Nursing Care of an Older Adult Experiencing Altered Mental Health

1. Knowing that older adults are less likely to receive mental health treatment, which of the following staff education programs is a high priority?

-Providing cost-effective eye care for older adults
-Identifying nutritional deficiencies in older adults
-Identifying clinical depression in older adults
-Providing counseling referrals for older adults

2. Which of the following are common alterations in mental health that may appear in older adults? Select that all apply.

-Neurocognitive disorders
-Substance abuse disorders
-Delirium
-Suicide risk
-Depression

3. During your nursing assessment, Mr. Jones is having difficulty walking because of shortness of breath secondary to chronic obstructive pulmonary disease (COPD). He says, "Every day is hard when you get old. No one cares about old people. I'm better off dead."

For Mr. Jones' statement, which is the best response by the nurse?

-"Rest periods are important. Don't try to overexert yourself."
-"You are still able to get around, and your mind is alert."
-"It sounds like you're having a difficult time. Tell me about it."
-"Let's not focus on the negative. Tell me something good."

4. Which factors could help reduce risk and protect older adults from suicide?

-**Substance misuse**
-Social connectedness
-Care for physical health problems
-Adapting to change
-Adequate coping skills

5. Which risk factors can contribute to caregiver elder abuse?

-Prior history of violence
-Adequate coping with caregiver role
-Substance misuse
-Economic stress
-White females, aged 70 or older

6. Who should be assessed first on the inpatient psychiatric unit?

You are to begin your nursing shift and receive reports on **three** older adult clients with alterations in mental health. Review their information below and determine the order to see the three patients. Which client should be seen first (immediate), second (urgent), and third (non-urgent)?

Nursing diagnosis	Assessment findings	Immediate / Urgent / Non-Urgent
Risk for suicide related to depressed mood	• depressed • feelings of low self-worth • history of alcohol abuse • self-harm	Immediate, Urgent, Non-urgent
Powerlessness related to dependence on others	• irritability and anger • depressed mood • stating "I have no control over my life anymore."	Immediate, Urgent, Non-urgent
Risk for trauma (elder abuse) related to caregiver role strain	• stating, "I'm just a burden on my family." • bruising on arms in different stages of healing • presenting in unclean clothing, body odor, and poor eye contact; looking at the floor when answering questions (withdrawn) • flat affect • denial of suicidal ideation • denial of abuse	Immediate, Urgent, Non-urgent

7. Review the nursing diagnosis items in the left column and the nursing action choices below. Drag and drop each nursing action item to match its corresponding diagnosis.

Report findings of suspected elder abuse to social services and law enforcement.

Teach clients deep breathing and relaxation techniques.

Help clients identify areas of life situations that clients can control.

-Powerlessness

-Risk for suicide

-Risk for trauma (elder abuse)

8. Which nursing actions can help achieve the expected outcomes below? Drag and drop the chosen action in the left column to match the corresponding outcome.

Possible Nursing Actions	Expected Outcomes
	The client no longer displays verbal, behavioral, or action cues about their intent to die by suicide.
	The client verbalizes an understanding of the need to report suspected abuse to investigative agencies.
	The client can verbalize various ways in which to manage their environment.

-Removing items from the room which a client might use to cause self-harm or harm to others.
-Report both objective and subjective assessment findings of suspected elder abuse to social services and law enforcement.
-Help identify areas of life situations that clients can control.

9. Recognizing Cues: Mr. David
Select all relevant data from both "Patient Information" and "Nurses' Notes" tabs, which suggests Mr. David is having an alteration in mental health.
Patient Information
Mr. David recently had to retire due to health problems and had planned to travel with his wife of 50 years, Gladys, when his health improved. Gladys had also been his caretaker, and died of natural causes shortly after his retirement. Mr. David is having difficulty eating, repeating "I'm just not hungry," and sleeping most of the day since her death.
Their only son, who lives in another state, has been staying with him, but must go home now to go back to work.
Date/Time NURSE'S NOTES1/15/20XX 09:05
Daily home health care visits have been set up to meet the client's skilled care needs. During the morning of the first home care visit, the home care nurse was unable to reach Mr. David by telephone or at his residence. After having a welfare check conducted, the client was found lying in his bed confused and crying inconsolably, stating,"I just want to die. I have nothing to live for anymore." Scattered over his bed were pictures of his wife, an empty prescription pill bottle of heart medicine, and an empty bottle of vodka. The client stated, "My heart is broken." He was taken by ambulance to the emergency department for further evaluation.

10 The client has actual ..... as evidenced ..... by and .....
-anxiety, grief, trauma (elder abuse)
-anxiety, multiple, losses, trauma
a depressed mood, an elated mood, signs of denial.

11. What expected outcomes are specific, measurable, attainable, relevant, and time-sensitive (SMART) for Mr. David to achieve prior to his hospital discharge? Select that all apply.
-Ability to recognize self-care needs
-Assurance of safety from self-harm
-Ability to verbalize thoughts and feelings
-Ability to forget about the losses
12. Match the appropriate rationale and its expected outcome with the corresponding nursing action.

	Rationale	Expected Outcomes
Use therapeutic communication techniques with the client and allow them to freely verbalize thoughts and feelings.		
Remove items from a client's room which one might use to cause self- harm or harm to others.		
Encourage clients to meet their self-care needs.		

-The client will verbalize assurance of his or her immediate safety and who to contact if having suicidal ideations.
-Alterations in normal activities may be evident during times of grief. Care should be taken to meet both physical and psychological needs to prevent alterations in mental health. Not treating the underlying conditions can further complicate both physical and mental health.
-Allow nurses to address the client's concerns and provide emotional support. Sharing feelings with a health care provider may help the client understand their experiences with loss.
-The client will verbalize self-care needs, including adequate amounts of rest and nutritious foods to meet dietary needs.
-The client will verbalize thoughts and feelings of their lived experience with loss.
Client and employee safety is the priority.

13. You have developed a list of nursing actions that meet expected outcomes. Determine whether these nursing actions would require immediate, urgent, or routine action.

Nursing Action	**Immediate/Urgent/Routine**
Use therapeutic communication techniques with the client and allow them to freely verbalize thoughts and feelings.	Immediate, Urgent, Routine
Remove items from a client's room which one might use to cause self-harm or harm to others.	Immediate, Urgent, Routine
Encourage clients to meet their self-care needs.	Immediate, Urgent, Routine

14. Which statement(s) made by Mr. David would provide evidence that the interventions were effective? Select that all apply.
-"I know crying is a way to express my feelings and it takes time to feel better."
-"I need to eat and sleep to keep my body and mind healthy."
-"I don't want to show emotion. I'm weak."