



## **Age-Specific Considerations in Patient Care**

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## Acknowledgements

**RN.com acknowledges the valuable contribution of...**

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## Purpose and Objectives

1. Explain what is meant by the term: age-specific competency.
2. Identify age-specific differences in the nurse's response to a patient's rights and basic needs.
3. Identify nursing actions that differ among age groups based upon physical and Motor/sensory differences.
4. Identify nursing actions that differ among age groups based upon cognitive differences.
5. Identify nursing actions that differ among age groups based upon psychosocial and developmental differences.
6. Name nursing actions that reduce risks to which specific age groups of patient are vulnerable.
7. Explain how a patient's individual characteristics other than age, such as culture or work role may combine with age-specific considerations in nursing actions.

***After successful completion of this course, you will be able to:***

The purpose of Age-Specific Considerations in Patient Care is to provide healthcare professionals with information about different age groups, how to identify needs related to these age groups, and how to vary approaches to patient care with age specific needs in mind.

## Introduction

Information in this course is culled and synthesized from several credible references and represents generally accepted characteristics of various age groups.

***Your patient has no hair on his head. He does not speak.  
Your nursing care for him will include feeding him and changing his diaper.***

Do you have a mental picture of this patient? Do you imagine a normal newborn? A brain injured teen-ager post-neurosurgery? A middle-aged man who has received surgical and chemotherapy treatments? An elderly man who has had a cerebrovascular accident?

The description might fit any of those patients. However, you care for each one quite differently because each age group has unique characteristics and needs: physical, including motor/sensory attributes; psychosocial and developmental tasks; cognitive and intellectual functioning, and major fears and stressors.

## Age-Specific Competency Requirements

The Joint Commission (TJC) assesses competence of facility staff as a part of the accreditation process. To comply with standards related to staff competence, facilities must define the patient

population served, the age and special needs groups within the patient population, and the staff members who deliver services to the patient population. Further, TJC clarifies that the hospital must assess competency of staff members, clearly addressing the special needs and behaviors of specific age groups of the patients whom they serve.

Each facility has defined age groupings of the population it serves. Many hospitals designate the following four categories:

- Neonatal and infant
- Child and adolescent
- Adult
- Geriatric

However, some facilities identify additional subcategories depending upon the population served. Specialty organizations such as the American Academy of Pediatrics and The John A. Hartford Foundation for Geriatric Nursing recognize additional age groupings of pediatric patients and geriatric patients.

## **Age-Specific Competency Requirements**

Know the framework used in your facility and the age group served by your patient care area. In addition, locate and use the specialized assessment tools pertinent for patients in the age group for whom you provide nursing care. Examples include pediatric pain assessment tools, cognitive assessment tools for elders, and fall risk assessment tools. Refer to the policies and procedures your facility has created to guide the use of specific tools.

Each state has laws governing age-related implications for healthcare professionals. Learn the requirements of the laws of your state related to treatment of minors and reporting child abuse, domestic abuse and elder abuse. Your state Nurse Practice Act and Rules and Regulations will contain most, if not all, of this information. The policies and procedures of your facility give direction for complying with these and other age-related legal requirements.

Continually update your knowledge of health risks and safety precautions specific to the age group of patients with whom you work. Know the normal findings for physical assessment, laboratory and other diagnostic tests specific to the age group to whom you provide care and the specialty in which you work – that level of detail is beyond the scope of this course.

## **Why Age Matters**

Regardless of a patient's age, nurses must respond to the patient's need for:

- Safety
- Privacy
- Confidentiality
- Comfort
- Pain Management
- Choices and control
- Involvement of family and/or significant others

Depending upon the age of the patient, the nurse may use different approaches, assessment tools, or

equipment to address the needs. These needs are also patients' rights and must be respected. Infants, pediatric and elderly patients are particularly vulnerable to safety risks. Often facilities use specific assessment and documentation tools to assure that these risks are addressed.

**In some aspects of care, your actions vary greatly with the age of the patient:**

- Performing physical assessment and interpreting the findings
- Administering medication
- Assessing and addressing nutritional status
- Communicating
- Encouraging the patient to ask questions
- Using an appropriate style and complexity of language, both oral and written
- Explaining interventions and procedures
- Involving the patient in care and decision-making
- Providing instruction and education
- Choosing appropriate techniques and tools
- Selecting medical equipment, and supplies
- Assisting the patient to cope with hospitalization
- Assessing risk for injury and instituting preventive measures

## **An Age-Specific Framework**

This course identifies seven age groups within which to highlight age-specific variations and nursing actions:

- Neonates
- Infants
- Toddlers
- Child: preschool and school aged
- Adolescent
- Adult: Young and middle-aged
- Elder: Older and oldest

Although your facility may define age groups differently, apply the information to the framework in use at your facility.

## **Pediatrics: Administering Medications**

Administering medications to infants and young children requires extra caution. Drug manufacturers conduct only minimal drug safety research with children. Because of their small size and immature body systems, pediatric patients are at increased risk for adverse effects of medication.

Preparing pediatric dosages often involves mathematical calculations, which also increases risk of error. In fact, one study found that calculation errors account for 60% of medication errors involving pediatric patients (research of Lesar cited by American Academy of Pediatrics, 2003). The same study identified that nearly 70% of medication errors reported involved pediatric patients. Experts

agree that medication errors have the potential to cause harm within the pediatric population at a higher rate than in the adult population. (Sentinel Event, 2008 JC, 2010).

Medication errors are three times more common among pediatric patients as compared with adult patients and have ten times the potential for harm (USP, 2003).

## **Pediatrics: Initiating & Monitoring IV Therapy**

Risks also accompany IV therapy with infants and children. Inserting a peripheral IV is complicated by:

- Small, fragile veins which may be difficult to stabilize
- Lack of cooperation from the child and/or parents

Once the IV is placed, older infants and children often want to play with the IV tubing. Secure the site using a transparent dressing to allow easy visibility and accessibility for palpation. Inspect and palpate the site every hour. Infants and small children have flexible subcutaneous tissues that distend readily to accommodate infiltrating fluid. Avoid wrapping tape too tightly – excessive pressure can cause infiltration or phlebitis. Complications of IV therapy with young children often result in severe tissue damage and even loss of limbs. Hourly assessment and extra caution with infusions containing vesicants can prevent these untoward outcomes (Morales, J, 2011).

## **Pediatrics: Neonates**

*Neonate, ages 1 day to 28 days*

- Offer support in the key developmental task of *Trust versus Mistrust*, development of the ability to rely on others.
- Cuddle and hug frequently: Gentle kinesthetic stimulation promotes neural development. Cuddling also facilitates development of trust.
- Address safety risks:
  - Position on the back for sleep to prevent suffocation.
  - Initiate Sudden Infant Death Syndrome (SIDS) preventive interventions.
  - Use extreme caution in administering medications and assess potential influence of maternal medications on the neonate. The Institute for Safe Medication Practices [ISMP], 2011 report that among children younger than 2 years of age, about 40% of the fatal adverse drug events occurred among children during their first month of life.

## **Pediatrics: Neonates**

Additional Safety Risks in Neonates:

- Position properly during feeding and burp the neonate. Risk for aspiration is high due to immaturity and proximity of respiratory and gastrointestinal passages.
- Touch gently over the anterior and posterior fontanelles, which are still soft.
- Assess body temperature and maintain constant environmental temperature.
- The neonate is at risk for both hypothermia and hyperthermia due to an immature heat regulation system.
- Assess fluid balance. Neonate is at risk for dehydration due to immature renal function, high metabolic rate and insensible fluid loss.
- Protect the neonate from stressors such as lights, noise, and excessive handling. Because of physical immaturity, the neonate has limited ability to manage stressors.

**Recognize that the neonate's behavior is largely reflex in nature.**

## **Pediatrics: Infants**

*Infant, ages 29 days to 1 year*

- Offer support in the key developmental task of *Trust versus Mistrust*, development of the ability to rely on others. Mistrust may result in failure to thrive:
  - Give familiar objects for comfort.
  - Limit number of strangers present.
- Promote bonding with parents:
  - Keep parents in infant's line of vision. Separation from primary caregiver is a major fear of the infant.
  - Assess carefully and use mother or primary caregiver's insights to interpret behavior. The infant has limited ability to express needs or problems.
- Minimize stressors: Strangers, loud noises, bright lights, and sudden environmental changes.

## **Pediatrics: Infant Safety Risks**

Address safety risks:

- Prevent choking or other injury due to foreign objects in the mouth. Infants tend to place objects in the mouth. The infant is in the oral stage of development, as described by Freud.
- Protect from upper respiratory infection and aspiration. The infant is particularly vulnerable due to small airways, proximity of gastrointestinal and respiratory passages, and immaturity.
- Protect from infection. The infant has a limited immune response.
- Assess respiratory status carefully. Poorly developed accessory muscles of respiration and limited diaphragmatic excursion may lead to respiratory failure.
- Assess fluid balance carefully. The infant is vulnerable to fluid, electrolyte, and acid-base imbalances.

- Assess nutritional needs. The infant has a high metabolic rate and due to liver immaturity has limited ability to store glycogen and respond to glucose needs.

In addition, it is important to provide visual, auditory, and tactile stimulation to support development. Cognitive and motor development depends upon age in months.

**Consult more detailed references for monthly milestones during the first year of life.**

## **Pediatrics: Toddlers**

*Toddler, ages 1 year to 3 years*

- Offer support in the key developmental task of *Autonomy versus Shame or Doubt*:
  - Give attention and approval to build pride in self.
  - Expect “No” as a negative expression of autonomy.
- Expect exaggerated response to pain, frustration and changes in the environment. Toddlers are often ritualistic. They are impulsive and their moods change quickly.
- Use a firm, direct approach. Toddlers test limits and may have temper tantrums. Power struggles with parents center around toilet training and food.
- Assess status regarding toilet training. Toilet training is a major developmental task for the toddler. Illness or injury may cause regression.
- Give one direction at a time. Toddlers have a short attention span.
- Prepare toddlers with information immediately before procedures. Their sense of time is the immediate present and their sense of distance includes only what they can see.
- Use play to prepare for and explain procedures.

## **Pediatrics: Toddlers**

- Provide support and comfort during procedures. Invasive procedures are especially threatening. Use least intrusive approach possible for taking temperature, administering medications, and other procedures.
- Recognize that loss of control and restriction of movement are very threatening to toddlers.
- Support the parental relationship. A major fear of toddlers is separation from parents, and separation anxiety may be intense. Hospital, strangers, and procedures may cause a terror response.
- Recognize that toddlers engage in magical thinking and may perceive machines as living things.



## **Pediatrics: Toddler Safety Risks**

Address safety risks:

- Provide a safe environment and supervision. Curiosity, energy, impulsiveness, and lack of inhibition lead to unsafe situations.
- Protect against infection. Although toddlers form antibodies, they are susceptible to gastrointestinal and respiratory infections in response to new organisms.
- Provide for rest and sleep. Toddlers need 10 – 12 hours of sleep nightly and a daytime nap.
- Provide opportunities for solitary play.
- Provide support and comfort. Toddlers have limited ability to think and reason. They will not be consoled by explanations. Their thinking is egocentric and concrete.
- Assess nutritional needs, including food preferences. Growth spurts increase nutritional needs. Iron intake is required to maintain red blood cell levels.
- Assess growth status. Prolonged or serious illness may retard growth.

**Assess a toddler carefully. The ability to describe discomforts is limited.**

## **Pediatrics: Preschool Child**

*Preschool Child, ages 3 years to 5 years*

- Offer support in the key developmental task of *Initiative versus Guilt*.
- The preschooler explores and seeks answers.
- Set limits to balance exploration with needed limits on behavior.
- Recognize that the preschooler is at the phallic stage as described by Freud, and is beginning to explore his own genitalia and develop a sense of sexual identity. Procedures involving the genitalia are especially anxiety producing.
- If appropriate and safe, provide opportunity to interact with other children. The preschooler develops an awareness of others and an ability to participate with a group.
- Offer snacks to meet nutritional needs related to high level of activity. Respect food preferences; often the preschooler prefers texture and separation of foods, rather than mixtures.

## **Pediatrics: Preschool Child**

- Explain when parents will return. The preschooler has the capacity to understand the concept and finds it comforting.

- Assess the preschooler's interpretation of the hospital environment. Preschoolers engage in magical thinking and may become fearful based upon imagined threats.
- Preserve home rituals and habits to the greatest extent possible.
- Support the preschooler when he is fearful. Fear of the unknown, the dark, mutilation, bodily injury, and being left alone are prominent.
- Remember that preschoolers can ask for help. They are eager to please and understand simple directions. Older preschoolers exhibit some control over painful experiences and can accept logical reasoning.
- Recognize that preschoolers conceptualize death in terms of separation and lack of movement.

## **Pediatrics: School-aged Child**

### *School-aged Child, ages 6 years to 12 years*

- Offer support in the key developmental task of *Industry versus Inferiority*. The school-aged child desires to make things, solve problems, and master tasks. Doing so builds feelings of confidence and prevents feeling of inadequacy.
- Allow the child to participate in care to the greatest extent possible; the child may resent forced dependence.
- Living up to expectations of others is very important to the school-aged child.
- Give permission to display fear or pain. The school-aged child may attempt to act bravely.
- Educate using play, games, rewards and praise.
- Assure that information and patient education is understood. Ask the child to tell you his understanding. School-aged children have limited understanding of the human body and may be reluctant to admit when they do not understand. Although their thinking is still concrete, literal and specific, they are beginning to develop logical and deductive reasoning. They may view treatments as punishments.
- Include a more mature concept of time in communication. The school-aged child can understand the past and foresee future consequences.

## **Pediatrics: School-aged Child**

- Recognize that death is understood more fully during the school-age years. Early in this stage, the children view death in terms of a dark magical force that would remove them from their parents. Later they view death as a permanent state and by the end of the school-age years have an adult concept of death.
- Offer support in fearful situations. Major fears of the school-aged child include bodily injury,

mutilation, separation, and death.

- Ask the child questions as a part of the assessment process. School-aged children can describe their discomforts and perceptions.
- Use least intrusive approach possible for taking temperature, administering medications, and other procedures.
- Respect need for privacy.
- Support relationships with friends. School-aged children feel great loyalty and affiliation to same-sex friends. Often they prefer socializing with friends over family members.
- Recognize that school-aged children may question parental authority and rebel against authority figures.
- Assess and provide for nutritional needs. Increasing height, weight, muscle mass and dental development requires adequate calories, iron, calcium, and vitamins A and B.

## **Pediatrics: Adolescent**

Sub-grouped into: *Young adolescents, ages 13 to 15 years*

*Older adolescents, ages 16 to 18 years*

- Offer support in the key developmental task of *Identity Formation vs. Identity Confusion (Diffusion)*. Identity includes:
  - Separating from parents and authority figures
  - Developing relationships with the opposite sex
  - Establishing sexual identity
  - Coping with body changes
  - Identifying who they are, where they fit in, and where they are going.
- Assess and address menarche needs with girls ages 11 – 13 years. Address other learning needs related to the development of secondary sex characteristics.
- If you work with adolescents, maintain an updated knowledge base about acne causes and treatments. Acne is a major concern for many adolescents. Take the opportunity to provide credible information and resources.
- Assess nutritional needs. Growth spurts last two to three years. Skeletal and body mass double, creating increased need for calories and protein.
- Encourage peer visitation if possible. Peers are critically important to adolescents. In early adolescence same sex friends predominate; later, opposite sex relationships are more important.
- Assess illicit substance use and sexual activity in private

## **Pediatrics: Adolescent Safety Risks**

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Address safety risks:

- Seek follow-up referral or resources if you identify indications of depression or suicidal thoughts. Suicide is the third most frequent cause of death in this age group.
- Provide support, information, and encouragement related to threats to body image. Adolescents are particularly concerned about body image, perceived flaws, and appearing different from their peers. Adolescents may be poorly informed, but reluctant to ask for information.
- Expect that many adolescents are emotionally labile. Hormonal changes, peer and parental relationships and identity adjustments lead to frequently changing emotions. Increased perception of pain may occur as well.

## Young Adults

Young adults, ages 20 years to 40 years

- Offer support in the key developmental task of *Intimacy versus Self-isolation*, reaching out and using one's self to enter a committed relationship with another person.
- Assess developmental stage, especially among young adult patients. In the early years of young adulthood, many may still be resolving adolescent tasks and issues.
- Yet, others have fully assumed adult roles at home, at work, and in the community.
- Assess lifestyle challenges. For example, young adults often face challenges to rearrange child-rearing responsibilities during illness, injury, or hospitalization.

## Middle Aged Adults

Middle-aged adults, ages 40 years to 65 years

- Offer support in the key developmental task of *Generativity versus Self-absorption*: Concern about providing for others is equal to the concern about providing for self. Concern about contributing to the next generation and to society heightens.
- Respect the fact that most middle-aged adults are at the peak of their influence and authority. They may be distressed by forced dependency in the patient role.
- Middle-aged adults experience changes of aging to varying degrees depending upon the individual. For some individuals these changes are very stressful.
- Assess to detect risk for:
  - Skin breakdown due to dryness and decreased subcutaneous tissue.
  - Hypertension and hyperlipidemia, which may not be the cause of hospitalization, but may be

detected during hospitalization.

- Sleep apnea.
- Skeletal injury due to diminished bone density and osteoporosis, especially in women.
- Obesity due to decreased basal metabolic rate. Assess and address nutritional needs.

## **Middle Aged Adults**

- Assess middle-aged female patients for menopausal status and distress associated with menopause. Be prepared to offer credible resources related to symptom relief and hormone replacement therapy.
- Health teaching for middle-aged adults includes clarifying information about screening tests such as regularly scheduled mammograms and bone density tests for women and prostate-specific antigen (PSA) prostate cancer screening for men.
- Presbyopia is likely among middle-aged patients. If the patient does not have reading glasses or magnifiers, assure that any important reading material is printed in a size of type that is legible to the patient, or read the materials aloud for the patient. Patients need to be able to read forms requiring signature, patient education materials, instructions, menus, and other written material related to hospitalization and care.
- Middle-aged persons are in the so-called sandwich generation – sandwiched between responsibilities and concerns related to their children and also to their aging parents. Major tasks during these years include achieving financial and emotional security and preparing for retirement.

## **Considerations for Adults of All Ages**

**Additional considerations for all adults include the following:**

- Assess the patient's physical and cognitive ability to work and communicate with coworkers, family, and friends. Provide options for communication and work as appropriate. Offer encouragement and reassurance as needed to assist the patient in setting realistic goals for communication, work, and other pursuits during hospitalization.
- Assess impact of hospitalization/illness on family, work, and body image.
- Involve spouse or significant other in care.

Most adults are actively involved in work life and in managing their home and family responsibilities. Most adults also engage in some form of hobbies or interests. Hospitalization requires adults to separate from these activities. Some adults make unrealistic plans for a hospital stay – such as accomplishing work, catching up on reading, or corresponding with family and friends. For example, the middle-aged person who undergoes an elective surgical procedure may be frustrated and disappointed to discover that the after effects of anesthesia and the stress of surgery interfere with the ability to concentrate.

## **Elders (or Later Adults)**

Traditionally and in much research, the terms elder and elderly describe persons 65 years of age and

older. Persons in this age group account for 48% of acute hospital admissions (Mezey, et al., 2001).

Most elders experience a series of losses and grieve these losses. Losses include progressive loss of physical capabilities, loss of memory, loss of a spouse, loss of peers, loss of independence, and loss of a sense of relevance.

The loss of a driver's license and the independence it symbolizes can also be devastating. Since the 1990s, the number of persons older than 65 years has increased and more persons are living into their late 80s, 90s and even early 100s.

Many people postpone retirement, or begin a second career or work life after retiring at age 65. Some experts have redefined elderly to mean people who are 75 years old and older.

**Offer support in the key developmental task of *Ego Integrity versus despair*, the acceptance of life and of the self as they are.**

## **Elders (or Later Adults)**

People within the age group 65 years to 100+ years vary considerably in their physical, motor/sensory, cognitive, and psychomotor characteristics, depending in part on age.

Some gerontological experts define three groupings within the age group 65 years to 100+ years:

- Young Old: Ages 65 years to 75 years
- Old: Ages 75 years to 85 years
- Old Old: Ages 85 years and older

Routine nursing care procedures create risks for elderly patients to a greater extent than for younger adults. For example:

- IV starts and blood draws are often difficult due to small and fragile veins.
- IV therapy presents the risk of fluid overload. Fluid balance is more delicate with elderly persons. The elderly are particularly vulnerable to dehydration –which may present as confusion.
- Fragile skin is easily torn during tape removal.
- Moving in bed can injure fragile skin.
- Due to osteoporosis, fractures may result from very minor trauma.
- Heightened sensitivity to the effects of drugs and the number of drugs received, place elders

at risk for potentially serious effects of polypharmacy. In addition, slower metabolism, relatively more body fat, compromised renal function, and alterations produced by disease conditions sensitize the elderly to the effects of drugs. A narrow margin of safety – between minimal effective dose and toxic dose – is often a factor.

## **Elders: Medication Safety Risks**

The approach to medication management in older persons differs from that for younger people, as medication needs in the elderly are often complex and multifactorial in the older population. In addition, older people may under-report pain (American Geriatric Society [AGS], 2009). Concurrent illnesses and multiple medical problems in the elderly make pain evaluation and treatment more difficult. Also, older persons are more likely to experience medication-related side effects and have a higher potential for complications and adverse events related to diagnostic and invasive procedures (AGS, 2009).

Despite these challenges, multiple medications can usually be effectively managed in this age group, but requires accurate assessment and documentation of existing medication therapies, to identify possible drug interactions or the potential for drug overdose (AGS, 2009). Routine screening and careful assessment of all older patients is crucial, because even pain that is causing severe impairment may not be spontaneously revealed for a variety of personal, cultural, or psychological reasons (AGS, 2009).

Absorption and metabolism of medications are altered in elderly patients because of decreased gastrointestinal (GI), renal, and liver function. Generally speaking, medications are not metabolized as quickly and blood levels of medications remain higher for a longer period of time. Elderly patients are more sensitive to medications and at increased risk of drug toxicity (AGS, 2009).

## **Geriatric Competencies: Communication**

The Hartford Institute for Geriatric Nursing is an important resource in the care of older adults. The Hartford Institute promotes the highest level of geriatric competence in all nurses, identifies and develops best practices, and communicates best practices to nursing students and practicing nurses.

The following competencies were developed by the Hartford Foundation to promote high quality care, dignity, and comfort for geriatric patients.

### **Communication**

- Carefully assess and validate the need for modified communication techniques.
- Seek and use resource persons as needed to communicate effectively with the patient who has dementia.
- Communicate respectfully and in a manner that preserves dignity.
- Ask the patient how he or she prefers to be addressed.
- Avoid terms such as honey, sweetie, and dear.
- Use communication strategies to meet patients' needs, such as:
  - Speak slowly and at an adequate volume as needed to ensure effective communication.

- Face the patient, speak slowly and distinctly.
  - Use closed-ended questions requiring only a yes or no response.
  - Communicate one thought at a time.
- Provide adequate time for decision-making and problem-solving.

**Assure patient participation in decision-making: advance directives, health care proxy, DNR, and informed consent.**

## **Geriatric Competencies: Communication (cont)**

Assess barriers that impact patients' understanding of information. Barriers include drug interactions, dementia, delirium, disease states, depression, and other factors that may interfere with understanding.

- Demonstrate familiarity with adaptive devices such as a hearing aid , and assure the use of applicable communication aids, including glasses or magnifiers.
- Direct instructions and information to family members and care partners as well as patient.
- Communicate respectfully and preserve patient dignity when performing physical care.

## **Geriatric Competencies: Assessing Physiological and Psychological Changes**

There are many age related physiological and psychological changes that must be addressed when caring for patients in this age group. Specific nursing competencies related to caring for the elderly patient include:

- Interventions to address changes in temperature, BUN and creatinine.
- Assessment of cognitive status for delirium, dementia, and/or depression.
- Use of standardized scale to assess:
  - Mental Status, e.g., Mini Mental Status Examination - MMSE [www.medafile.com/mmse.htm](http://www.medafile.com/mmse.htm)
  - Delirium, e.g., Confusion Assessment Method – CAM [www.hartfordign.org/publications/trythis/issue13.pdf](http://www.hartfordign.org/publications/trythis/issue13.pdf)
  - Depression, e.g., Geriatric Depression Scale - GDS [www.healthplace.com/communities/depression/elderly-2.asp](http://www.healthplace.com/communities/depression/elderly-2.asp)
- Use the facility's established criteria for management of polypharmacy.
- Interventions to curtail adverse events associated with medications, diagnostic or therapeutic procedures, nosocomial infections or environmental stressors.

**Monitor the elderly closely for adverse effects of medications related to decreased clearance of drugs.**



# Geriatric Competencies: Pain & Skin Integrity

## Pain

- Assess pain in cognitively impaired patients using valid and reliable self-report instruments and/or observations of patient behaviors such as agitation, withdrawal, vocalizations, facial responses, and grimaces. Assessment and management of pain in cognitively intact older patients is no different than for younger patients.
- Intervene for the cognitively impaired when assessment is inconclusive and pain is to be expected (AGS, 2009).

## Skin Integrity

- Assess the risk of skin breakdown using a standardized scale, e.g., Braden Scale, [www.bradenscale.com](http://www.bradenscale.com)
- Use the facility's established criteria to implement appropriate bathing, choice of skin products, and positioning.

# Geriatric Competencies: Functional Status

The overall functional status of the elderly patient must be assessed and documented in detail. Appropriate interventions to promote function in response to change in activities of daily living (ADL) and instrumental activities of daily living (IADL) should be demonstrated within care plan.

The care plan should include:

- Assisting with activities of daily living as needed.
- Assisting the patient in maintaining an optimal activity level to prevent de-conditioning with special attention to:
  - Skin
  - Functionality/Mobility
  - Continence
- Using assistive devices and initiating referral to appropriate therapies such as OT, PT.
- Assess need for sleep medication. Monitor carefully for toxic effects and prolonged effect if sleep medication or benzodiazepines are administered.

# Geriatric Competencies: Functional Status (Cont).

## Functional Status: Urinary Continence

- Identify and refer to an appropriate clinician for recent onset of urinary incontinence (UI).

- Document the rationale for use of indwelling catheters other than in specified clinical situations such as, stage III/IV pressure ulcers, monitored acutely ill patients, urinary retention not manageable by other means, or other situations in which there is no appropriate alternative to an indwelling catheter.

### **Functional Status: Nutrition/Hydration**

- Use the facility's established criteria to identify patients who are at high risk for nutritional or fluid deficit; assess carefully for swallowing difficulties.
- Intervene to address barriers to nutritional or fluid adequacy, such as difficulty with chewing and swallowing, alterations in hunger and thirst, inability to self feed, and capacity of others to feed.
- Assist with meeting nutritional needs related to difficulty chewing, decrease in taste sensation, loss of appetite and decreased absorption of nutrients.

## **Geriatric Competencies: Restraints & Elder Abuse**

### **Restraints**

- Document discussion of the use of a physical restraint, such as jackets, belts, mitts, chairs with fixed trays, sheets, and side rails.
- Document behavior of the patient who is physically restrained.
- Intervene to eliminate or sharply curtail the use of physical restraints. Initiate alternate strategies to prevent falls, to prevent treatment interference, and to manage agitated or combative behavior.
- Always exhaust all less restrictive means before applying physical restraints. Complications of restraint use include injuries sustained while struggling against the restraint, depression, agitation, confusion, withdrawal, and anger.

### **Elder Abuse**

- Use the facility's established criteria to identify and report elder abuse.

## **Geriatric Competencies: Discharge Planning**

Thorough and comprehensive discharge planning is an important competency in the elderly, as there is usually a need for co-ordination of multiple care services post discharge.

On discharge, complete information should be transmitted in a timely manner to all appropriate persons: Patient, family, home care professionals, or skilled nursing facility personnel.

Minimal data elements include diagnoses and medications, including dose and last dose taken.

Provide patient education materials that are legible, printed clearly, and at appropriate level of medical literacy.

Refer for evaluation of the need for special resources for transition to home, such as Meals on

Wheels, adaptive devices, and other services.

## **Geriatric Competencies: Falls & Injuries**

- Use your facilities established falls prevention protocol.
- Assess for postural hypotension and encourage the patient to change position slowly to prevent postural hypotension.
- Use a valid and reliable measure of fall risk assessment.
- Institute fall and injury preventive measures, such as:
  - Ensure that non-slip footwear is worn
  - Maintain toileting programs
  - Maintain an obstacle-free room
  - Keep call bell within reach

## **Geriatric Competencies: Falls & Injuries (cont).**

Falls present a serious threat to the elderly patient. Elders are at risk for falls for many reasons. In addition, an elderly patient who has fallen previously is at increased risk for falling in the future. Many elderly persons live in fear of falling and for good reason. Among elderly persons, one of seven falls results in a fracture. Elders account for 70% of all persons who die as a result of a fall.

Help your elderly patient address the risk of falling by explaining falls precautions and promoting involvement of the patient and all visitors in fall prevention efforts.

Elderly patients are at increased risk for falling, because the following factors are likely to be present:

- Cognitive impairment
- Medications which can cause disorientation, hypotension, hypoglycemia or weakness
- Impaired mobility or cognitive limitations due to disease or treatment
- Elimination problems
- Unsafe environment: Cluttered, requiring reaching, lack of proper footwear, uneven floor or wet surfaces, unstable furniture

- Sensory deficits
- Alcohol use
- Postural hypotension

## **Geriatric Competencies: Pressure Ulcers**

Elders are at increased risk for skin breakdown for the following reasons:

- Reduced sensory perception and therefore lack of awareness of early indications of skin damage
- Collection of moisture due to incontinence or other causes
- Dryness of the skin creating fragile skin surfaces
- Limitation of activity including the ability to reposition oneself and immobility
- Inadequate nutrition
- Friction and shear during movement and positioning

Inspect the skin thoroughly for evidence of early skin breakdown. If unlicensed assistive personnel (UAP) are providing hygienic care, assure that they observe for early indications of skin breakdown and to institute preventive measures.

## **Patient and Family Teaching**

Elders are often discharged from facilities with complex care and treatment plans.

Assure that the patient and appropriate others such as family members and other caregivers are fully informed about care needs and procedures.

Place particular emphasis upon the knowledge and skill needed to manage the medication regime. Misuse of drugs is the fifth leading cause of death among elderly persons (Zwicker & Fullner, 2008).

Protecting elderly patients from potential hazards requires careful observation and monitoring, as well as gentle handling.

## **Resources for Care of the Elderly Patient**

Keep up-to-date on new developments in care of the elderly. Use geriatric nursing resources such as university research centers:

- University of Pennsylvania
- Indiana University: <http://www.indiana.edu/~iugeri/>
- University of Iowa: <http://www.nursing.uiowa.edu>

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- The Hartford Foundation: <http://www.hartfordign.org/>

For more detailed information about special precautions when administering medications to elderly patients, see the RN.com course, Critical Thinking: Administering Medications to Elderly Patients.

## **A Unique Package of Individual Differences**

In addition to age-related differences, some of the ways in which individual patients differ from one another include:

- Cultural Practices
- Religious values, beliefs and practices
- Generational orientation
- Community affiliations
- Sexual orientation
- Personality type and family role
- Educational background, learning style and work role
- Social and economic status
- Interests and talents
- Personality type
- Diagnosis, treatment and prognosis

Age-specific considerations must be combined with any and all other individual differences.

## **Examples of Individual Differences**

The following are some fictional examples of the unique, individualized differences among patients:

- An adolescent who must adjust to the diagnosis of diabetes might be expected to experience disruptions related to peer relationships that are so important to adolescents. Yet, the findings of one recent study indicated that teenagers with Type I diabetes did not differ from a control group of teens in perceptions of close friendships, physical appearance, social acceptance, and romantic appeal. The teens who had diabetes did express lower life satisfaction and health perception than the control group (Faulkner, 2003).
- Adults who experienced the Great Depression may view health prevention expenses differently from Baby Boomers.
- An older adult may observe specific religious practices that younger persons of the same religion

do not observe. Certain practices which older adults learned as children may have changed and been eliminated from the religious education of younger persons.

- An older adult who has AIDS may be affected by age-specific factors such as denial, extreme secrecy, a compromised immune system, and erectile and vaginal changes associated with aging. The drug therapy maxim regarding dosage for older adults: “Start low, go slow” is at odds with the AIDS drug therapy maxim, “Hit early, hit hard.”

## Avoiding Stereotyping

The most important thing to remember about individual differences is to avoid stereotyping or assuming that a patient practices certain behaviors or espouses certain values and preferences based upon any category or combination of categories into which that patient appears to fit. Nevertheless, to practice with cultural competence, the nurse learns typical behaviors, values, and preferences associated with various groups. The nurse uses this information to assess and validate whether and how those norms apply to a specific patient.

Even age group norms require validation, particularly among older adults. According to the Two-Thirds Rule often referred to in assessment of elders, most persons of a given age have certain age-related characteristics. For example, a typical 70-year-old might have certain physical, motor/sensory, cognitive and psychomotor characteristics. However, a few 70-year-olds resemble the typical 47-year-old, while a few 70-year-olds resemble the typical 93-year-old. In addition, many 70-year-old individuals fall somewhere between their true chronological age and one of those two extremes.

**The competent nurse uses knowledge of typical characteristics and expectations as a guide and a basis for further assessment and validation, not as a basis for making assumptions.**

## Conclusion

As you manage patients in different age groups, keep in mind that there are specific psychologic and physiologic needs.

These vary by age group, or by developmental level.

By understanding these differences, you can provide more individualized care to your patients.