum every 4 hours***
 - e. Renew orders every calendar day after evaluation by a licensed independent practitioner***
- 7. After reviewing the information for alternate care strategies, which one(s) do you think might be the most challenging for a patient who is agitated and why?***
- 8. The use of physical restraints often presents an ethical dilemma for nurses. Develop a statement to explain the conflict between beneficence (nursing) and autonomy (of the patient) in regard to restraints.***

Suggested Resources

- Bradas, C. M., Sandhu, S. K., & Mion, L. C. (2012). *Use of physical restraints with elderly patients*. Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/topics/physical_restraints/want_to_know_more
- Doerflinger, D. M. C. (2013). *Try this: Mental status assessment of older adults: The mini-cog*. Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_3.pdf
- Hendrich, A. (2013). *Fall risk assessment for older adults: The Hendrich II Fall Risk Model*. Try this: Best practices in nursing care to older adults. Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_8.pdf
- Horgas, A. L. (2012). *Assessing pain in older adults with dementia*. Try this: Best practices in nursing care to older adults. Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_d2.pdf
- Horgas, A. L., Yoon, S. L., & Grall, M. (2102). *Pain assessment for older adults*. Try this: Best practices in nursing care to older adults. Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/topics/pain/want_to_know_more
- U. S. Food and Drug Administration. (2014). *A guide to bed safety bed rails in hospitals, nursing homes and home health care: The facts*. Retrieved from <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/ucm123676.htm>
- Waszynski, C. M. (2012). *The confusion assessment method (CAM)*. Try this: Best practices in nursing care to older adults. Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_13.pdf

Case 1.4 ■ Patient's Bill of Rights (Long-Term Care)

Edward Newsom and his family are visiting a new skilled nursing facility to complete a preliminary assessment and ask questions before his admission on Monday. Mr. Newsom's daughter, son-in-law, and grandson are present at the assessment. Mr. Newsom is an 86-year-old, well-groomed man, who is 6 feet 3 inches and weighs 240 pounds. He is dressed seasonably appropriate in a navy cardigan, white long-sleeved shirt, khakis, and skid-proof loafers. He has a little pocket on his shirt in which he keeps a small notepad and a pencil to take notes. He pulls this notepad out as you start your assessment and leafs through previous notes that he has taken. You observe that Mr. Newsom is withdrawn and flustered in the process of answering questions about his medical history. Martha Smith, his daughter, pats her father on the leg and reassures him that they are there to help him answer questions.

Martha states that it was a hard decision to transfer her father from her family's care. They managed using an occasional sitter and a global positioning satellite (GPS) tracking device for the couple of times he had gotten lost when taking a "walk," while family members were at work and school. The family has had increasing concern about his safety and well-being, because all family members work full time and are

unable to care for him 24/7. They have noticed that he has become more confused and gets agitated when he is unable to recall events.

Mr. Newsom served as a lieutenant colonel in the army and, in the past, loved to tell detailed stories about his military experience and leadership skills in running a battalion. Mr. Newsom has Stage IV (mild or early stage) Alzheimer's disease (Alzheimer's Association, 2014). His family appears stressed and anxious. He is expected to be admitted to the level I Alzheimer's care unit. Mr. Newsom states, "How do I know people are going to listen to me and not just assume I am an old, muttering fool?" Carol, the RN, states, "All nursing homes have to adhere to a patient's bill of rights, and would take seriously any concerns you might voice."

1. The nurse knows that a patient's bill of rights was

a. Established by county ordinances

b. Always changing to allow flexibility and changes as the nursing home administration evaluates the residents' and staffing needs

c. Set forth by the Omnibus Budget Reconciliation Act (OBRA) of 1987 that governs and protects resident rights in long-term care settings

d. Created by the American Hospital Association

Mr. Newsom asks, "What rights? I am here, aren't I? But I am trying to make the best of this situation, as I know my mind is getting cloudy."

2. What are patient rights?

3. Go to <http://ezinearticles.com/?Federal-Nursing-Home-Care-Reform-Act&id=1332677> (Devine, 2008) and review the Federal Nursing Home Reform Act from the OBRA of 1987. Outline these rights.

Carol, the RN, explains to the family and Mr. Newsom that a patient's bill of rights must be posted in a clearly visible area of the unit. Every long-term care (LTC) facility must inform a resident or guardian of these rights. Martha takes an audible sigh of relief and states, "I want to make sure my father is getting the best care possible, what if we are not here or in town and he has a concern?" Carol explains all personnel must respect and honor these rights. The nurse explains that the National Long-Term Care Ombudsman (n.d.) program provides special oversight for resident care.

4. The National Long-Term Care Ombudsman Resource Center has provided a video related to volunteering as an ombudsman. View the short program at www.youtube.com/watch?v=RdiqlifurOE and comment on what you learned about this role.

5. What is an ombudsman?

6. Use your Internet search engine (e.g., Google or Yahoo) and type the term "long-term care ombudsman" and your state name. List your area ombudsman contacts.

Carol knows that all staff need to be knowledgeable about legal issues affecting older adults. She understands that laws vary from state to state and some states have adopted these rights plus additional ones, so it is essential to check state laws to obtain the full rights established.

7. What could occur if the ombudsman finds a violation or the facility fails to follow and grant rights?

- a. Job loss**
- b. Lawsuits and fines**
- c. Imprisonment**
- d. All of the above**

Mr. Newsom's daughter pulls the nurse aside and asks, "As his condition worsens, I don't want to come and find him strapped to a wheelchair." The RN reassures Martha.

8. What are the laws from OBRA 1987 pertaining to restraint and use of physical and chemical restraints?

Martha hugs the nurse and thanks her for taking the time to explain what patient rights are, and how her facility has concern for, and takes the time to explain these rights to, new residents and their families. Carol notices the family is visibly more at ease, and Mr. Newsom voices an interest in learning more on Monday about the activities for his care unit.

Suggested Resources

- Alzheimer's Association. (2014). *Seven stages of Alzheimer's*. Retrieved from http://www.alz.org/alzheimers_disease_stages_of_alzheimers.asp
- Devine, J. (2008). Federal Nursing Home Care Reform Act. E-zine articles. Retrieved from <http://ezinearticles.com/?Federal-Nursing-Home-Care-Reform-Act&id=1332677>
- National Long-Term Care Ombudsman Resource Center. (n.d.). *Volunteer ombudsman* (Video file). Retrieved from <http://www.youtube.com/watch?v=RdiqIifurOE>
- Tabloski, P. (2010). Principles of geriatrics. In P. Tabloski (Ed.), *Gerontological nursing* (2nd ed., pp. 75–77). Upper Saddle River, NJ: Pearson.

Case 1.5 ■ The Older Driver

Jane Kircher is an RN who volunteers two mornings a week as a parish nurse at her church. She has been contacted by several parishioners about a church member, Jack Billings, with regard to concerns of his driving capabilities. It is reported

that Jack has been observed parked up to 6 feet from the curb in front of the church, backed into another member's car and didn't appear to realize it, and running a stop sign a few blocks away. The concerned members ask Jane for assistance in discussing these incidents with Jack, as they fear not only for his safety but others' as well. This topic is all too familiar to Jane as she has been worried about her own father's driving capabilities in recent years. A conversation she had with him was very similar to the short video found at www.usatoday.com/story/money/cars/2014/05/08/elderly-drivers-stop-keys/8852851.

Jane arranges a home visit with Jack and discovers the following information. He is 79 years old; lives alone in a small, well-kept home; and has been divorced for several decades. He has an estranged relationship with his only son who lives in another state. He states his health is "pretty darn good" and takes the following medications: Lopressor (metoprolol) 50 mg orally daily, Zocor (simvastatin) 40 mg orally at bedtime, and Prilosec (omeprazole) 20 mg orally daily. When asked about common side effects of these medications, Jack denies experiencing any. His height and weight are within proportionate norms; he walks with a steady gait and is oriented to person, place, time, and event. Jack states he drives daily, primarily to a local diner to have breakfast and talk with other older men over coffee. In addition, he goes to the grocery and church once a week, and the local Walmart twice a month.

For the first two questions, utilize the website www.maximhomecare.com/uploadedFiles/Resources/Checklist_content/MHC-Checklist-Elderly-Drivers.pdf.

1. At this point in Jack's interview, what other assessments might the nurse initiate within the confines of his home to evaluate driving risks?

Once Jane believes Jack feels comfortable with her, she initiates conversation regarding his driving, openly sharing that church members have witnessed problems. She reviews common events that can affect an older individual's ability to drive safely.

2. What might be several environmental factors to discuss with Jack?

Jane prepared for the visit by exploring websites on the Internet. She found the information distributed by the American Medical Association (AMA), titled "Older Driver Safety," particularly helpful.

3. What are six specific tests that the AMA recommends for Assessment of Driving-Related Skills (ADReS)?

4. Dealing with impaired older drivers can present ethical conflicts for the health care provider. What are several potential ethical issues you think might arise in Jack's situation?

Jack shares that he sees a local physician every 3 months for blood pressure checks. He has not had an eye exam in more than 5 years. Jane is aware of an ophthalmologist whose office is located in a nearby city, which requires using the interstate.

5. What transportation options might be suggested for Jack to explore?

In her role as parish nurse, Jane has frequently used the Eldercare Locator (n.d.), a public service of the U.S. Administration on Aging, to find services such as transportation.

6. Go to the following website, www.eldercare.gov/eldercare.net/Public/Search_Results.aspx, and cite a source of transportation in your own community using Eldercare Locator services.

A month later, Jack phones to relay that his eye exam showed bilateral cataracts. He will have surgery to remove these in the upcoming months.

7. How did the presence of cataracts adversely affect Jack's ability to drive?

8. Use the simulator located at www.geteyesmart.org/eyesmart/diseases/cataracts/vision-simulator.cfm to understand the progression of visual decline from cataracts. Describe this experience.

Nearly a year has passed since Jane's initial visit with Jack, and she is aware of his upcoming 80th birthday through church records. She phones to wish him well. He tells Jane that he will be renewing his driver's license within a week and states, "I sure hope they don't hassle this old man."

9. If Jack were a resident of your state, what would the Bureau of Motor Vehicles require of him? Address the following: (a) how often a license is to be renewed based on age and (b) any special provisions. Compare your state to any other two of your choice. Use the following link for assistance: www.iihs.org/iihs/topics/laws/olderdrivers.

Suggested Resources

American Academy of Ophthalmology. (2014). Cataract vision simulator. Retrieved from <http://www.geteyesmart.org/eyesmart/diseases/cataracts/vision-simulator.cfm>

Eldercare Locator. (n.d.). U.S. Administration on Aging. Department of Health and Human Services. Retrieved from http://www.eldercare.gov/eldercare.net/Public/Search_Results.aspx

Erb, R. (2014, May 8). Taking the car keys away from elder drivers. *USA Today*, Gannett Company. Retrieved from <http://www.usatoday.com/story/money/cars/2014/05/08/elderly-drivers-stop-keys/8852851/>

Insurance Institute for Highway Safety Highway Loss Data Institute. (n.d.). *Older drivers. Highway safety research & communications*. Retrieved from <http://www.iihs.org/iihs/topics/laws/olderdrivers>

Maxim Healthcare Services. (n.d.). Knowing when to put the breaks on older drivers. Retrieved from http://www.maximhomecare.com/uploadedFiles/Resources/Checklist_content/MHC-Checklist-Elderly-Drivers.pdf

Case 1.6 ■ Iatrogenesis and the Elderly

Betty Hamlin is attending a care conference at Rockville Manor, a long-term care (LTC) facility where her mother has resided for over 5 years. The facility director, clinical nurse manager, staff physician, and social worker asked Betty to join them for decision making in relation to sending her mother out to the local hospital for pneumonia treatment and monitoring. Betty is against this idea for a number of reasons.

Her mother is an 84-year-old woman who, prior to admittance, had a left hemisphere stroke resulting in right hemiplegia and dysphagia. Betty is the only child and has a home located across the road from the facility. She never learned to drive and walks to the grocery, bank, doctor, and church in the small town where she and her mother, Phyllis Hamlin, reside. If her mother transfers to the hospital, it would prevent Betty from being with her daily, which she greatly fears. The following is a description of three events that occurred at the local hospital, resulting in Betty losing all trust for the health care provision her mother will receive.

Phyllis Hamlin experienced fever, chills, and generalized fatigue a couple of years ago. She was transported to the ED with her records, along with a report from the staff physician at the LTC facility. It was determined she had a urinary tract infection and the decision was made to administer 72 hours of IV antibiotics. Following cultures, the ED physician ordered Levaquin (levofloxacin) 500 mg daily with the intention she would return to the LTC facility and take an oral dose for an additional 4 days. Betty got a ride to the hospital on the day her mother was to be discharged from the ED. She put her mother on the bedpan and noted blood in her urine, which was not present prior to admission. She also noted blood oozing from the IV site under the dressing. When she inquired about these findings, they were dismissed.

She contacted the staff physician at Rockville Manor to ask his opinion, and he suggested her INR (international normalized ratio) be checked prior to discharge. Phyllis had been using Coumadin (warfarin) 2 mg daily per gastrostomy tube (G-tube) for years following her stroke, which was continued in the hospital. When the results came back, Betty was told the discharge to the LTC facility was cancelled; her mother's bleeding time was "a bit high." In actuality, the INR was 9.4: over three times increased for patients on anticoagulant therapy.

Phyllis stayed another 3 days receiving many transfusions of plasma that required multiple IV sticks and transfer to a telemetry unit for cardiac monitoring. It was explained to Betty that the plasma would "dilute" the amount of circulating Coumadin (warfarin). She could not receive an explanation for what happened; her worry was that a much higher than usual dose of the anticoagulant had been given. The plasma transfusions triggered another problem; her mother's blood pressure stayed consistently high due to hypervolemia, and at one point on the monitor, Betty noted it was 198/120 mmHg; her fear was that another stroke would occur. In addition, she began having labored breathing and required oxygen therapy.

After her mother's return to the LTC facility, the staff physician explained to Betty that the reason for the dangerous increase in bleeding times was due to the combination of her particular antibiotic (a fluoroquinolone) and the Coumadin (warfarin).

Betty had the reference clerk at the local library look up information about this interaction and received volumes of information about the hazards.

1. Explore the Internet to determine what the potential risks for combining these two medications entails.

Approximately 1 year later, Phyllis returned to the hospital for elective surgery and an overnight stay for monitoring. She had cataract removal, along with three highly decayed teeth extracted. She tolerated the procedures well with no obvious complications. However, several days after returning to Rockville Manor, Phyllis had a thin, greenish drainage from the operative eye. In addition, the administrator of the LTC facility was informed by the hospital that a swab taken on the day of discharge for methicillin-resistant *staphylococcus aureus* (MRSA) was positive. The hospital infection-control nurse emphasized it was community acquired and Phyllis “brought it in with her,” yet couldn’t offer an explanation why the admission culture was negative.

Finally, the staff at the LTC facility noted Phyllis had a low heart rate, which continued to drop over a 24-hour period to the mid-40s. She was admitted to the local hospital for a cardiac evaluation and placed on a telemetry unit. It was determined she had a third-degree atrial-ventricular (AV) block and required a pacemaker implantation. Betty was there for the procedure and stayed until the next morning. She observed an evening shift nurse give her mother the nine routine morning medications withheld earlier due to her procedure. A cup containing them all (some liquid and some crushed) was brought to the room, and all the meds were inserted into her G-tube at once, and then it was plugged. Betty asked the nurse to flush the tube with water as she had witnessed at the LTC facility for years; the nurse complied with less than a tablespoon of water. Betty was worried this technique had been the norm for the several days prior when she couldn’t be at the hospital. The next morning, a different nurse did the same thing before Phyllis was transferred back to the LTC facility.

As Betty feared, the G-tube that was inserted shortly after her mother’s stroke was completely clogged after returning to the nursing home. The staff tried a variety of ways to get the tube opened; all were unsuccessful. Phyllis had to undergo another surgical procedure to replace her only source of feeding and medication administration.

2. Briefly describe the correct method for giving multiple medications through a G-tube.

The events Phyllis experienced are representative of the concept of iatrogenesis. The term comes from the Greek language; “iatros” means doctor or healer and “gennan” means “as a result” (Torrey, 2014). Questions 3 to 7 of this case require the use of the Hartford Institute for Geriatric Nursing website, http://consultgerirn.org/topics/iatrogenesis/want_to_know_more (Francis, 2012).

3. What is the definition provided for iatrogenesis? Do you believe any, or all, of the events described in this case fall under this definition?

4. The most common iatrogenic events result from which of the following? Select all that apply.

a. Falling accidentally

b. Hospital-acquired pressure ulcer

c. Adverse reaction to a medication

d. Inadequate staffing

e. Prejudicial attitude of providers

5. Adverse drug events (ADEs) are the most common form of iatrogenesis. In relation to the elderly population, what primarily contributes to drug–drug interactions in this age group?

Phyllis Hamlin received a “therapeutic” treatment for her drug–drug ADE, supposedly, yet it caused additional health risks.

6. Under the section titled “Adverse Effects of Diagnostic, Therapeutic, and Prophylactic Procedures,” find a rationale for what transpired.

7. A hospitalized patient, who is immobilized due to a fractured hip develops a fecal impaction. How is this form of iatrogenesis labeled?

A study presented by James (2013) suggests over 440,000 deaths due to medication errors in hospitalized patients occur each year; this would represent the third leading cause of death in the United States. A tremendous amount of focus has been put on evidence-based strategies toward medication reconciliation.

8. What is the definition of medication reconciliation? Describe the three-step process used to accomplish this safety goal.

The “Brown Bag Method” for reporting medications is briefly described at <http://live.psu.edu/story/7079> (Penn State News, 2010).

A major policy change for health care coverage and reimbursement occurred in late 2008 when Medicare chose to stop paying U.S. hospitals for eight preventable medical errors/events, all of which are addressed at the Hartford Institute for Geriatric Nursing website.

9. Provide a list of these, and cite your source.

The Quality and Safety Education for Nursing (QSEN) task force developed a number of competencies for schools of nursing across the nation. Review the section regarding safety at <http://qsen.org/competencies/pre-licensure-ksas/#safety>.

10. What are three examples from your nursing program you believe assist in meeting the competency of being a safe provider?

Betty told a friend, “I have to go to the hospital with my mother for surveillance [of all health care provided], not just support [emotional reassurance].”

11. What is your reaction to this statement? Do you think patients truly need a family member or significant other with them when hospitalized to observe the care provided?

Suggested Resources

- Francis, D. F. (2012). *Iatrogenesis*. Hartford Institute for Geriatric Nursing. Retrieved from http://consultgerirn.org/topics/iatrogenesis/want_to_know_more
- James, J. T. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety*, 9(3), 122–128.
- Penn State News. (2010). *Brown bag gives more complete picture of meds taken by older adults*. Retrieved from <http://news.psu.edu/story/215617/2004/06/03/brown-bag-gives-more-complete-picture-meds-taken-older-adults>
- Quality and Safety Education for Nurses. (2006). *Pre-licensure competencies*. Institute of Medicine. Retrieved from <http://qsen.org/competencies/pre-licensure-ksas/#safety>
- Rosenthal, M. B. (2007). Nonpayment for performance? Medicare's new reimbursement rule. *New England Journal of Medicine*, 357, 1573–1575. Retrieved from <http://content.nejm.org/cgi/content/full/357/16/1573>; <http://www.nejm.org/doi/full/10.1056/NEJMp078184>
- Torrey, T. (2014). Iatrogenic—What is the definition of iatrogenic? *About.com: Patient empowerment*. Retrieved from <http://patients.about.com/od/glossary/g/iatrogenic.htm>