Introduction to the Care of the Older Adult

Statement of Goals

A. Understand the importance and function of the geriatric patient interview.
B. Understand the components of a geriatric interview.
C. Understand the biological, social and emotional aspects of aging and their implications for effective care of the older adult.

Learning Objectives

A. Recognize that the geriatric interview has modifications that physicians use for diagnosis and treatment plans for older adults.
B. List and describe the basic components of the geriatric interview.
C. Describe a geriatric interview in the context of a comprehensive adult medical history.
D. Describe the potential barriers to obtaining an effective medical interview with an older patient and how those barriers may be addressed.
E. Describe functional assessment. List Activities of daily living (ADL) and Instrumental activities of daily living (IADL) and how this functional information is applied to the care of the older adult.
F. Demonstrate how to obtain the functional assessment during an interview with an older patient.
G. Recognize the importance of gait and balance assessment in the older patient.
H. Demonstrate the “get up and go test” to identify persons at risk for falls.
I. Understand the use of the Mini-Cog and Clock Draw Tests as a quick screen for dementia.
J. Be familiar with needs that caregivers have and identify resources to provide support.
K. Describe the importance of the interdisciplinary team approach to care of the geriatric patient.
L. Identify learning activities that help to develop geriartic interviewing skills.

* This unit is included here in order to prepare you for a standardized patient workshop you will do at your next Small Group session. In this workshop you evaluate a geriatric patient. You will be expected to learn the patients History of Present Illness (HPI), as well as complete a functional assessment, Mini-Cognitive Exam (Mini-Cog), and assess a fall risk via the "Get Up and Go Test".
Student’s Preparation for the Unit

A. Reading Assignments:

  Required:

Bates 9th Edition
pp.848-854 (up to Advance Directives); Page 857-59 or Care of the Geriatric Patient Video in CBIL(Website: CBIL Menu: M-1: FCM: Geriatric or GeriatricFuncAssess\autorun.html. Note: the video resource is quite good. It covers the same information as the assigned reading. Personal learning preference should dictate which resource students choose to utilize.

F & C 2nd Edition
pp 94-97 (up to Diagnosis)

Optional:


Geriatric Assessment Video: CBIL Website: CBIL Menu: M-1: FCM: Geriatric or GeriatricFuncAssess\autorun.html

B. The Care of the Older Adult is covered in 2 different sessions:

Session 5 (this session): Introduction to the geriatric patient and preparation for next session and the visit with the geriatric standardized patient.

Session 6(next session) : Standardized geriatric patient interview with a focus on the effective medical interview, functional assessment and get up and go to test.

Curriculum Comments

Objective A-C

Components of the traditional adult interview that are modified in the geriatric interview include the addition of the functional assessment and mental status examination during the interview. In addition, during the physical examination special emphasis is given to testing and evaluation of gait, balance and mobility.
Objective D: Barriers to effective interviewing:

1. **Decreased hearing:** Choose a quiet setting. Make sure the patient’s hearing aid (if any) is on. Speak slowly, with a low pitched, *slightly* loud voice. Do not shout. Sit where your lips can be seen. Let the patient know when a new topic is being introduced. If you have not been understood, give the same message with different words, instead of shouting the same words over and over. Accompany your message with gestures or diagrams. Have the patient repeat the main points in his/her own words to verify understanding.

2. **Elderly patients may be reluctant to disclose symptoms:** This reluctance may have various underlying causes. Patients may feel embarrassed about incontinence or sexual concerns. They may assume that their problem is an unavoidable consequence of aging or that no treatment will be available. They may be trying to avoid the expense or discomfort of diagnostic tests or treatment. They may fear loss of independence, such as loss of a driver’s license, if the problem is known.

   Demonstrate interest and respect for your patient’s concerns. Make sure your medical history includes specific questions about problems common to elderly persons and includes a careful functional assessment.

3. **Elderly patients may have multiple, complex medical problems:** Do not assume that the first concern of the patient is the single ‘chief complaint’. Continue to ask "What else?" until all concerns have been raised. Allow enough time and/or schedule more than one visit. You might have the patient complete pre-interview history forms and checklists if vision and literacy permit. Consider multi-disciplinary assessment, involving nurse, social worker, pharmacist, etc.

4. **Reminiscing and talking about the losses that accompany aging may take considerable time:** Physician and patient may need to set priorities and negotiate the use of available time to accomplish the goals of both individuals. Again, a multi-disciplinary team may be able to meet more of a patient’s needs.

5. **Third party interviews, including a family member or caregiver, may be necessary when there are cognitive changes:** Include the patient in the interview. Do not talk about problems and treatment as if the patient is not there. Ensure the patient some time with you alone, perhaps during the physical exam, in case there are concerns that don’t surface with a third party present. Be alert for possible stress in the caregiver.

6. **Transference:** The patient’s feelings and behavior toward the physician will affect the encounter. This may be particularly evident with younger physicians. The elder patient may give the younger physician advice, or may feel discomfort with the discrepancy between age and power/authority.
7. **Countertransference:** The physician’s attitude toward the elderly will affect the relationship. It may be hard to discuss certain problems, give advice or consider difficult decisions when the patient is the same age as your own parent or grandparent. Negative stereotypes and our own fears of aging and death can become barriers to communication and effective care.

8. **Culture, Language, Education:** Consider how these issues may be particularly important when caring for elderly patients.

**Objective E-F**

**Functional Assessment**

Functional status refers to the ability to function physically, mentally and socially in the activities of daily life. Its assessment is an essential component of the evaluation of elderly patients, especially the frail elderly. Changes in functional status may be presenting symptoms of medical illness in the elderly. When treating illness, the priority is often maintaining independence or preventing functional decline, rather than prolonging life.

The functional tasks of daily living have been organized as Activities of Daily Living (ADL’s) and Instrumental Activities of Daily Living (IADL’s). Think of ADL’s as basic self-care functions. Without them, living alone safely would be unlikely. IADL’s are more complex functions that allow independent life in interaction with the community. **Note that Bates p. 852 lists managing money as an ADL. It is more commonly classified as an IADL related to living independently in a community. Here, it is included with IADL’s.**

<table>
<thead>
<tr>
<th>ADL’s (basic self-care)</th>
<th>IADL’s (independence in community)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing / Hygiene</td>
<td>Telephone Use</td>
</tr>
<tr>
<td>Dressing</td>
<td>Housekeeping</td>
</tr>
<tr>
<td>Feeding</td>
<td>Shopping</td>
</tr>
<tr>
<td>Toileting</td>
<td>Food preparation</td>
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<tr>
<td>Continence</td>
<td>Transportation</td>
</tr>
<tr>
<td>Transfers / Ambulation</td>
<td>Managing Finances</td>
</tr>
<tr>
<td></td>
<td>Medications</td>
</tr>
</tbody>
</table>
Functional assessment begins with the interview. Specific questions, such as, ‘Who prepared the meals that you ate yesterday?’ may yield more reliable information than general questions, like, ‘Are you able to cook?’ Ask simple questions in a non-stigmatizing fashion. For example, ask ‘Do you ever leak urine?’ rather than, ‘Do you wet yourself?’ Depression is relatively common in the elderly, so inquire about mood. Family members may also provide critical information about functional status.

**Objective G-H**

**Assessing risk for falls:**

Falls in the elderly can have serious consequences, including injury, functional decline, hospitalization, nursing home placement, and even death. About 5% of falls result in fractures; osteoporosis increases the risk of fracture during a fall. Even the fear of falling can lead to restricted activity and loss of function.

Risks for instability and falls should be identified, so that appropriate treatment and adaptations can be put in place. Begin by asking about previous falls and the setting in which they occurred. Ask about the fear of falling and to what degree activities have been restricted. Check blood pressure in the standing position as well as sitting. Use the physical examination to observe balance and gait (Get-up-and-go test).

Falls occur in an environmental context. Hazards include loose rugs, clutter, and slick or uneven surfaces. Safety precautions include adequate lighting, handrails for stairs, and grab bars in bathrooms.

Physical examination is also used to assess functional status. Observe the patient’s hygiene and nutritional state as clues. Note whether assistance is needed to undress, put on a gown and get dressed again. Observe the patient’s gait and balance; one approach is the "Get-up-and-go" test described below. Balance is also evaluated with the Romberg test (Bates page 628).
Get-up-and-go

<table>
<thead>
<tr>
<th>Action</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit in a straight-backed chair</td>
<td>Observe sitting balance.</td>
</tr>
<tr>
<td>Get up from chair</td>
<td>Does he/she push up with arms?</td>
</tr>
<tr>
<td>Stand still momentarily</td>
<td>Observe standing balance.</td>
</tr>
<tr>
<td>Walk forward 10 feet</td>
<td>Note pace and stability of gait, length of steps.</td>
</tr>
<tr>
<td>Turn and walk back to chair</td>
<td>Note pace and safety of turn.</td>
</tr>
<tr>
<td>Turn and be seated</td>
<td>Can he/she ease down to chair?</td>
</tr>
</tbody>
</table>

Objective I

The Mini-Cog Assessment Instrument for Dementia and the Clock Draw Test.

The Mini-Cog and clock Draw Test can be administered quickly in a clinical setting in order to screen for dementia. The administration and scoring instructions are included at the end of this section.

Objective J

Family caregivers provide most of the care received by patients in the community. In the United States, three out of four caregivers are women, either wives or daughters. The caregivers’ emotional and physical health may be affected, resulting in depression and a worsening of his or her own health problems. What questions would you ask to assess “caregiver stress”?

- How is the caregiver doing?
- Is the caregiver feeling exhausted, depressed, hopeless, alone?
- Does the caregiver have a support system?

Risk Factors for Inadequate or Abusive Caregiving

Cognitive impairment in patient, caregiver or both
Dependency of the caregiver on the elderly patient, or vice versa

Family conflict

Family history of

- alcohol or drug misuse or abuse
- mental illness
- mental retardation

Financial stress or lack of funds to meet new health demands

Living arrangements inadequate to the needs of the ill person

Stressful events in the family, e.g.:

- death of a loved one
- loss of employment

What is caregiver burden?

This term describes the emotional, social, medical, and financial impacts of caregiving on a person. Manifestations include depression, isolations, stress-related illnesses, and poverty. Caregiver burden is significant for three reasons:

- a caregiver’s ability to accurately assess a patient is influenced by the caregiver’s mood and burden.
- patients and caregivers benefit when caregivers receive interventions to relieve burden
- the caregiver is a person, not an instrument, who deserves the dignity and respect accorded to all persons.

How to provide support:

Home health care services

Adult day care

Respite

Financial assessment
Support groups

Objective K

What is an interdisciplinary team?

Geriatric medicine focuses on function, which is broadly defined to encompass the physical, cognitive, psychological, and social domains. These domains are often combined to measure quality of life. To effectively address the needs of an older patient among these domains the team approach is commonly applied. This team is made up of different disciplines to provide comprehensive care that addresses not only medical needs. The primary focus in geriatrics being the promotion of wellness and interdependent function.

Interdisciplinary Team members often include: physicians, nursing, physical therapy, occupational therapy, and social work.

Objective L

Methods for learning geriatric interviewing skills include the following:

1. Reading texts and other resources (articles, videos)
2. Class discussion
3. Role Playing (practice with peers)
4. Practice with standardized patients
5. Observing preceptor
6. Work with patients
7. Feedback from peers, small group leader, preceptor, standardized patients, and patients

Apply Your Skills

During an interview with an older patient complete a functional assessment and include this in your encounter note.

Web References

For information about the practice of caring for older adults consult www.americangeriatrics.org and www.aafp.org. Other useful information pertaining to older adults may be obtained from www.aarp.org.
**Study Questions:**

1. What are the basic components of the geriatric interview?

2. What is a functional history? Can you list the ADL’s, IADL’s?

3. How can you overcome common barriers encountered during a geriatric interview (e.g. hearing loss, dementia)?

4. Why is assessing gait and balance important for elderly patients?

5. Can you describe the “Get Up And Go Test”? What do you watch for?

6. How do you use the Mini-Cog and Clock Draw Test to screen for dementia?

7. What are factors that can cause “caregiver stress”? How might you address this with the caregiver?