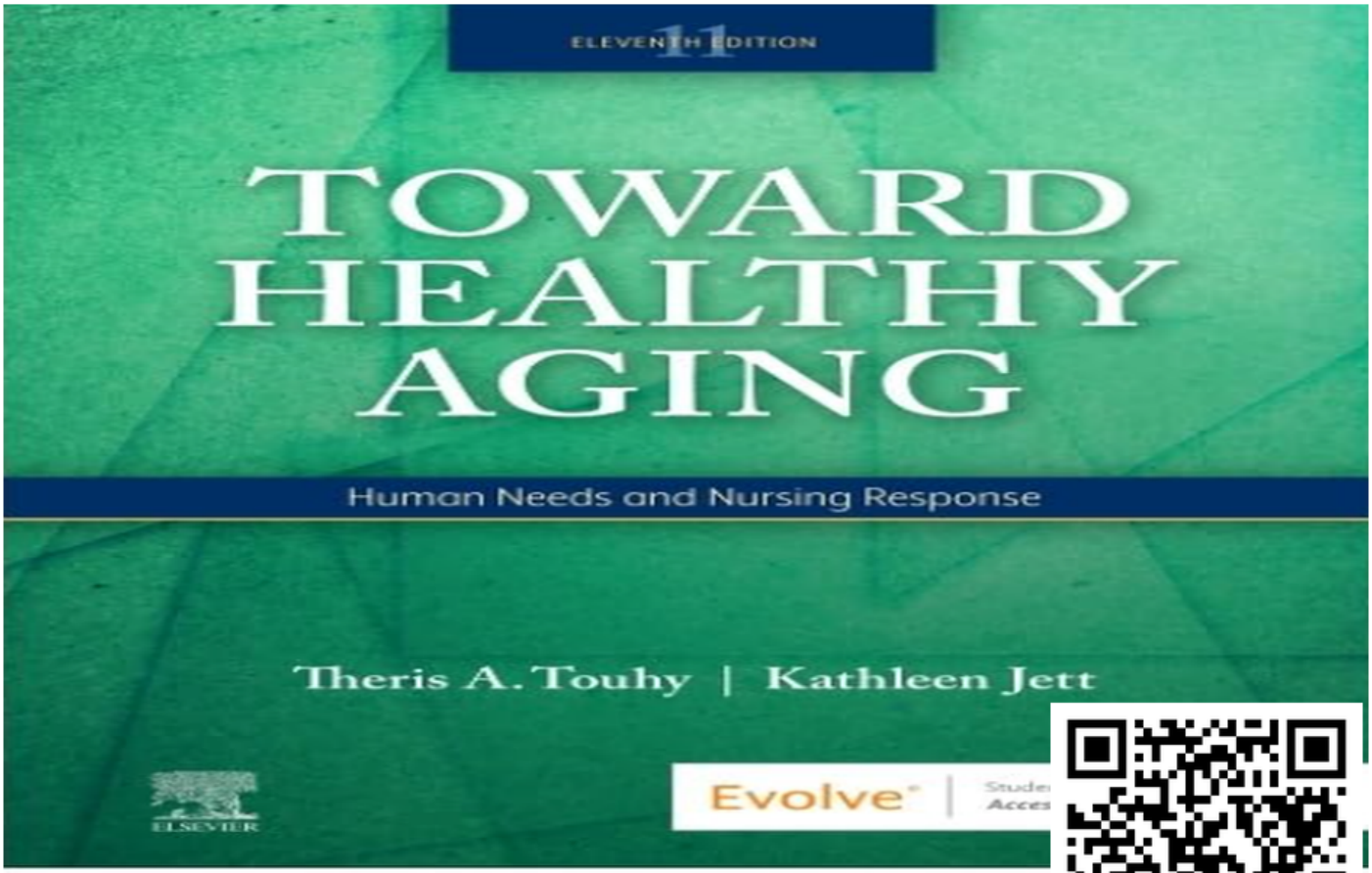

ELEVENTH EDITION

11

TOWARD HEALTHY AGING

Human Needs and Nursing Response

Theris A. Touhy | Kathleen Jett

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TOWARD HEALTHY AGING

Human Needs and Nursing Response

Theris A. Touhy, DNP, CNS, DPNAP
Emeritus Professor
Christine E. Lynn College of Nursing
Florida Atlantic University
Boca Raton, Florida

Kathleen Jett, PhD, GNP-BC, DPNAP
Gerontological Nurse Practitioner
Memphis, Tennessee

ELSEVIER

Elsevier
3251 Riverport Lane
St. Louis, Missouri 63043

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For Danny
You touched your family and so many others in your social work practice
with your presence, caring, deep love, and your music.
Your gentle spirit lives on.

To all the students who read this book: I hope each of you will improve the journey toward healthy aging through your competence and compassion.

To all of my students who have embraced gerontological nursing as their specialty and are improving the lives of older adults through their practice and teaching.

To the older adults I have been privileged to nurse, and their caregivers, thank you for making the words in this book a reality through your caring and for teaching me how to be a gerontological nurse.

Theris Touhy

To the older adults in my personal and professional life who have taught me the most important things to share with students.

To my husband, Steve, and our wonderful children and grandchildren, who never cease to remind me that the best part of life and aging is the love we share.

To my mother-in-law, Gloria Jett, one of the many victims of the COVID-19 pandemic. Through her illness and my caregiving, I discovered that I really do know how to be a gerontological nurse and how many ways the knowledge found within this text can be used.

Kathleen Jett

ABOUT THE AUTHORS

Theris A. Touhy, DNP, CNS, DPNAP, has been a clinical specialist in gerontological nursing, nurse practitioner, and nursing educator for more than 40 years. Her expertise is in the care of older adults in long-term care and those with dementia. Dr. Touhy received her BSN degree from St. Xavier University in Chicago, a master's degree in care of the aged from Northern Illinois University, and a Doctor of Nursing Practice from Case Western Reserve University. She is an emeritus professor in the Christine E. Lynn College of Nursing at Florida Atlantic University, where she has served as Assistant Dean of Undergraduate Programs and taught gerontological nursing and long-term, rehabilitation, and palliative care nursing in the undergraduate, graduate, and doctoral programs. Her research is focused on spirituality in aging and at the end of life, caring for persons with dementia, caring in nursing homes, and nursing leadership in long-term care. Dr. Touhy was the recipient of the Geriatric Faculty Member Award from the John A. Hartford Foundation Institute for Geriatric Nursing, is a two-time recipient of the Distinguished Teacher of the Year at the Christine E. Lynn College of Nursing at Florida Atlantic University, and received the Marie Haug Award for Excellence in Aging Research from Case Western Reserve University. Dr. Touhy was inducted into the National Academies of Practice in 2007. She is co-author with Dr. Kathleen Jett of *Gerontological Nursing and Healthy Aging* and co-author with Dr. Priscilla Ebersole of *Geriatric Nursing: Growth of a Specialty.* In addition to her professional activities, Dr. Touhy and her husband of 54 years are blessed with a loving family of three sons, two grandsons, and one granddaughter. Being a grandparent is the greatest adventure and joy of growing older!

Kathleen Jett, PhD, GNP-BC, DNAP, brings more than 40 years of gerontological nursing practice to this text. Her clinical experience is broad, from her roots in public health to leadership in long-term care, assisted living, hospice, and gerontological education, to her work as a researcher and advanced practice nurse as both a clinical nurse specialist and a nurse practitioner. Dr. Jett received her bachelor's, master's, and doctoral degrees from the University of Florida, where she also holds a graduate certificate in gerontology. In 2000 she was selected as a Summer Scholar by the John A. Hartford Foundation—Institute for Geriatric Nursing. In 2004 she completed a Fellowship in Ethno-Geriatrics through the Stanford Geriatric Education Center. Dr. Jett has received several awards, including recognition as an Inspirational Woman of Pacific Lutheran University in 1998 and 2000 and for her excellence in undergraduate teaching in 2005 and Distinguished Teacher of the Year at the Christine E. Lynn College of Nursing at Florida Atlantic University. A board-certified gerontological nurse practitioner, Dr. Jett was inducted into the National Academies of Practice in 2006. She has taught an array of courses, including public health nursing, women's studies, advanced practice gerontological nursing, and undergraduate courses in gerontology. She has coordinated two gerontological nurse practitioner graduate programs and an undergraduate interdisciplinary gerontology certificate program. Most of her research has been in the area of reducing health disparities experienced by older adults. The thread that ties all of her work together has been a belief that nurses can make a difference in the lives of older adults. She is currently retired and enjoys putting her skills to use through volunteer work in service to vulnerable older adults.

CONTRIBUTORS AND REVIEWERS

CONTRIBUTORS

Lenny Chiang-Hanisko, PhD, RN
Associate Professor
Christine E. Lynn College of Nursing
Florida Atlantic University
Boca Raton, Florida

Priscilla Ebersole, PhD, RN, FAAN
Professor Emerita
San Francisco State University
San Francisco, California

Debra Hain, PhD, ARNP, ANP-BC, GNP-BC, FAANP
Associate Professor/Lead Faculty AGNP Program
Christine E. Lynn College of Nursing
Florida Atlantic University
Boca Raton, Florida
Nurse Practitioner, Department of Hypertension/Nephrology
Cleveland Clinic Florida
Weston, Florida

María de los Ángeles Ordóñez, DNP, ARNP/GNP-BC
Director
Louis and Anne Green Memory and Wellness Center
Florida Atlantic University
Boca Raton, Florida
Assistant Professor
College of Nursing
Florida Atlantic University
Boca Raton, Florida
FAU Memory Disorder Clinic Coordinator
Louis and Anne Green Memory Disorder Clinic
Department of Elder Affairs
Boca Raton, Florida

REVIEWERS

Cynthia R. Becker, MSN, RN
Professor
Black Hawk College
Moline, Illinois

Keisha Butler, MSN, RN
Instructor of Nursing
Tennessee Technological University
Cookeville, Tennessee

Jacqueline M. Garland, MSN, RN, LMT
Assistant Professor of Nursing
Rockford University
Rockford, Illinois

Deborah S. Petty, DNP, APRN, ACNS-BC
Clinical Assistant Professor
Louise Herrington School of Nursing
Baylor University
Dallas, Texas

Debra D. Rapaport, MSN, RN
Nursing Faculty, Tenured
Helena College
University of Montana
Helena, Montana

PREFACE

In 1981, Dr. Priscilla Ebersole and Dr. Patricia Hess published the first edition of *Toward Healthy Aging: Human Needs and Nursing Response,* which has been used in nursing schools around the globe. Their foresight in developing a textbook that focuses on health, wholeness, beauty, and potential in aging has made this book an enduring classic and the model for gerontological nursing textbooks. In 1981, few nurses chose this specialty, few schools of nursing included content related to the care of older adults, and the focus of care was on illness and problems. Today, gerontological nursing is a strong and evolving specialty with a solid theoretical base and practice grounded in evidence-based research. Dr. Ebersole and Dr. Hess set the standards for the competencies required for gerontological nursing education and the promotion of healthy aging. Many nurses, including us, have been shaped by their words, their wisdom, and their passion for care of elders. We thank these two wonderful pioneers and mentors for the opportunity to build on such a solid foundation in the multiple editions of this book we have co-authored since their retirement. We hope that we have kept the heart and spirit of their work, for that is truly what has inspired us, and so many others, to care for older adults with competence and compassion.

We are very excited to have been able to offer a timely and completely revised 11th edition of this text guided by the National Council of State Boards of Nursing (NCSBN) model of clinical judgment. In 2019, the NCSBN identified the need to enhance the clinical judgment skills of entry-level nurses and, in a few years, the Next-Generation NCLEX® Examination for nursing licensure will be based on the new model of clinical judgment. *The Essentials: Core Competencies for Professional Nursing Education* (American Association of Colleges of Nursing, 2021) identifies clinical judgment as one of the key attributes of professional nursing. Clinical judgment refers to the process by which nurses make decisions based on nursing knowledge (evidence, theories, ways, and patterns of knowing), other disciplinary knowledge, critical thinking, and clinical reasoning (Manetti, 2019). This process is used to understand and interpret information in the delivery of care. Clinical decision making based on clinical judgment is directly related to care outcomes for nursing at all levels.

Enhancing clinical judgment skills is especially relevant to guide the design of nursing actions in care of older adults. Older adults are complex, and their responses to illness are often subtle and may not meet standard diagnostic criteria seen in younger individuals. Cues to impending health concerns are often missed or blamed on age, leading to unnecessary disability, complications, and compromised quality of life. Nurses are key to recognizing and analyzing cues leading to the prioritization of hypotheses needed to generate solutions, take action, and evaluate outcomes to enhance the healthiest aging while dealing with the most common challenges facing an aging population. This text provides comprehensive information to guide the development of competent clinical judgment in nursing practice with older adults across the continuum of care.

Toward Healthy Aging is a comprehensive gerontological nursing text. The framework is holistic, addressing body, mind, and spirit along a continuum of wellness, within the context of culture, and grounded in caring and respect for older adults. Within the covers, the reader will find gerontological nursing actions based on the latest evidence-based practice guidelines available. This fosters the provision of the highest level of care to adults in settings across the continuum. The content is also consistent with the Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults, the Hartford Institute for Geriatric Nursing Best Practices in Nursing Care to Older Adults, and content relevant to the gerontological nursing and adult-gerontological nurse practitioner certification exams. Although *Toward Healthy Aging* is written with baccalaureate and graduate students in mind, it also can be used in associate degree programs or as a reference for interprofessional care teams, care facilities, and nurses' libraries. The text makes an ideal supplement to health assessment, medical-surgical, community, and psychiatric and mental health textbooks in programs that do not have a freestanding gerontological nursing course.

ORGANIZATION OF THE TEXT

Toward Healthy Aging has 35 chapters, organized into 5 sections.

Section 1 begins with foundational information from demographics to long-term care structure. It includes information about the roles and responsibilities of contemporary gerontological nurses in making timely, sound, evidence-based clinical judgments to optimize wellness.

Section 2 provides the reader with foundational information needed to make clinical judgments to inform nursing actions. This section includes details about the cues nurses use to recognize and analyze maximize overall outcomes for older adults. This ranges from optimizing communication, to recognizing the cues needed for a comprehensive assessment, to ensuring safe medication use.

Section 3 provides information to enable nurses to recognize and prioritize functional needs that may be overlooked when caring for older adults, such as vision, physical activity, and safety and security. Prevention is emphasized to decrease the risk for unnecessary frailty, morbidity, mortality, and development of multidimensional geriatric syndromes.

Section 4 addresses the most common chronic disorders seen in later life. Content includes the recognition of cues, development of hypotheses, and nursing actions leading to optimal outcomes. The emphasis is on the interplay between the disorder, aging, and living with chronic disease.

Section 5 steps beyond health conditions and functional needs to consider the older adult within the greater context of relationships, ethical dilemmas, loss, and finding meaning in life.

KEY COMPONENTS OF THE TEXT

A Student Speaks/An Older Adult Speaks: Introduces every chapter to provide perspectives of older adults and nursing students on chapter content.

Using Clinical Judgment to Promote Healthy Aging: Special headings detailing pertinent cues, nursing actions, and outcomes.

Key Concepts: Concise review of important chapter points.

Clinical Judgment and Next-Generation NCLEX® Examination–Style Questions: Practice examples designed to assist students in the recognition of key cues, hypotheses, and the identification of essential nursing actions to maximize outcomes to ensure safety in care delivery.

Nursing Studies: Accompanying select chapters, these provide short nursing studies to help students see content put into practical use.

Critical Thinking Questions and Activities: Assist students in developing critical thinking related to chapter and nursing study content and include suggestions for in-classroom activities to enhance learning.

Research Questions: Suggestions to stimulate thinking about ideas for nursing research related to chapter topics.

Boxes: Key Essential Learning is Highlighted

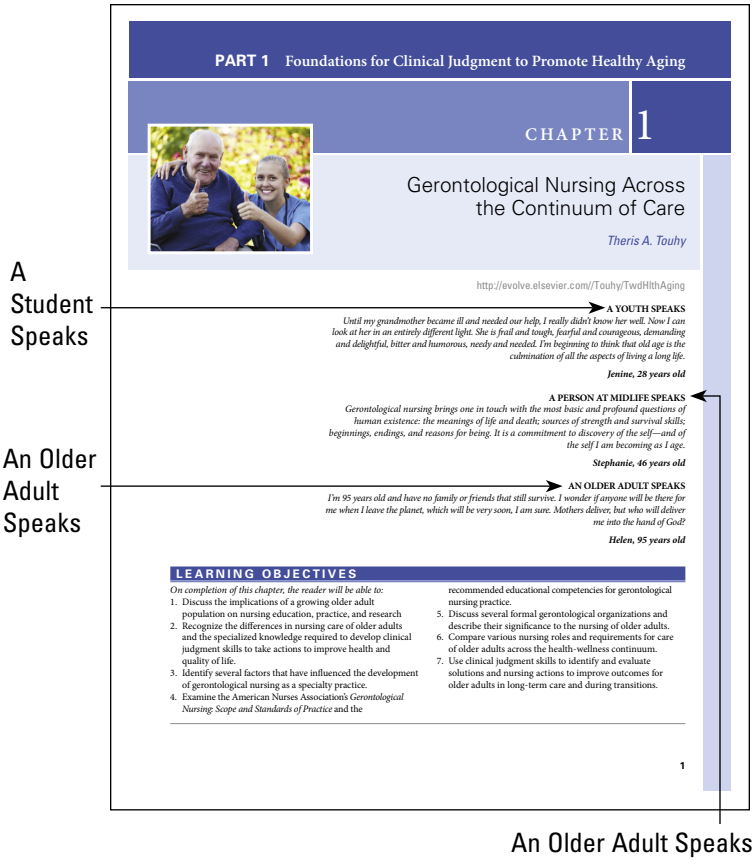
Safety Tips: Safety issues related to care of older adults.

Research Highlights: Summary of pertinent current research related to chapter topics.

Resources for Best Practice: Suggestions for further information for chapter topics and tools for practice.

Tips for Best Practice: Summary of evidence-based nursing actions for practice.

Healthy People 2030: Reference to the goals cited in *Healthy People 2030.*



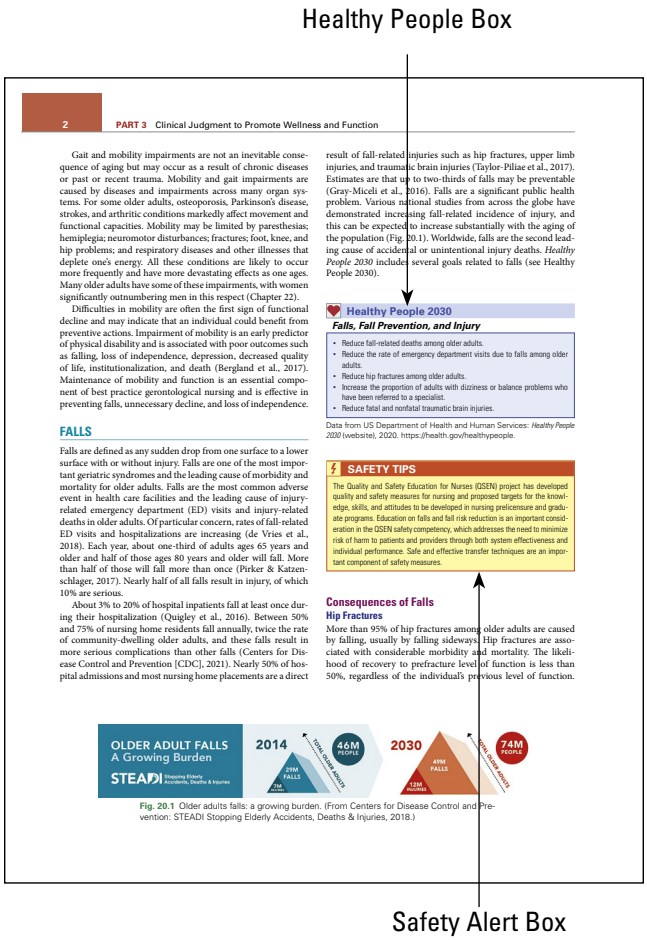


Fig. 20.1 Older adult falls: a growing burden. (From Centers for Disease Control and Prevention: STEADI Stopping Elderly Accidents, Deaths & Injuries, 2018.)

Research Highlights Box

Tips for Best Practice Box

RESEARCH HIGHLIGHTS

Original Research: Understanding the Hospital Experience of Older Adults With Hearing Impairment

Purpose

To assess the hospital experience of older adults with hearing impairment and to use findings to formulate suggestions for improving nursing care.

Method

Participants were 5 men and 3 women, ranging in age from 70 to 95 years, who had a self-reported hearing loss and were hospitalized in a large 600-bed hospital in the Midwest United States. Interviews were conducted, and each interview began with an open-ended question asking participants to share their experiences as hospitalized patients with hearing loss. As each person's story unfolded, additional questions that arose naturally were asked. Interviews were recorded, and field notes were taken. Data were analyzed, and themes were compiled representing the patients' hospital experiences.

Results

All the participants discussed communication barriers in the hospital setting, including reluctance to share hearing problems with staff, frustration and embarrassment related to misunderstanding conversation, and not wanting to inconvenience staff. Barriers to understanding included speech and unfamiliar accents, staff speaking too loudly, and difficulty hearing telephone conversations and conversations through the call system speakers. Several disclosed that they only revealed hearing problems to staff who showed concern about and interest in helping with communication difficulties. Some participants had left their hearing aids at home out of concern about loss and replacement costs.

Conclusion

Based on findings, the following primary nursing actions were identified to improve the hospital experiences of older adults with hearing impairments:

1. **Assess:** Bedside screening for hearing impairment; ask individual if there is a hearing impairment and about circumstances that make hearing difficult (e.g., background noise, unfamiliar accents). Discuss patient's preferred method for reducing barriers (e.g., using personal sound amplifiers, communicating with paper and pen or written materials) and include methods in plan of care.
2. **Accommodate:** Give ample time to establish trust and rapport. Provide accommodations such as a quiet setting, minimizing noise, and speaking clearly and slowly. Document helpful actions and share information during hand-offs. Provide adequate supplies of personal sound amplifiers.
3. **Educate:** Educate patients and families on key communication strategies and provide a handout outlining strategies. Explain the importance of using hearing-assistive devices while in the hospital.
4. **Empower:** Encourage active participation in care. Tell patients it is important to inform nursing staff if they have trouble hearing and what will help them.
5. **Advocate:** Advocate for system-wide education on hearing impairment in older adults. Provide staff education to promote awareness of the consequence of hearing deficits on care outcomes, hearing screening techniques, and communication strategies.

Data from Funk A, Garcia C, Mullen T: Original research: understanding the hospital experience of older adults with hearing impairment, *Am J Nurs* 118(6):28–34, 2018.

BOX 13.4 Tips for Best Practice

Communication Strategies to Improve Hearing

- Never assume hearing loss is from age until other causes are ruled out (infection, cerumen buildup).
- Inappropriate responses, inattentiveness, and apathy may be symptoms of a hearing loss.
- Face the individual, and stand or sit on the same level; do not turn away while speaking (e.g., face a computer).
- Determine if hearing is better in one ear than another, and position yourself appropriately.
- If hearing aid is used, make sure it is in place and batteries are functioning.
- Lower your tone of voice, articulate clearly, and use a moderate rate of speech.
- Use nonverbal approaches: gestures, demonstrations, visual aids, and written materials.
- Reduce background noise (e.g., turn off television, close door).
- Utilize assistive listening devices such as pocket talker.
- Verify that the information being given has been clearly understood. Be aware that the person may agree to everything and appear to understand what you have said even when he or she did not hear you (listener bluffing).
- If the person is in a hospital or nursing facility, label the chart, note on the intercom button, and inform all caregivers that the patient has a hearing impairment.
- Share resources for the hearing-impaired and refer as appropriate.

From Adams-Wendling L, Pimple C: Evidence-based guideline: nursing management of hearing impairment in nursing facility residents, *J Gerontol Nurs* 34(11):9–16, 2008.

TINNITUS

Tinnitus is defined as the perception of sound in one or both ears or in the head when no external sound is present. It is often referred to as "ringing in the ears" but also may manifest as buzzing, hissing, whistling, crickets chirping, bells, roaring, clicking, pulsating, humming, or swishing sounds. The sounds may be constant or intermittent and are more acute at night or in quiet surroundings. The most common type is high-pitched tinnitus with sensorineural loss; less common is low-pitched tinnitus with conduction loss, such as is seen in Ménière's disease. Tinnitus affects about 1 in 5 people.

Tinnitus is the number one service-related disability for US military personnel and veterans and is the leading cause of service-connected disability of veterans returning from Iraq or Afghanistan. Other high-risk groups include older adults; individuals employed in loud work environments; musicians and music lovers; motorsports and hunting enthusiasts; and individuals with depression, anxiety, and obsessive-compulsive disorder (American Tinnitus Association, 2019).

The exact physiological cause or causes of tinnitus are not known, but several likely factors are known to trigger or worsen tinnitus. Exposure to loud noises is the leading cause of tinnitus, and the exposure can damage and destroy cilia in the inner ear. Once damaged, the cilia cannot be renewed or replaced. Other possible causes of tinnitus include head and neck trauma, certain types of tumors, cerumen accumulation, jaw misalignment, cardiovascular disease, and ototoxicity from medications. More than 200 prescription and nonprescription medications list tinnitus as a potential side effect, aspirin being the most common.

There is some evidence that caffeine, alcohol, cigarettes, stress, and fatigue may exacerbate the problem, so lifestyle changes may be part of the plan of care. Tinnitus research

A family-centered, FFC intervention (Fam-FCC) incorporates an educational empowerment model for family caregivers that focuses on improving function during and after an acute care hospitalization. Outcomes of Fam-FCC include fewer 30-day hospital readmissions, less delirium severity, improved ADL performance, less decrease in walking ability, and an increase in preparedness for caregiving and less anxiety among family caregivers (Boltz et al., 2015). Box 19.2 includes information on FCC.

Key Concepts

KEY CONCEPTS

- Few factors contribute as much to health in aging as being physically active.
- Physical activity enhances health and functional status while also decreasing the number of chronic illnesses and functional limitations often assumed to be a part of growing older.
- Despite a large body of evidence about the benefits of physical activity to maintain and improve function, physical activity levels of older adults remain low and have not improved over the past decade.
- Components of a health assessment for older adults should include assessment of function and mobility. Exercise counseling should be provided as a part of that assessment.
- The benefits of physical activity extend to older adults who are more physically frail, those who are nonambulatory or experience cognitive impairment, and those residing in assisted living facilities or SNFs. In fact, these individuals may benefit most from an exercise program in terms of function and quality of life.
- Nursing actions to assist older adults to improve physical activity include evaluation of functional ability, mobility, level of activity, education, and exercise counseling.

NEXT-GENERATION NCLEX® (NGN) EXAMINATION–STYLE QUESTIONS

A 65-year-old male patient who was hospitalized 3 weeks prior for generalized weakness after an episode of dehydration has come to the health care provider's office today for a follow-up appointment. The patient, who arrived using a walker, reports adhering to discharge teaching and says, "I feel better than I did when I was in this hospital. I still don't feel great, but I think I'm on the right track." When asked to describe his daily activity routine, the patient says, "After breakfast, I sit in my chair and do some stretching of my arms and legs. I've been going outside a little bit each day. When I first went home from the hospital, I could only walk a few minutes before I was tired, even with my walker. Now I can walk twice a day for 10 minutes each, and I still use my walker so I won't fall. Next week I'm going to try to do three little walks with my walker. My wife also got me some of these little hand weights so when I sit down to watch TV, I do about 10 repetitions of lifting them up." The patient's wife says, "I am checking on him all day long and I always bring him a cup of water to drink every time I see him so that he stays hydrated." Assessment reveals a well-dressed and appropriately groomed older adult, temperature 98.9°F (37.2°C), blood pressure 122/70 mm Hg, respirations 18 breaths/minute, and moist mucous membranes,

Indicate whether today's assessment findings suggest that each item of posthospitalization discharge teaching by the nurse listed in the table below was effective or ineffective.

Discharge Teaching	Effective	Ineffective
Use a walker at all times to avoid falls		
Perform muscle-strengthening activities at least twice weekly		
Perform flexibility exercises at least twice weekly		
Work your way up to doing 10 minutes of activity three times daily		
Drink water before, during, and after activity		

Nursing Study

NURSING STUDY

Exercise and Activity

Tom, 75 years old, had lost his wife, Ella, a year ago and had been feeling down and tired for much of each day. He had retired at age 70 from his job as a housing contractor and had spent much of his time since then with Ella. They had been married for 50 years. He now sometimes seemed to sit in front of the television for most of the day without actually remembering what it was that he had viewed. Many of the couple's friends had moved away or relocated to retirement settings, and other than his daughter, who lived about 45 minutes from his house, Tom rarely saw anyone anymore. He had lived like this for nearly a year, and it had become his daily pattern of life. After a suggestion from his daughter, Tom took the initiative to go to the local senior center. He had lunch there nearly every day. At one point he was asked if he would allow a nursing student to spend time with him during her semester in a gerontology course. He agreed. In the course of her assessment, she (and he) found that his activity level was nearly completely sedentary. She gave Tom information about the ramifications of such a sedentary life. She pointed out that the center had an exercise class every day between 10:00 a.m. and 12 noon. Because he came to the center every day (except Saturday and Sunday) for lunch, it seemed a good thing to do. Tom said to the nursing student, "This isn't anything I am really interested in doing, but I will give it a try." Though he did not admit it, he was worried because he usually felt weak and listless during the day after lunch. When he did attend the first class, he found that there were both basic exercises and more advanced ones for older adults who had participated regularly for 6 months. He found that after a few weeks he was enjoying the social aspect of the exercise, if not the exercise itself. After nearly a year of fairly regular participation, Tom began playing golf with some of the men from the center. Once, he even attended a dance.

Resources for Best Practice Box

Bladder Diary ("Uro-Log")

Complete one form for each day for 4 days before your appointment with a health care provider. In order to keep the most accurate diary possible, you'll want to keep it with you at all times and write down the events as they happen. Take the completed forms with you to your appointment.

Your Name: _____

Date: _____

Time	Fluids		Foods		Did you urinate?		Accidents		
	What kind?	How much?	What kind?	How much?	How many times?	How much? (sm, med, lg)	Leakage How much? (sm, med, lg)	Did you feel an urge to urinate?	What were you doing at the time? Sneezing, exercising, etc.
Sample	Coffee	1 cup	Toast	1 slice	✓✓	med	sm	Yes (No)	Running
6-7 a.m.								Yes No	
7-8 a.m.								Yes No	
8-9 a.m.								Yes No	
9-10 a.m.								Yes No	
10-11 a.m.								Yes No	
11-12 noon								Yes No	
12-1 p.m.								Yes No	
1-2 p.m.								Yes No	
2-3 p.m.								Yes No	
3-4 p.m.								Yes No	
4-5 p.m.								Yes No	
5-6 p.m.								Yes No	
6-7 p.m.								Yes No	
7-8 p.m.								Yes No	
8-9 p.m.								Yes No	

Fig. 17.1 Bladder diary.

BOX 17.5 Resources for Best Practice

Assessing Continence: Video presentation of nurse conducting a continence assessment. https://www.youtube.com/watch?v=NHoZUFLEZs.
Catheter Out: Protocols, educational tools, toolkit. https://www.catheterout.org.
Continence Product Advisor: Impartial advice for continence product users and health care professionals. https://www.continenceproductadvisor.org/.
International Continence Society: Educational materials, product guide, research, advocacy. https://www.ics.org/.
National Association for Continence (NAC): Comprehensive site for information on urinary and fecal incontinence for caregivers, professional clinicians, and individuals. Includes educational materials, management and treatment, resources, product guides. https://www.nafc.org/.
Safe Care Campaign: Preventing health care–and community-associated infections: urinary tract infections. https://www.safecarecampaign.org/.
Simon Foundation for Continence: Educational materials, resources, and products. Stool diary and Bristol Stool Form Scale. https://simonfoundation.org/.

diary useful in assessment of continence. Information on a video of a nurse conducting an evaluation for transient UI and other resources related to continence can be found in Box 17.5. More extensive examinations are considered after the initial findings are evaluated. Individuals who do not fit a simple pattern for UI should be referred promptly for urodynamic assessment.

Solutions, Nursing Actions, and Outcomes

Nursing actions focus primarily on the appropriate evaluation of continence, teaching about treatments, and implementation and evaluation of supportive and therapeutic modalities to promote and restore continence and to prevent incontinence-related complications, such as skin breakdown. The nurse should share appropriate resources and explain clinical information and differences in treatment choices. An important nursing role is to provide education to caregivers about UI and strategies to assist in practical and effective management (Box 17.6). Supportive and therapeutic modalities to promote and restore continence are discussed in the following section.

Lifestyle Modifications

Several lifestyle factors have been associated with either the development or the exacerbation of UI. These include increased fluid intake, smoking cessation, bowel management, avoiding caffeine and alcohol, physical activity, and weight reduction (if identified as contributing to UI) (See Research Highlights box). Women with stress UI who undergo a 5% to 10% weight loss experience a positive impact on UI symptoms. This is most likely due to the effects of reduced abdominal weight, intraabdominal pressure, and intravesicular pressure (Vasavada et al., 2021). The benefits of weight loss in older adults who are frail is more complex (Chapter 15). Good diabetic control to manage the hyperglycemic symptoms of osmotic diuresis and constipation management are also important.

Clinical Judgment and Next-Generation NCLEX® Examination–Style Questions

NEXT-GENERATION NCLEX® (NGN) EXAMINATION–STYLE QUESTIONS

The nurse is completing the monthly nursing assessment of Mr. Dawson. Mr. Dawson is a 92-year-old male. He has been at the long-term care facility for the past 5 years. His weight this month is 300 pounds (BMI 26.6 kg/m^2). His blood pressure is 145/82 mm Hg, heart rate 90 beats per minute, respirations 18 breaths per minute, and temperature 97.4°F. He responds to questions appropriately. During the physical examination at 0900 hours, the nurse notes that Mr. Dawson is drooling and coughing intermittently. His upper dentures fall when he opens his mouth for evaluation. His lungs are clear on examination, and his heart has regular rhythm.

Choose the most likely options for the information missing from the statements below by selecting from the lists of options provided.

The nurse recognizes that ____1____, ____2____, and ____3____ put Mr. Dawson at increased risk of ____4____, and he should be ____5____ until the ____6____ is completed.

Options
Overnutrition
Swallowing evaluation
Depression
Coughing after eating
NPO
Dry mouth
Dysphagia
Copious secretions
Difficulty chewing
Occupational therapy

NURSING STUDY

Nutrition

Helen, 77 years old, had dieted all her life—or so it seemed. She often chided herself about it. "After all, at my age who cares if I'm too fat? I do. It depresses me when I gain weight and then I gain even more when I'm depressed." At 5 feet, 4 inches tall and 138 pounds, her weight was ideal for her height and age, but Helen, like so many women of her generation, had incorporated the image of women on TV who weigh 105 pounds as her ideal. She had achieved that weight for only a few weeks three or four times in her adult life. She had tried high-protein diets, celery and cottage cheese diets, fasting, commercially prepared diet foods, and numerous fad diets. She always discontinued the diets when she perceived any negative effects. She was invested in maintaining her general good health. Her most recent attempt at losing 30 pounds on an all-liquid diet had been unsuccessful and left her feeling constipated, weak, irritable, and mildly nauseated and experiencing heart palpitations. This really frightened her. Her physician criticized her regarding the liquid diet but seemed rather amused while reinforcing that her weight was "just perfect" for her age. In the discussion, the physician pointed out how fortunate she was that she was able to drive to the market, had sufficient money for food, and was able to eat anything with no dietary restrictions. Helen left his office feeling silly. She was an independent, intelligent woman; she had been a successful manager of a large financial office. Before her retirement 7 years ago, her work had consumed most of her energy. There had been no time for family, romance, or hobbies. Lately, she had immersed herself in reading the Harvard Classics, as she had promised herself she would when she retired. Unfortunately, now that she had the time to read them, she was losing interest. She knew that she must begin to "pull herself together" and "be grateful for her blessings" just as the physician had said.

Critical Thinking Questions and Activities

CLINICAL JUDGMENT QUESTIONS AND ACTIVITIES

Questions 1 to 5 refer to the Nursing Study above.

1. In the nursing study, discuss how you would counsel Helen regarding her weight.
2. If Helen insists on dieting, what diet would you recommend, considering her age and activity level?
3. What lifestyle changes would you suggest to Helen?
4. What are the specific health concerns that require attention in Helen's case?
5. What factors may be involved in Helen's preoccupation with her weight?
6. Choose one of the contributing factors to malnutrition and list nursing actions to reduce risk.
7. Assess your nutrition using the Nutrition Screening Initiative and discuss your score and risk.

Research Questions

RESEARCH QUESTIONS

1. What are the dietary patterns of older men living alone?
2. What percentage of women and men older than age 60 are satisfied with their weight?
3. What factors influence older adults to implement dietary changes suggested by nurses, dietitians, or primary care providers?
4. What nursing actions can enhance the nutritional intake of older adults who are frail and residing in nursing facilities?
5. What is the level of knowledge about dysphagia among acute care and long-term care nurses?

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Theris A. Touhy
Kathleen Jett

CONTENTS

CHAPTER 1

Gerontological Nursing Across the Continuum of Care

Theris A. Touhy

http://evolve.elsevier.com//Touhy/TwdHlthAging

A YOUTH SPEAKS

Until my grandmother became ill and needed our help, I really didn't know her well. Now I can look at her in an entirely different light. She is frail and tough, fearful and courageous, demanding and delightful, bitter and humorous, needy and needed. I'm beginning to think that old age is the culmination of all the aspects of living a long life.

Jenine, 28 years old

A PERSON AT MIDLIFE SPEAKS

Gerontological nursing brings one in touch with the most basic and profound questions of human existence: the meanings of life and death; sources of strength and survival skills; beginnings, endings, and reasons for being. It is a commitment to discovery of the self—and of the self I am becoming as I age.

Stephanie, 46 years old

AN OLDER ADULT SPEAKS

I'm 95 years old and have no family or friends that still survive. I wonder if anyone will be there for me when I leave the planet, which will be very soon, I am sure. Mothers deliver, but who will deliver me into the hand of God?

Helen, 95 years old

LEARNING OBJECTIVES

On completion of this chapter, the reader will be able to:

1. Discuss the implications of a growing older adult population on nursing education, practice, and research
2. Recognize the differences in nursing care of older adults and the specialized knowledge required to develop clinical judgment skills to take actions to improve health and quality of life.
3. Identify several factors that have influenced the development of gerontological nursing as a specialty practice.
4. Examine the American Nurses Association's *Gerontological Nursing: Scope and Standards of Practice* and the recommended educational competencies for gerontological nursing practice.
5. Discuss several formal gerontological organizations and describe their significance to the nursing of older adults.
6. Compare various nursing roles and requirements for care of older adults across the health-wellness continuum.
7. Use clinical judgment skills to identify and evaluate solutions and nursing actions to improve outcomes for older adults in long-term care and during transitions.

CARE OF OLDER ADULTS: A NURSING IMPERATIVE

Healthy aging is now an achievable goal for many. It is essential that nurses have the knowledge and skills to help people of all ages, races, and cultures to achieve this goal. Older adults today are healthier, are better educated, and expect a much higher quality of life as they age than did earlier generations. Enhancing health in aging requires attention to health throughout life, as well as expert care from nurses. Most nurses care for older adults during their careers, and estimates are that up to 75% of nurses' time is spent with older adults. In addition, the public will look to nurses to have the knowledge and skills needed to assist people to age in health. Every older adult should expect care provided by nurses with competence in gerontological nursing. Knowledge of aging and gerontological nursing is core knowledge for the profession of nursing.

The terms *geriatric nursing* and *gerontological nursing* are both used in the literature and in practice to describe the specialty of caring for older adults. Although both terms are used in the text, we prefer *gerontological nursing* because this reflects a more holistic approach encompassing both health and illness.

Who Will Care for an Aging Society?

By 2040, the number of older adults in the world will be at least 1.3 billion. The increase in the older adult population will far outpace growth in other age groups. It is a critical health and societal concern that gerontological nurses, other health professionals, and direct care workers be prepared to deliver care in all settings across the globe. The eldercare workforce is in shortage in most of the developed world, and the increased aging population is posing challenges for many countries to meet the expanding need for care services for older adults. Developing countries are experiencing the most rapid growth in numbers of older adults, and at the same time they lack systems of care and services.

The eldercare workforce shortage also presents a looming crisis for the 43.5 million unpaid family caregivers providing care for someone age 55 years or older. Without improvement in the eldercare workforce, even more stress will be placed on family and other informal caregivers. With smaller family sizes, the rising divorce rate, and the increase in geographical relocation, the next generation of older adults may be less able to rely on families for caregiving (Chapter 32). Will there be enough care workers to assist families in the care of loved ones?

In the United States, eldercare is projected to be the fastest growing employment sector in health care. Despite demand, the number of health care workers who are interested and prepared to care for older adults remains low (Institute of Medicine [IOM], 2008). Less than 1% of registered nurses (RNs) and less than 3% of advanced practice nurses (APNs) are certified in geriatrics. "We do not have anywhere close to the number of nurses we need who are prepared in geriatrics, whether in the field of primary care, acute care, nursing home care, or in-home care" (Christine Kovner, RN, PhD, FAAN, as cited in Robert Wood Johnson Foundation, 2013).

Geriatric medicine faces similar challenges, with about 7000 prepared geriatricians, 1 for every 2546 older Americans—and this number is falling, with the trend predicted to be less than 5000 geriatricians by 2040 (IOM, 2008). Other professions such as social work, physical therapy, and psychiatry have similar shortages. It is estimated that by 2030, nearly 3 million additional health care professionals and direct care workers will be needed to meet the care needs of a growing older adult population. *Healthy People 2030* has addressed this concern.

HEALTHY PEOPLE 2030

Older Adults Workforce

Increase the proportion of the health care workforce with geriatric certification.

Data from US Department of Health and Human Services, Office of Disease Prevention and Health Promotion: *Healthy People 2030* (website), 2020. https://health.gov/healthypeople.

DEVELOPMENT OF GERONTOLOGICAL NURSING

Historically, nurses have always been in the frontlines of caring for older adults. They have provided hands-on care, supervision, administration, program development, teaching, and research and to a great extent are responsible for the rapid advancement of gerontology as a profession. Gerontological nurses have made significant contributions to the body of knowledge guiding best practice care of older adults. Gerontological nursing has emerged as a circumscribed area of practice only within the past 6 decades. Before 1950, gerontological nursing was seen as the application of general principles of nursing to the older adult with little recognition of this area of nursing as a specialty similar to obstetric, psychiatric, or surgical nursing. Whereas most specialties in nursing developed from those identified in medicine, this was not the case with gerontological nursing because health care of the older adult traditionally was considered within the domain of nursing.

Gerontological nurses provide care in a number of settings (© iStock.com).

The foundation of gerontological nursing as we know it today was built largely by a small cadre of nurse pioneers, many

BOX 1.1 Reflections on Gerontological Nursing From Gerontological Nursing Pioneers and Current Leaders in the Field

Mary Opal Wolanin, Gerontological Nursing Pioneer

"I believe that one of the most valuable lessons I have learned from those who are older is that I must start with looking inside at my own thinking. I was very guilty of ageism. I believed every myth in the book, was sure that I would never live past my seventieth birthday, and made no plan for my seventies. Probably the most productive years of my career have been since that dreaded birthday, and I now realize that it is very difficult, if not impossible, to think of our own aging."
(From interview data collected by Priscilla Ebersole between 1990 and 2001.)

Terry Fulmer, President of The John A. Hartford Foundation

"I soon realized that in the arena of caring for the aged, I could have an autonomous nursing practice that would make a real difference in medical outcomes. I could practice the full scope of nursing. It gave me a sense of freedom and accomplishment. With older patients, the most important component of care, by far, is nursing care. It's very motivating."
(From Ebersole P, Touhy T: *Geriatric nursing: growth of a specialty,* New York, 2006, Springer, p 129.)

Jennifer Lingler, PhD, CRNP, Professor, Vice Chair for Research, Health and Community Systems, University of Pittsburgh

"When I was in high school, a nurse I knew helped me find a nursing assistant position at the residential care facility where she worked. That experience sparked my interest in older adults that continues today. I realized that caring for frail elders could be incredibly gratifying, and I felt privileged to play a role, however small, in people's lives. At the same time, I became increasingly curious about what it means to age successfully. I questioned why some people seemed to age so gracefully, while others succumbed to physical illness, mental decline, or both. As a Building Academic Geriatric Nursing Capacity (BAGNC) alumnus, I now divide my time serving as a nurse practitioner at a memory disorders clinic, teaching an ethics course in a gerontology program, and conducting research on family caregiving. I am encouraged by the realization that as current students contemplate the array of opportunities before them, seek counsel from trusted mentors, and gain exposure to various clinical populations, the next generation of geriatric nurses will emerge. And, I am confident that in doing so, they will set their own course for affecting change in the lives of society's most vulnerable members."
(As cited in Fagin C, Franklin P: Why choose geriatric nursing? Six nursing scholars tell their stories, *Imprint* 5[4]:72–76, 2005.)

of whom are now deceased. The specialty was defined and shaped by those innovative nurses who saw, early on, that older adults had special needs and required the most subtle, holistic, and complex nursing care. This history is similar to that of pediatric nursing and the recognition that pediatric nursing is "not med-surg nursing on little people" (Taylor, 2006, p. E128), and nurses need special skills to care for children. In examining the history of gerontological nursing, one must marvel at the advocacy and perseverance of nurses who have remained committed to improving the care of older adults despite struggling against great odds over the years. Box 1.1 presents the views of some of the geriatric nursing pioneers, as well as those of current leaders, on the practice of gerontological nursing and the reasons they are attracted to this specialty.

Nursing was the first of the professions to develop standards of gerontological care and the first to provide a certification mechanism to ensure specific professional expertise through credentialing. The most recent edition of *Gerontological Nursing: Scope and Standards of Practice* (American Nurses Association [ANA], 2018) provides a comprehensive overview of the scope of gerontological nursing, the skills and knowledge required to address the full range of needs related to the process of aging, and the specialized care of older adults as a group and as individuals. The document also identifies levels of gerontological nursing practice (basic and advanced) and standards of clinical gerontological nursing care and gerontological nursing performance. Box 1.2 presents some of the early history of gerontological nursing.

Current Initiatives

The most significant influence in enhancing the specialty of gerontological nursing has been the work of the Hartford Institute for Geriatric Nursing, established in 1996 and funded by the John A. Hartford Foundation. Initiatives in nursing education, nursing practice, nursing research, and nursing policy have addressed enhancement of geriatrics in nursing education programs through curricular reform and faculty development, creation of the National Hartford Center of Gerontological Nursing Excellence, predoctoral and postdoctoral scholarships for study and research in geriatric nursing, and clinical practice improvement projects to enhance care for older adults (http://www.hartfordign.org). The National Hartford Center of Gerontological Nursing Excellence offers a Distinguished Educator in Gerontological Nursing Program as well as Leadership Conferences on Aging. Another resource is Sigma Theta Tau's Center for Nursing Excellence in Long-Term Care, which sponsors the Geriatric Nursing Leadership Academy (GNLA) and offers a range of products and services to support the professional development and leadership growth of nurses who provide care to older adults in long-term care (LTC). Box 1.3 provides additional resources.

GERONTOLOGICAL NURSING EDUCATION

Essential educational competencies and academic standards for care of older adults have been developed by national organizations such as the American Association of Colleges of Nursing (AACN) for both basic and advanced nursing education. Comprehensive competencies and curricular guidelines for baccalaureate programs were published in 2010 by the AACN and the Hartford Institute of Geriatric Nursing. In addition, gerontological nursing competencies for advanced practice graduate programs have been developed. All of these documents can be accessed from the AACN website. There are also competencies for gerontological nursing educators published by the National Hartford Center of Gerontological Nursing Excellence (Skemp & Wyman, 2019). There has been some improvement in the

BOX 1.2 Highlights of Early History of Gerontological Nursing

1906 First article is published in *American Journal of Nursing* (AJN) on care of the elderly.
1925 AJN considers geriatric nursing as a possible specialty in nursing.
1950 Newton and Anderson publish first geriatric nursing textbook.
1966 American Nurses Association (ANA) creates the Division of Geriatric Nursing.
First master's program for clinical nurse specialists in geriatric nursing developed by Virginia Stone at Duke University.
1970 ANA establishes *Standards of Practice for Geriatric Nursing.*
1974 Certification in geriatric nursing practice offered through ANA; process implemented by Laurie Gunter and Virginia Stone.
1975 *Journal of Gerontological Nursing* published by Slack; first editor, Edna Stilwell.
1976 ANA begins certifying geriatric nurse practitioners.
Nursing and the Aged, edited by Burnside and published by McGraw-Hill.
1979 *Education for Gerontic Nursing,* written by Gunter and Estes; suggested curricula for all levels of nursing education.
1980 *Geriatric Nursing* first published by AJN; Cynthia Kelly, editor.
1983 Florence Cellar Endowed Gerontological Nursing Chair established at Case Western Reserve University, first in the nation; Doreen Norton, first scholar to occupy chair.
National Conference of Gerontological Nurse Practitioners established.
1984 National Gerontological Nurses Association established.
1989 ANA certifies gerontological clinical nurse specialists.
1992 Terry Fulmer of the John A. Hartford Foundation founds a major initiative to improve care of hospitalized older patients: Nurses Improving Care for Healthsystem Elders (NICHE). NICHE is an international nursing education and consultation program designed to improve geriatric care in health care organizations.
1996 John A. Hartford Foundation establishes the Institute for Geriatric Nursing at New York University under the direction of Mathy Mezey.
2007 Atlantic Philanthropies provides a grant of $500,000 to the American Academy of Nursing to improve care of older adults in nursing homes by improving the clinical skills of professional nurses (Nursing Home Collaborative).
American Association for Long-Term Care Nurses formed.
2008 *Research in Gerontological Nursing* launched by Slack Inc; Dr. Kitty Buckwalter, editor.
Institute of Medicine publishes *Retooling for an Aging America: Building the Health Care Workforce* report and addresses the need for enhanced geriatric competencies for the health care workforce.
Consensus Model for Advanced Practice Registered Nurses (APRN) Regulation: Licensure, Accreditation, Certification & Education designates adult-gerontology as one of six population foci for APRNs

BOX 1.3 Resources for Best Practice

American Association of Managed Care Nurses: Certification, educational resources. http://www.aamcn.org/
American Geriatrics Society: CoCare: HELP (formerly Hospital Elder Life Program): Model of hospital care designed to prevent both delirium and functional decline. https://help.agscocare.org/About_AGS_CoCare_program_help.
American Nurses Credentialing Center: Nursing Case Management Certification (CMGT-BC): https://www.nursingworld.org/our-certifications/nursing-case-management/.
American Nurses Credentiality Center: Geriatric Nursing Certification: https://www.nursingworld.org/our-certifications/gerontological-nurse/.
APRN Gerontological Specialist–Certified (GS-C) Exam: https://www.gapna.org/certification.
CARES Dementia-Friendly Hospitals: Online training program to improve care of individuals with dementia in acute care. https://hcinteractive.com/hospitals.
Case Management Society of America: Standards of practice, certification, educational resources. https://www.cmsa.org/.
Core Competencies for Gerontological Nurse Educators: https://www.nhcgne.org/core-competencies-for-gerontological-nursing-excellence.
End of Life Nursing Education Consortium (ELNEC): Education programs for end-of-life care. https://www.aacnnursing.org/ELNEC.
Hartford Institute for Geriatric Nursing: Try This Series: assessment tools for best practices of care for older adults. https://hign.org/consultgeri-resources/try-this-series.
Hospice & Palliative Nurses Association: Education, research, certification examination (Certified Hospice and Palliative Nurse). https://advancingexpertcare.org/.
National Hartford Center of Gerontological Nursing Excellence: https://www.nhcgne.org/.
National Hospice and Palliative Care Organization: https://www.nhpco.org/.

amount of geriatrics-related content in nursing school curricula, but it is still uneven across schools and hampered by lack of faculty expertise in the subject.

The vast majority of schools have no faculty members certified in gerontological nursing by the American Nurses Credentialing Center. There is a critical need for nurses with master's and doctoral preparation and expertise in the care of older adults to assume faculty roles. Most schools still do not have freestanding courses in the specialty that are similar to courses in maternal/child or psychiatric nursing. This means that a substantial number of graduating nurses have not had the education needed to competently meet the needs of the burgeoning number of older adults for whom they will care. "In the past, nursing education has been dogged about assuring that every student has the opportunity to attend a birth, but has never insisted that every student have the opportunity to manage a death, even though the vast majority of nurses are more

likely to practice with clients who are at the end of life" (AACN, 2007, p. 7). Best-practice recommendations for nursing education include provision of a stand-alone course, as well as integration of content throughout the curriculum so that care of older adults is valued and considered an integral part of nursing care.

Curriculum and clinical experiences have to be inspirational and so do faculty and clinical mentors teaching students.

Care of older adults now covers a 50-year span of ages 60 to 110 and older, so there need to be practice experiences in a variety of settings, including the community and LTC (Kydd et al., 2014). Experiences with well older adults in the community and opportunities to focus on health promotion should be the first experience for students. This will assist them to develop more positive attitudes, understand the full scope of nursing practice with older adults, and learn nursing responses to enhance health and wellness. Practice in rehabilitation centers, subacute and skilled nursing facilities (SNFs), and hospice settings is suited for more advanced students and provides opportunities for leadership experience, nursing management of complex problems, interprofessional teamwork, and research application (Sherman & Touhy, 2017).

ORGANIZATIONS DEVOTED TO GERONTOLOGY RESEARCH AND PRACTICE

The Gerontological Society of America (GSA) demonstrates the need for interdisciplinary collaboration in research and practice. The divisions of Biological Sciences, Health Sciences, Behavioral and Social Sciences, Social Research, Policy and Practice, and Emerging Scholar and Professional Organization include individuals from myriad backgrounds and disciplines who affiliate with a section based on their particular function rather than their educational or professional credentials. Nurses can be found in all sections and occupy important positions as officers and committee chairs in the GSA.

This mingling of the disciplines based on practice interests is also characteristic of the American Society on Aging (ASA). Other interdisciplinary organizations have joined forces to strengthen the field. The Association for Gerontology in Higher Education (AGHE) has partnered with the GSA, and the National Council on Aging (NCOA) is affiliated with the ASA. These organizations and others have encouraged the blending of ideas and functions, furthering the understanding of aging and the interprofessional collaboration necessary for optimal care. International gerontology associations, such as the International Federation on Ageing and the International Association of Gerontology and Geriatrics, also have interdisciplinary membership and offer the opportunity to study aging internationally.

Organizations specific to gerontological nursing include the National Gerontological Nursing Association (NGNA), Gerontological Advanced Practice Nurses Association (GAPNA), National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC) (also includes assisted living RNs and licensed practical/vocational nurses [LPNs/LVNs] as associate members), American Association of Directors of Nursing Services (AADNS), American Assisted Living Nurses Association (AALNA), and Canadian Gerontological Nursing Association (CGNA).

RESEARCH ON AGING

Inquiry into and curiosity about aging is as old as curiosity about life and death itself. Gerontology began as an inquiry into the characteristics of long-lived people, and we are still intrigued by them. Anecdotal evidence was used in the past to illustrate issues assumed to be universal. Only in the past 60 years have serious and carefully controlled research studies on aging flourished. The impact of disease morbidity and impending death on the quality of life and the experience of aging have provided the impetus for much of the study by gerontologists. Much that has been thought about aging has been found to be erroneous, and early research was conducted with older adults who were ill. As a result, aging has been inevitably seen through the distorted lens of disease. However, we are finally recognizing that aging and disease are separate entities, although frequent companions.

Aging has been seen as a biomedical problem that must be reversed, eradicated, or controlled for as long as possible. The trend toward the medicalization of aging has influenced the general public as well. The biomedical view of the "problem" of aging is reinforced on all sides. A shift in the view of aging to one that centers on the potential for health, wholeness, and quality of life, and the significant contributions of older adults to society, is increasingly the focus in research, popular literature, the public portrayal of older adults, and the theme of this text.

The National Institute on Aging (NIA), National Institute of Nursing Research (NINR), National Institute of Mental Health (NIMH), and Agency for Healthcare Research and Quality (AHRQ) continue to make significant research contributions to our understanding of older adults. Research and knowledge about aging are strongly influenced by federal bulletins that are distributed nationwide to indicate the type of research most likely to receive federal funding. These are published in requests for proposals (RFPs). Ongoing and projected budget cuts are of concern in the adequate funding of aging research and services in the United States.

Nursing Research

Nursing research draws from its own body of knowledge, as well as from other disciplines, to describe, monitor, protect, and evaluate the quality of life while aging and the services more commonly provided to the aging population, such as hospice care. Nurses have generated significant research on the care of older adults and have established a solid foundation for the practice of gerontological nursing. Research with older adults receives considerable funding from the NINR, and its website (http://www.ninr.nih.gov) provides information about results of studies and funding opportunities. Gerontological nurse researchers publish in many nursing journals and journals devoted to gerontology, such as *The Gerontologist* and *Journal of Gerontology* (GSA), and there are several gerontological nursing journals, including *Journal of Gerontological Nursing, Research in Gerontological Nursing, Geriatric Nursing,* and the *International Journal of Older People Nursing.*

Knowledge about aging and the lived experience of aging has changed considerably and will continue to change in the future. Past ideas and current practices will not be acceptable to present and current cohorts of older individuals. Nursing research will continue to examine the best practices for care of older adults who

BOX 1.4 Suggestions for Gerontological Nursing Research

- Staffing patterns and the most appropriate staffing mix to improve care outcomes in long-term care settings
- Strategies to increase preparation in gerontological nursing and increase recruitment into the specialty
- Gay, lesbian, bisexual, transgender couples, families, and relationships
- Dementia as a chronic illness and staying well with the disease
- Interventions for drug and alcohol abuse and mental health problems of current and future generations of older adults
- Integration of current best practice protocols into settings across the continuum in cost-effective and care-efficient models
- Health promotion and illness management interventions in the assisted living setting; role of professional nurses and advanced practice nurses in this setting
- Development of models for end-of-life care in the home and nursing home
- Aging in developing countries
- Older adults in the context of natural disaster management

are ill and living in institutions, but increasing emphasis will be placed on strategies to maintain and improve health while aging. In 2021, Young stressed the critical need for gerontological nursing research to address: "1) the growing heterogeneity of older adults with three generations older than 65 with a wide range of priorities, strengths, and abilities; 2) the growing diversity of the aging population, with increases in the proportion of Latinx, African American, and LGBTQ older adults; and 3) the invisible family workforce of caregivers who provide the majority of long-term care for older adults" (Young, 2021, p. 2) (Chapter 32).

Other research priorities include a focus on community and home care resources, primary and acute care provided to older adults, improving quality of life for individuals with chronic illness, end-of-life and palliative care, translational research, interprofessional studies, and societal and policy issues affecting older adults. The urgent need for gerontological nursing research has been amplified by the "triple pandemic of COVID-19, racism, and ageism. The pandemic has revealed health inequities and systemic racism. The pandemic has also prompted a faster pace of change and invention, as communities, health systems, and academic settings respond to new demands" (Young, 2021, p. 2). Schutte (2020) suggests the following goals for a research agenda focused on the health of older adults during the COVID-19 pandemic: (1) mitigating harms during the expected ongoing waxes and wanes of the current pandemic; and (2) preventing harm in future large-scale disruptions (whether infectious disease outbreaks, natural disasters, or other rapid change). Other suggestions for nursing research are provided in Box 1.4.

GERONTOLOGICAL NURSING ROLES

Gerontological nursing roles encompass every imaginable venue and circumstance. The opportunities are limitless because we are a rapidly aging society. Specialized knowledge in gerontological nursing is essential for nurses to fulfill these emerging roles. In 2019, the National Council of State Boards of Nursing (NCSBN) identified the need to enhance the clinical judgment skills of entry-level nurses, and the National Council Licensure Examination (NCLEX) will be modified toward a greater focus on clinical judgment. Using the NCSBN Clinical Judgment Measurement Model and Action Model, our emphasis in the text is on use of the six cognitive skills identified as essential for nurses to make appropriate clinical judgment in the care of older adults: Recognize Cues, Analyze Cues, Prioritize Hypotheses, Generate Solutions, Take Action, Evaluate Outcomes.

The Essentials: Core Competencies for Professional Nursing Education (AACN, 2021) identifies clinical judgment as one of the key attributes of professional nursing. Clinical judgment refers to the process by which nurses make decisions based on nursing knowledge (evidence, theories, ways or patterns of knowing), other disciplinary knowledge, critical thinking, and clinical reasoning (Manetti, 2019). This process is used to understand and interpret information in the delivery of care. Clinical decision making based on clinical judgment is directly related to care outcomes.

Increasing client age and acuity, as well as changes in health care, make this especially important for nurses who care for older adults. The dearth of curricular content, as well as inadequate faculty preparation and interest in care of older adults, makes improvement of clinical judgment skills in the care of older adults challenging. Older adults are complex, and their responses to illness may not meet standard diagnostic criteria and are often missed, leading to unnecessary disability, complications, and quality-of-life issues. Nurses are key to recognizing and analyzing cues and taking action to improve outcomes of care. The text provides comprehensive information to guide the development of competent clinical judgment in nursing practice with older adults across the continuum of care.

Gerontological nursing is important in our rapidly aging society. (© iStock.com/DianaHirsch.)

A gerontological nurse may be a generalist or a specialist. The generalist functions in a variety of settings (primary care, acute care, home care, post–acute and LTC, and the community), providing nursing care to individuals and their families. National certification as a gerontological nurse is a way to demonstrate one's special knowledge in the care of older adults and should be encouraged (https://www.nursingworld.org/our-certifications/gerontological nurse/#:~:text=The%20ANCC%20Gerontological%20Nursing%20board,specialty%20after%20initial%20RN%20licensure) (see Box 1.3). The gerontological nursing specialist has advanced

preparation at the master's level and performs all the functions of a generalist but has developed advanced clinical expertise as well as an understanding of health and social policy and proficiency in planning, implementing, and evaluating health programs.

Specialist Roles

Under the Consensus Model for APRN Regulation, advanced practice registered nurses (APRNs) must be educated, certified, and licensed to practice in a role and a population. APRNs are educated in one of four roles, one of which is adult–gerontology. This population focus encompasses individuals from age 13 years (adolescent) to older adults. Titles of APRNs educated and certified across both areas of practice include Adult–Gerontology Acute Care Nurse Practitioner, Adult–Gerontology Primary Care Nurse Practitioner, and Adult–Gerontology Clinical Nurse Specialist. Certification is available for all these levels of advanced practice; in most states this is a requirement for licensure. The APRN Gerontological Specialist–Certified (GS-C) is also available to APRNs and recognizes expertise at the proficient level in managing complex older adults (see Box 1.3).

Advanced practice nurses with certification in adult–gerontology will find a full range of opportunities for collaborative and independent practice both now and in the future. Direct care sites include geriatric and family practice clinics, LTC, acute care and post–acute care facilities, home health care agencies, hospice agencies, continuing care retirement communities, assisted living facilities, managed care organizations, and specialty care clinics (e.g., Alzheimer's disease, heart failure, diabetes). Gerontological nursing specialists are also involved with community agencies such as local Area Agencies on Aging, public health departments, and national and worldwide organizations such as the Centers for Disease Control and Prevention and the World Health Organization. They function as care managers, eldercare consultants, educators, and clinicians.

One of the most important advanced practice nursing roles that emerged over the last 40 years is that of the gerontological nurse practitioner (GNP) and the gerontological clinical nurse specialist (GCNS) in SNFs. Nurse practitioners have been providing care in nursing homes in the United States since the 1970s, in Canada since 2000, and only recently in the United Kingdom. Recommendations from expert groups in the United States and Canada have called for a nurse practitioner in every nursing home, but numbers remain small and there is a need for continued attention at the policy and funding level for increased use of nurse practitioners with expertise in the care of older adults in LTC settings (Chapter 6). This role is well established, and there is strong research to support the impact of advanced practice nurses working in LTC settings (Campbell et al., 2019, 2020) (Box 1.5).

An encouraging trend is that the number of doctors and advanced practitioners in the United States who focus on providing care to individuals in skilled care facilities is increasing. The skilled nursing facility (SNF) provider is similar to the hospitalist role in acute care. This suggests the rise of a significant new specialty in medical and nursing practice that will affect patient outcomes. The Society for Post-Acute and Long-Term Medicine provides educational programs for this role (Morley, 2017).

BOX 1.5 Outcomes of Advanced Practice Nurse Working in Long-Term Care Settings

- Improvement in or reduced rate of decline in incontinence, pressure ulcers, aggressive behavior, and loss of affect in cognitively impaired residents
- Lower use of restraints with no increase in staffing, psychoactive drug use, or serious fall-related injuries
- Improved or slower decline in some health status indicators, including depression
- Improvements in meeting personal goals
- Lower hospitalization rates and costs
- Fewer emergency department visits and costs
- Improved satisfaction with care

Data from Ploeg J, Kaasalainen S, McAiney C, et al: Resident and family perceptions of the nurse practitioner role in long term care settings, *BMC Nurs* 12(1):24, 2013; Campbell T, Bayly M, Peacock S: Provision of resident-centered care by nurse practitioners in Saskatchewan long-term care facilities: qualitative findings form a mixed methods study, *Res Gerontol Nurs* 13(2):73–81, 2020.

Generalist Roles

Acute Care

Older adults often enter the health care system with admissions to acute care settings. Older adults comprise 60% of the medical-surgical patients and 46% of the critical care patients. Acutely ill older adults frequently have multiple chronic conditions and comorbidities and present many challenges. Hospitals can be dangerous for older adults. Despite almost two decades of research to counter harmful iatrogenic problems, iatrogenic complications occur in as many as 29% to 38% of hospitalized older adults, a rate three to five times higher than that seen in younger patients (Inouye et al., 2000; Parke & Hunter, 2014). Thirty-four percent of Medicare patients who were hospitalized experienced functional decline resulting in readmission (AARP, 2021). Older adults may be admitted for heart failure or pneumonia, and during their stay the condition improves; however, the person who came in walking and able to perform activities of daily living on their own often leaves unable to function (Box 1.6) (Chapter 19). In most cases, iatrogenic complications can be prevented.

Common iatrogenic complications associated with hospitalization include functional decline, pneumonia, delirium, new-onset incontinence, malnutrition, pressure ulcers, medication reactions, and falls. Many of these are geriatric syndromes that require prevention and treatment to prevent untoward consequences for older adults. The geriatric syndromes (also called geriatric giants) are discussed in Chapter 8 and in Chapters 12 to 20.

Older adults with dementia have higher rates of hospitalizations compared to their age-matched counterparts without dementia and have worse outcomes and longer hospital stays, resulting in higher costs of care than for patients without dementia (Fogg et al., 2018). Acute care hospitals generally are not equipped to provide best care to individuals with dementia (Chapter 26; Healthy People 2030 box). The CARES Dementia-Friendly Hospitals program provides dementia training in acute care settings. The online program consists of 16 video-based modules that include real-life video footage illustrating the effects of common and best practices to improve care of individuals with dementia in the acute care setting (see Box 1.3). All acute care

BOX 1.6 Example: The Spiral of Iatrogenesis

An 84-year-old man lives alone and has no family. He has osteoarthritis and hypertension and wears bilateral hearing aids and glasses for reading. He is independent in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and takes care of his small home. He avidly reads the newspaper, watches sports, drives, and participates in a water aerobics class at the local YMCA. He is admitted to the hospital after a fall on the sidewalk in front of his home. Neighbors called an ambulance, and he was admitted through the emergency department (ED). X-rays revealed no fractures, but he has pain in the left leg and in his back. Unfortunately, he was not wearing his hearing aids when admitted, so communication has been problematic. He often appears distracted and does not always respond readily.

He was unable to participate in the brief cognitive assessment and has been labeled confused on the chart. He has been agitated at night and not sleeping, so a benzodiazepine was ordered. An indwelling catheter was inserted in the ED, and he is being given narcotics for pain. Oral intake is poor, and he has not had a bowel movement in the 3 days since admission. He has been maintained on bedrest and identified as a high fall risk. When the catheter is removed, he is unable to hold his urine and is placed in adult briefs. His mental status has deteriorated further, and he is dehydrated, in a negative caloric balance, incontinent, and constipated. He is unable to ambulate and is considered unsafe to return home, so plans are being made to discharge him to an assisted living facility.

facilities need to have education, training, and institutional support for improving care of individuals with dementia (Hobday et al.,2017; Murray et al., 2019; Yates et al., 2018). *Healthy People 2030* addressed acute care of individuals with dementia.

HEALTHY PEOPLE 2030

Older Adults: Dementias

Reduce the proportion of preventable rehospitalizations in older adults with dementia

Data from US Department of Health and Human Services, Office of Disease Prevention: *Healthy People 2030* (website), 2020. https://health.gov/healthypeople.

Recognizing the impact of iatrogenesis, both on patient outcomes and on the cost of care, the Centers for Medicare and Medicaid Services (CMS) has instituted changes that will reduce payment to hospitals relative to these often-preventable outcomes (https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/hospital-acquired_conditions.html). The changes target hospital-acquired conditions (HACs) that are high cost or high volume, result in a higher payment when present as a secondary diagnosis, are not present on admission, and could have reasonably been prevented through the use of evidence-based guidelines. Targeted conditions include several of the common geriatric syndromes, such as catheter-associated urinary tract infections, pressure ulcers, and falls.

To improve acute care of older adults, it is essential that all health care professionals (hospitalists, primary care providers, members of the interprofessional team, and nurses) are knowledgeable about care of older adults. "Acute care nursing specialty knowledge alone is not enough to ensure quality hospital care for older adults. Important nursing care actions are overlooked when gerontological expertise is absent from medical and surgical inpatient units. Acute care nursing of older adults must reflect a sense of responsibility for functional outcomes, not just carrying out interventions associated with biomedical concerns. Nursing care of hospitalized older adults requires integration of acute care specialty knowledge with gerontological nursing knowledge and skill" (Parke & Hunter, 2014, pp. 1574, 1579).

Roles for nurses caring for older adults in hospitals include direct care provider, care manager, discharge planner, care coordinator, transitional care, and leadership and management positions. Many acute care hospitals are adopting new models of geriatric and chronic care to meet the needs of older adults and maintain cognitive and physical function when hospitalized. These include geriatric emergency departments and specialized units such as acute care for the elderly (ACE), geriatric evaluation and management (GEM) units, and transitional care programs. These new models of care have been successful in coordinating care, maintaining physical and cognitive function, preventing iatrogenesis, and reducing the risk of delirium (Chapter 26). The American Geriatrics Society CoCare: HELP (formerly Hospital Elder Life Program) is a well-studied, effective, and innovative model of hospital care designed to prevent both delirium and functional decline. The program provides a successful intervention geared toward helping older adults maintain cognitive and physical functioning that includes early mobilization with walking and exercises (Lach, 2021) (see Box 1.3).

ACE units are distinct areas of a hospital specifically designed to reduce the incidence of functional disability of older adults occurring during hospitalization for acute medical illness (Palmer, 2018) by proactively identifying and managing geriatric syndromes to help maintain the patient's function (Box 1.7). Three randomized clinical trials and systematic review of ACE or related interventions demonstrate reduced functional disability, reduced risk of nursing home admission, and lower costs of hospitalizations. ACE principles could improve care of older adults

BOX 1.7 Characteristics of Acute Care for the Elderly (ACE) Units

- Patient-centered as opposed to disease-centered care
- Comprehensive geriatric assessment with emphasis on functional abilities
- Transition planning from beginning of a patient's stay
- Involvement of patient and all caregivers from physicians to family in care planning
- Interdisciplinary teams (geriatrician, nurse coordinator, nurses, physical and occupational therapists, pharmacists, dietitians, social workers) making daily rounds
- Environmental modifications such as handrails in patient rooms, bathrooms, hallways; contrasting colors to aid people with vision loss and other safety features
- Promotion of self-care activities
- Homelike atmosphere, common rooms where patients can gather to socialize and engage in cognitive stimulation and therapeutic activities

Data from Cowan-Lincoln M: *10 things geriatricians want hospitalists to know* (website), 2015. https://www.the-hospitalist.org/hospitalist/article/122103/10-things-geriatricians-want-hospitalists-know; Palmer R: The acute care for elders unit model of care, *Geriatrics* 3(3):59, 2018.

in any acute setting, and future designs of medical units for older adults should resemble the ACE unit (Palmer, 2018).

Other initiatives include Nurses Improving Care for Health-system Elders (NICHE), a program developed by the Hartford Geriatric Nursing Institute in 1992 and designed to improve outcomes for hospitalized older adults (http://www.nicheprogram.org). NICHE-LTC recently was developed to enhance quality of care delivered to older adults in long-term and residential care facilities and is designed around the CMS Five-Star Quality Rating System (Greenberg et al., 2018) (Chapter 6). NICHE offers many opportunities for new roles for acute and LTC nurses, such as the geriatric resource nurse (GRN). The GRN role emphasizes the pivotal role of the bedside nurse in influencing outcomes of care and coordination of interprofessional activities. NICHE-LTC also uses certified geriatric nursing assistant roles to promote geriatric expertise among front-line staff. These types of initiatives will increase the need for well-prepared geriatric professionals working in interprofessional teams to deliver needed services.

Community-Based and Home-Based Care

Nurses will care for older adults in hospitals and LTC facilities, but the majority of older adults live in the community. Care will continue to move out of hospitals and LTC institutions into the community because of rapidly escalating health care costs and the person's preference to "age in place" (Chapter 21). Community-based care occurs through home and hospice care provided in persons' homes, independent senior housing complexes, retirement communities, residential care facilities such as assisted living facilities, hospice facilities, and adult day health centers. It also takes place in primary care clinics and public health departments.

Nurses in the home setting provide comprehensive assessments, including physical, functional, psychosocial, family, home, environmental, and community assessments. Care management and working with interprofessional teams are integral components of the home health nursing role. Nurses may provide and supervise care for older adults with a variety of care needs (including chronic wounds, intravenous therapy, tube feedings, unstable medical conditions, and complex medication regimens) and for those receiving rehabilitation and palliative and hospice services. Hospice care is provided in residential hospices, long-term and skilled facilities, and acute inpatient hospice units. However, most hospice care is provided in the individual's home.

Nurses are leaders in hospice care and assume roles as team leaders and direct caregivers. It is a very rewarding role, and the ability to form caring relationships with patients and families, similar to nursing in LTC settings, is a rewarding component of hospice nursing practice. Nurses described "working with the dying as an honour, as life affirming, and as encouraging them to appreciate their own lives more fully" (Ingebretsen & Sagbakken, 2016). However, nursing education in palliative care is limited, and this lack of education can be a source of moral distress for nurses working with individuals who are dying (Wolf et al., 2019). Schools of nursing must increase education and practice experiences for nursing students in home- and community-based care as well as hospice and palliative care (Research Highlights A box). Chapter 34 discusses hospice and palliative care in greater depth.

RESEARCH HIGHLIGHTS A

Palliative Care and Moral Distress: An Institutional Survey of Critical Care Nurses

Purpose

To examine critical care nurses' perceived knowledge of palliative care, their recent experiences of moral distress, and possible relationships between these variables.

Method

The Palliative Care Competencies of Registered Nurses survey and the Moral Distress Thermometer instrument were mailed to 517 critical care nurses across 17 intensive care units at an academic health center.

Results

One hundred and sixty-seven completed questionnaires were analyzed. Age of respondents were 22 to 35 years, with fewer than 5 years of nursing practice experience. Most respondents perceived palliative care as a highly important competency but fewer than 40% of respondents reported being highly competent in any palliative care domain. Most had little palliative care education, and most reported moral distress during the study period.

Conclusions

Many critical care nurses do not feel prepared to provide palliative care and experience moral distress when palliative care is perceived as inadequate. Palliative care education must be provided to nursing students and practicing nurses to reduce barriers to palliative care.

Data from Wolf A, White K, Epstein E, et al: Palliative care and moral distress: an institutional survey of critical care nurses, *Crit Care Nurse* 39(5):38–48, 2019.

Case management and care management roles. Nurses are especially well suited for roles as case managers and care managers. There are increasing opportunities for these roles both in the care of individuals with chronic illnesses and in transitional care (discussed later in the chapter). Although the terms *case manager* and *care manager* have slightly different connotations, in practice the roles are seldom that clear and there is much overlap. Both roles include that of advocate, broker, leader, manager, counselor, negotiator, administrator, and communicator. Ideally the care manager follows the person through the entire continuum of care. Care managers must be experts regarding community resources and understand how these can best be used to meet the person's needs. They are expected to make appropriate referrals within the person's expectations and abilities and to monitor the quality of arranged services. The care or case manager is a resource person whom the older adult or caregiver can seek out for advice and counsel and for brokering (negotiating, arranging) the flow of services. As a gatekeeper, the care or case manager controls the entrances and exits to services to make sure that the individual gets what is needed without wasting resources.

Care managers usually are paid privately. Those who cannot afford the out-of-pocket expenses of purchased care management services must rely on services available through Medicaid-managed care plans or nonprofit community agencies, such as Catholic Senior Services, if available. Access to publicly funded programs varies by state and areas within the state and

is dependent on state, county, and agency budgets and priorities. Hospitals, SNFs, and insurance agencies also use care or case managers. Care that is well managed is believed to be a solution to both the spiraling costs and the fragmentation of care often experienced by older individuals with multiple needs. The care manager works to optimize the resources and outcome for the client and the agency or community in which the person resides. Standards of Practice and certifications are available for care or case manager roles (see Box 1.3).

Certified Nursing Facilities

Certified nursing facilities, commonly called nursing homes, have evolved into a significant location where health care is provided across the continuum, part of long-term and postacute care (LTPAC) services. The old image of nursing homes caring for older adults in a custodial manner is no longer valid. Today, most facilities have postacute care units that more closely resemble the general medical-surgical hospital units of the past. Postacute care in nursing facilities will continue to grow with health care reform, and many new roles and opportunities for professional nursing exist in this setting (Chapter 6).

Roles for professional nursing include nursing administrator, manager, supervisor, charge nurse, educator, infection control nurse, Minimum Data Set (MDS) coordinator (Chapter 9), case manager, transitional care nurse, quality improvement coordinator, and direct care provider. Professional nurses in nursing facilities must be highly skilled in the complex care concerns of older adults, ranging from postacute care, to rehabilitation, to end-of-life care. The nurse in this setting needs specialized knowledge to be able to recognize and analyze the complexity of cues unique to individuals and families in this setting. Excellent assessment skills; ability to work with interprofessional teams in partnership with residents and families; skills in acute, rehabilitative, and palliative care; and leadership, management, supervision, and delegation skills are essential.

Practice in this setting requires independent decision making and is guided by a nursing model of care because fewer physicians and other professionals are on-site at all times. In addition, stringent federal regulations governing care practices and greater use of licensed practical nurses and nursing assistants influence the role of professional nursing in this setting. Many new nurses will enter this setting upon graduation, so it is essential to provide education and practice experiences, particularly leadership and management skills, to prepare them to function independently in this setting. The opportunity to form long-term relationships with individuals and families is valued by nurses and cited as one of the most rewarding aspects of practice in LTC facilities (Box 1.8). LTC and home-based care share similar role responsibilities and rewards for nurses. Chapter 6 provides in-depth information on LTC.

BOX 1.8 Caring Nurse and Resident Relationships in Long-Term Care (LTC)

"The residents become our friends and surrogate family. Nowhere else in healthcare are relationships formed the way they are in LTC. I would say that we have more value for our residents as people and patients than they are given elsewhere in healthcare."

From Sherman R, Touhy T: Unpublished data from a study of nurse leader challenges and opportunities in nursing home settings, 2017.

NURSING ROLES IN TRANSITIONS OF CARE ACROSS THE CONTINUUM

Care transition refers to the movement of patients from one health care practitioner or setting to another as their condition and care needs change. Older adults may have complex health care needs and often require care in multiple settings across the health-wellness continuum. This makes them and their families and/or caregivers vulnerable to poor outcomes during transitions. Despite efforts to streamline care transitions, the journey from hospital to home remains hazardous and frustrating for many patients and caregivers (Mitchell et al., 2018). An older adult may be treated by a family practitioner or internist in the community and by a hospitalist and specialists in the hospital; discharged to a postacute care setting and followed by another practitioner; and then discharged home or to a less care-intensive setting (e.g., assisted living facilities, residential care settings) where their original providers may or may not resume care.

The lack of coordinated care often contributes to serious consequences and frequent readmissions. Approximately 1 in 4 patients experiences an adverse event from medical mismanagement within 3 weeks of discharge from the hospital; 66% of those events are drug related (Jusela et al., 2017). Most health care providers practice in only one setting and are not familiar with the specific requirements of other settings. Each setting is seen as a distinct provider of services, and little collaboration exists (Jones et al., 2017) (Chapter 6). The purpose of health care reform initiatives (accountable care organizations, medical homes, bundled care) is to improve coordination and communication among providers so that the individual receives the most appropriate care in the most appropriate setting.

Readmissions: The Revolving Door

Avoidable readmissions are one of the leading problems facing the US health care system. Hospital readmission is a critical event for both the patients and the health care system, with extraordinary associated costs. One in four Medicare patients is readmitted to the hospital within 30 days of discharge. Approximately 1 in 5 emergency department visits by individuals over the age of 65 years result in readmission, even when the initial visit is for something minor (AARP, 2021). Readmissions have been a critical quality indicator for more than two decades because they cost the health care system money and they indicate incomplete discharge planning (Horney et al., 2017; Jones et al., 2017).

To address the concern of hospital readmission, the Hospital Readmissions Reduction Program (HRRP) was established in 2013 as a permanent component of Medicare's inpatient hospital payment system. The HRRP requires Medicare to reduce payments to hospitals with relatively high readmission rates for selected conditions for patients in traditional Medicare (Box 1.9). Under the HRRP, hospitals with readmission rates that exceed the national average are penalized by a reduction

BOX 1.9 Conditions Included in the Hospital Readmissions Reduction Program

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Total hip and knee replacement
- Chronic obstructive pulmonary disease
- Coronary artery bypass surgery

in payments from the CMS across all of their Medicare admissions, not just those that resulted in readmissions.

Since the HRRP, readmission rates for the selected conditions have dropped nationwide, and the HRRP has been the impetus for many hospitals to institute—system-wide interventions to prevent readmissions that also have contributed to the decline in readmission rates. Readmission concerns have encouraged the development of closer alliances (e.g., accountable care organizations) and communication between hospitals and posthospital care providers, including SNFs, home health, and primary care. Hospital readmission rates are posted on the CMS Hospital Compare website (Boccuti & Casillas, 2017).

In addition, 30-day readmissions to acute care for patients at SNFs are common and preventable. Medicare patients discharged to an SNF have a 25% likelihood of readmission within 30 days, with a quarter readmitted to the hospital in the first week (Mendu et al., 2018). Individuals with dementia are an especially high-risk group for readmissions. Challenges unique to this population include the need for dementia care expertise among the team, the reliance on the caregiver as an essential member of the team, the need for caregiver education and preparation, and the challenges of behavioral symptom management (Hirschman & Hodgson, 2018).

Interventions to Reduce Acute Care Transfers (INTERACT) is an exemplary program for reducing the frequency of transfers to acute care hospitals from SNFs. INTERACT is a quality improvement program with communication tools, care paths or clinical tools, and advance care planning tools to assist nursing homes in identifying and managing acute changes in condition without hospital transfer when safe and feasible (https://pathway-interact.com/). Other successful interventions include the use of nurse practitioners working as part of collaborative teams with physicians, standardized admission assessments, palliative care consultations for residents with recurrent hospitalizations, and interprofessional case conferences. A decision aid based on nursing research, *"Go to the hospital or stay here?"* (Tappen et al., 2020), has been found to help families make decisions about whether to have a family member stay in the nursing home or transfer to acute care when there is a change in condition (Box 1.10).

Multiple factors contribute to poor outcomes during transitions: patient, provider, and system (Boxes 1.11 and 1.12). Coordination and communication between settings contribute to poor outcomes during transitions (especially between acute care and SNFs), as does medication management. Contributing factors related to medication management include complex medication regimes, a lack of recognition by health professionals of the medication activities performed by families, haphazard and disorganized medication plans of care, and a lack of shared decision making (Manias et al., 2019).

BOX 1.10 Resources for Best Practice

Transitional Care

Transitional Care Model: http://evidencebasedprograms.org/1366-2/transitional-care-model-top-tier; https://www.nursing.upenn.edu/ncth/transitional-care-model/.

Agency for Healthcare Research and Quality: Taking Care of Myself: A Guide for When I Leave the Hospital. https://www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/index.html.

Interventions to Reduce Acute Care Transfers (INTERACT): Program to reduce frequency of transfers to acute care hospitals from SNFs when feasible. Nursing home capabilities list, stop and watch early warning tool. https://pathway-interact.com/.

Go to the Hospital or Stay Here?: A Decision Guide for Residents, Families, Friends, and Caregivers. http://decisionguide.org/.

BOX 1.11 Clinical Judgment: Transitional Care

Story of Mr. Jones

Mr. Jones is an 87-year-old ambulatory male who presents to the emergency department (ED) with altered mental status and an unwitnessed fall in the skilled nursing facility (SNF) where he was admitted after being discharged 1 week ago from an acute care facility. While in the hospital, his food and fluid intake was deficient and remained poor during the SNF stay. After undergoing an extensive evaluation, it was determined that Mr. Jones had acute kidney injury (AKI) related to dehydration.

Suggested Solutions and Nursing Actions

This visit to the ED potentially could have been prevented. The first step in prevention is performing a comprehensive history and physical upon admission to the SNF to discover possible risk factors.

Risk factors for Mr. Jones include: decreased food and fluid intake; polypharmacy (10 medications including a diuretic; decreased mobility (unable to obtain fluids without assistance); and preexisting chronic disease (diabetes mellitus and chronic kidney disease stage 3b).

Other important interventions for newly admitted individuals include 1) developing person-centered, evidence-based nursing actions; 2) intensive monitoring of high-risk patients upon admission to the SNF (more frequent vital signs, including weight in individuals with heart failure, pulse oximetry in patients at risk for hypoxia, specific monitoring for high-risk conditions in this patient population (volume depletion, bleeding, hypoglycemia in those with diabetes); and 3) facilitate effective communication at the time of discharge between health care facilities and/or other health care professionals involved in the individual's care.

SAFETY TIPS

Medication discrepancies are the most prevalent adverse events after hospital discharge and the most challenging component of a successful hospital-to-home transition (Hain et al., 2012; Tong et al., 2017). Nurses' attention to an accurate prehospital medication list; medication reconciliation during hospitalization, at discharge and after discharge; and patient and family education about medications are required to enhance safety

BOX 1.12 Clinical Judgment: Transitional Care

Story of Mr. Jordan

Mr. Jordan is a 68-year-old retired farm laborer who was readmitted for heart failure 10 days after hospital discharge. He lives alone in a rural community, has no friends or family to assist in his care, and was not given a referral for home health care follow-up. His medical records document teaching about medication usage and his ability to repeat back the instructions correctly. On his first postdischarge medical visit, he brought all his pill bottles in a bag; all the bottles were full, not one had been opened. When questioned why he had not taken his medication, he looked away and began to cry, explaining that he had never learned to read and could not read the instructions on the bottles.

Suggested Solutions and Nursing Actions

Adequate discharge planning is essential upon hospital discharge. Risk factors for this man's readmission include low literacy, living alone, and complex chronic illness. Suggested interventions are 1) assessment of literacy and adaptations of health teaching; 2) collaboration with a pharmacist to develop a person-centered plan of care for medication administration, medication reconciliation; 3) determination of the most appropriate setting for posthospital care; 4) informing the patient about symptoms that should be reported after discharge; and 5) social work collaboration to identify community resources and other forms of assistance and support (e.g., Meals on Wheels, transportation).

Adapted from Center for Patient Safety: *Hot topics in healthcare: transitions of care: the need for a more effective approach to continuing patient care* (website), 2020. https://www.centerforpatientsafety.org/resource/hot-topics-in-healthcare-transitions-of-care-the-need-for-a-more-effective-approach-to-continuing-patient-care/. Accessed January 2020.

BOX 1.13 Factors Associated With Readmission Risk

- The presence of complex comorbidities
- Sensory impairment
- Functional decline
- Cognitive dysfunction
- Poor communication between disciplines and across sites of care
- Inadequate discharge planning and involvement of caregivers
- Increasing acuity of patients in skilled nursing facilities (SNFs)
- Inadequate reimbursement for postacute care and staff shortages
- Shorter hospital stays
- Increasing acuity of patients in SNFs
- Scarcity of geriatric trained professionals
- Inadequate knowledge and use of evidence-based protocols for geriatric care
- Social concerns (e.g., isolation, living situation, lack of caregiver support, socioeconomic factors)
- Language and literacy
- Culture
- Place of residence and health care available
- Inadequate end-of-life planning or advance directives

Other factors contributing to poor outcomes identified in the literature are presented in Box 1.13. The importance of feeling cared for and cared about has been found to be a desired outcome of excellent transitional care in studies with patients and caregivers (Research Highlights B box).

RESEARCH HIGHLIGHTS B

Care Transitions From Patient and Caregiver Perspectives

Purpose

The aims of this study were to (1) describe patient and caregiver experiences during care transition and (2) characterize patient and caregiver desired outcomes of care transitions and the health services associated with them.

Method

Interviews with 138 patients and 110 family caregivers recruited from 6 health networks in the United States. Forty-four focus groups were conducted, and audio transcripts were transcribed and analyzed using principles of grounded theory to identify themes and the relationship between them.

Results

Patients and caregivers identified three desired outcomes of care transition services: (1) to feel cared for and cared about by medical providers; (2) to have accountability from the health care system; and (3) to feel prepared and capable of implementing care plans. Five care transition services deemed important to achieving the outcomes were: (1) using empathic language and gestures; (2) anticipating patient needs to support self-care at home; (3) collaborative discharge planning; (4) providing actionable information; and (5) providing uninterrupted care with minimal handoffs.

Conclusion

Clear accountability, continuity of care, and caring attitudes across the care continuum are important outcomes for patients and caregivers. When these outcomes are achieved, care is perceived as trustworthy and excellent. Otherwise the care transition is experienced as unsafe and leaves patients and caregivers feeling abandoned by the health care system.

Data from Mitchell S, Laurens V, Weigel G, et al: Care transitions from patient and caregiver perspectives, *Ann Fam Med* 16(3):225–231, 2018.

Using Clinical Judgment to Promote Healthy Aging: Transitional Care

Solutions, Nursing Actions, and Outcomes

Transitional care "refers to a broad range of time-limited services to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of these patient groups from one level of care (e.g., acute to subacute) or setting (e.g., hospital to home) to another" (Naylor, 2012, p. 116). National attention to improving patient safety during transfers and preventing avoidable readmissions is increasing, and a growing body of evidence-based research provides data for design of care to improve transition outcomes.

Nurse researchers Dorothy Brooten and Mary Naylor, along with their colleagues, have significantly contributed to knowledge in the area of transitional care and the critical role of nurses in transitional care improvement. The Transitional Care Model (TCM) is a rigorously tested, comprehensive advanced practice model of care that starts in the hospital and continues through SNFs and back to the community. The TCM focuses on person-centered care; education and promotion of self-managed care; and continuity, collaboration, and care coordination with all members of the interprofessional team. The TCM has been one of the most rigorously studied transitional care approaches

and has demonstrated reductions in preventable hospital readmissions, improvements in health outcomes, improved care transitions for individuals with dementia and their caregivers, enhancement in patient satisfaction, and reductions in total health care costs (Garcia, 2017; Hirschman & Hodgson, 2018).

Nurses in acute and long-term care are uniquely positioned to play a lead role in transitional care to improve outcomes and form a "bridge across settings" (Jones et al., 2017, p 18). This will require closer collaboration and knowledge of the settings and valuing of the different nursing practice roles. In addition to roles as care managers and transition coaches, nurses play a key role in many of the elements of successful transitional care models, such as medication management, patient and family caregiver education, comprehensive discharge planning, and adequate and timely communication between providers and sites of service.

The nursing role in discharge planning and patient and family education is critical. Engaging patients and families in learning about care required after discharge contributes to improved outcomes. Teaching must be based on a complete assessment of the unique needs of the individual and adapted to ensure understanding (Chapter 8). Patients who lack the knowledge, skills, and confidence to manage their own care after discharge have nearly twice the rate of readmissions as patients with the highest level of engagement (Kangovi et al., 2014; Schneidermann & Critchfield, 2012–13). Box 1.14 gives tips for best practice in preventing readmissions.

Working with the patient and the caregiver to provide education to enhance self-care abilities and to facilitate linkages to resources is important to promote safe discharges and transitions to home and other care settings. (©iStock.com/Pamela Moore.)

BOX 1.14 Tips for Best Practice

Nursing Role in Preventing Readmissions

- Identify patients at high risk for poor outcomes (e.g., low literacy, living alone, frequent or recent hospitalizations, complex chronic illness, cognitive impairment, socioeconomic deprivation).
- Adapt patient teaching for health literacy, language, culture, cognitive function, and sensory deficits.
- Determine most appropriate setting for posthospital care and educate discharge planners and family about capacity of skilled nursing facility (SNF) to care for high-risk patients (see Chapter 6, Box 6.13).
- Timely transfer of accurate information between hospital and SNF, including direct communication of time-sensitive information critical to care of high-risk patients (phone, secure text, or other form of protected health information technology).
- More intensive monitoring of high-risk patients upon admission to SNF (more frequent vital signs, including weight in patients with congestive heart failure, and pulse oximetry in patents at risk for hypoxia, and specific monitoring for high-risk conditions in this patient population, including volume depletion, bleeding, and hypoglycemia or hyperglycemia in adults with diabetes.
- Discussion of goals of care and advance directive status; palliative or hospice care consultations as appropriate.
- Provide a complete and updated medication record; explain purpose of all medications, side effects, correct dosing, and how to obtain more medication. Evaluate barriers to successful medication management (delirium, financial, transportation).
- Perform a medication reconciliation.
- Assist in establishing a regimen for proper administration of medication (consider patient's usual routine when developing a plan of care).
- Discuss symptoms that should be reported after discharge and how to contact provider; provide follow-up plan for how outstanding diagnostic tests and follow-up appointments will be completed.
- Coach patient and family in self-care skills and encourage active involvement in care.

New roles for nursing are emerging in the era of health care reform and heightened attention to improved patient outcomes. Nursing education must prepare graduates to develop the clinical judgment skills to practice effectively in roles across the continuum and work collaboratively to improve care outcomes, particularly during times of transition. We can no longer work in our individual "silos" and not be concerned with what happens after the patient is out of our particular unit or institution. Nurses are well positioned "to create services and environments that embrace values that are at the core of this profession—patient/caregiver centered care, communication and collaboration, and continuity" (Naylor, 2012, p. 140).

KEY CONCEPTS

- Older adults are complex, and their responses to illness may not meet standard diagnostic criteria and are often missed, leading to unnecessary disability, complications, and quality-of-life issues. Nurses are key to recognizing and analyzing cues and taking action to improve outcomes of care through competent clinical judgment.
- The major changes in health care delivery and the increasing number of older adults have resulted in numerous revised, refined, and emergent roles for nurses in the field of gerontological nursing. There is a critical shortage of nurses and nurse educators with expertise in care of older adults.

- Nursing has led the field of gerontology, and nurses were the first professionals in the United States to be certified as geriatric specialists.
- Advanced practice role opportunities for nurses are numerous and seen as potentially cost-effective in health care delivery while facilitating more holistic care.
- Professional nursing involvement is an essential component in models to improve transitions of care across the continuum.

NEXT-GENERATION NCLEX® (NGN) EXAMINATION–STYLE QUESTIONS

The registered nurse (RN) at a long-term care agency is providing orientation and education to new assistive personnel (AP) who have limited experience working with older adults. All of the new AP are eager to learn and to provide assistance to the residents. After the orientation, the RN asks if there are any questions or comments from the AP before they begin working on a care unit.

From the following list, select three statements made by new AP that require the RN to provide further education.

1. "When caring for older adults, we may have patients who are age 50 and older."
2. "We should report any new or unusual resident behavior to the nurse promptly."
3. "It sounds like residents with dementia are at high risk for hospital readmissions."
4. "Forming professional relationships with residents on hospice is important to me."
5. "I might be called upon by the nurse to provide teaching to the resident and family."
6. "The older adult population will continue to increase in number in the coming years."
7. "An Adult-Gerontology Nurse Practitioner can provide primary care for our residents."
8. "I worked with children in my previous job, so caring for older adults will be very similar."

CLINICAL JUDGMENT QUESTIONS AND ACTIVITIES

1. Discuss your clinical education experiences and reflect on how they have influenced your views about care of older adults and gerontological nursing.
2. Reflect on the Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults (Appendix 1.1). Which have you had the opportunity to encounter in your nursing program?
3. Review one of the gerontological nursing journals *(Geriatric Nursing, Journal of Gerontological Nursing, Research in Gerontological Nursing)* and choose a research study of interest to you. How could you use the findings of the study in your clinical practice with older adults?
4. You are asked to write a small proposal for a research project related to care of older adults. What would be the focus of your research and why?
5. Based on your experience in the acute care setting, what would you suggest to improve transitions to other care settings? Discuss any experience you or your friends and family may have had with transitions after hospital discharge.

RESEARCH QUESTIONS

1. Which aspects of gerontological nursing roles do practicing nurses find most rewarding and which do they find most challenging?
2. Why do so few students choose gerontological nursing as an area of practice? What factors might encourage more interest in the specialty?
3. What is the actual amount of time in the curricula of baccalaureate nursing schools spent on content and practice experiences related to the care of older adults?
4. How do nurses perceive their role in transitional care?

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