1. When performing a comprehensive geriatric assessment of an older adult, the nurse should focus on the patient’s
   a. Chronic illnesses
   b. Functional abilities
   c. Immunologic function
   d. Physical signs of aging

2. The nurse admitting an elderly patient to the hospital asks the patient about advance directives. The patient notes that he has a living will. The nurse recognizes that the patient has:
   a. Left instructions about actions to be taken regarding his care in the event of a terminal or irreversible condition.
   b. The specific document needs to be identified, since “living will” is a lay term used to describe various documents that give instructions about future medical care.
   c. Designated another person to make legally binding health care decisions for him if he is unable to do so for himself.
   d. Documented directions that are legally binding about actions to be taken regarding his care in the event of a terminal or irreversible condition.

3. In establishing a therapeutic environment for an elderly patient, the nurse provides special considerations by:
   a. Keeping the contact to 15 minute intervals.
   b. Speaking slowly and loudly to ensure understanding.
   c. Ensuring that the patient has assistive devices, such as hearing aids, in place.
   d. Allowing greater time to gather a medical history because elderly patients have complex, chronic conditions.

4. In planning care for elderly patients with chronic illnesses, the nurse recognizes that management of chronic illness requires:
   a. Institutionalization in long-term care facilities.
   b. Restricting social interactions outside of the home.
   c. Intensive rehabilitation to prevent progression of disease.
   d. Planning to manage crises that may occur during the illness.

5. A 72 year old woman hospitalized with pneumonia becomes disoriented and confused 2 days after admission. When assessing the patient’s status, the nurse determines that the patient is experiencing delirium rather than dementia, based on the knowledge that:
   a. Memory is impaired in delirium but not in dementia.
   b. Awareness is clear in delirium but impaired in dementia.
   c. Delirium usually has an identifiable cause, while dementia does not.
   d. The onset of delirium is acute, while that of dementia is usually insidious.
6. A patient with unscheduled surgery for a hip fracture develops delirium while hospitalized. The nurse recognizes that most instances of acute confusion can be attributed to:
   a. Undiagnosed illnesses
   b. A single etiologic event
   c. An underlying dementia
   d. Multiple interacting factors

7. When teaching the husband of a woman who is being evaluated for Alzheimer’s disease about the disorder, the nurse explains that:
   a. The most important risk factor for Alzheimer’s disease is a family history of the disorder.
   b. A diagnosis of Alzheimer’s disease can be made only when other causes of dementia have been ruled out.
   c. New drugs, such as Donepezil (Aricept), ha been shown to dramatically reverse Alzheimer’s disease in some patients.
   d. The presence of brain atrophy and enlarged ventricles detected by MRI confirm the diagnosis of Alzheimer’s disease in patients with dementia.

8. An 88-year-old woman is brought to the health clinic for the first time by her 64-year-old daughter. During the initial comprehensive nursing assessment of the patient, the nurse should
   a. ask the daughter whether the patient has any urgent needs or problems
   b. obtain a health history using a functional health pattern and assess ADLs and mental status
   c. interview the patient and daughter together so that pertinent information can be confirmed
   d. refer the patient for an interdisciplinary comprehensive geriatric assessment because at her age she will have multiple needs.

9. Risperidone (Risperdal) is prescribed for a patient with moderate Alzheimer’s disease. In evaluating the effectiveness of this drug, the nurse would expect the patient to demonstrate:
   a. Less agitation and aggression
   b. Enhanced functional abilities
   c. Improved memory and judgment
   d. Stabilization of mood and sleep patterns

10. In planning care for an older adult, the nurse recognizes that a major goal of health promotion and prevention of health problems in the elderly is
    a. adequate planning for post-hospital care
    b. preventing the physiological degeneration of aging
    c. teaching the elderly about alternative care options
    d. increasing personal participation and responsibility in health