INTRODUCTION

In Medicine for the Elderly, we aim to prepare you as future physicians diagnosing and managing older people within a health care team. There have been significant advances in our understanding of common diseases that disable older people. The last decade has seen greater specialisation and development of team approaches to managing diseases such as stroke, Parkinson’s Disease and Dementia. Numerous RCTs have informed prescribing and preventative care. Clinical decision-making has become more complex and ‘patient and family’ centred. Hence, this is an exciting time to be studying Medicine for the Elderly and everyone in the university department and clinical academies involved in delivering this element welcomes you to Medicine for the Elderly!

The GMC’s publication Tomorrow’s Doctors 2009 lists a number of practical skills. There are updates in this booklet around clinical skills that you will get an opportunity to learn, practice and be assessed on during your time in Medicine for the Elderly.

Aims
You should prepare yourself in your future role as a doctor managing the range of patient centred problems presenting in care of the elderly. This element will have particular relevance with respect to:

- Formulation of appropriate differential diagnoses and investigations
- Effective communication with patients and carers and relatives
- A research-based approach in therapeutic decision-making
- Understanding of the roles of different health professionals and effective team work in care of older people
- Understanding of how the health services is organised for older people

Learning outcomes: By the end of this unit, you should be able to:

- Describe common health problems in old age and their non-drug and drug management in an older patient with complex physical and social problems who is hospitalised or residing in the community,
- Carry out a clinical assessment, construct working diagnoses
- Take a collateral history from the patients relative/carer/GP
- Define appropriate investigations and management plans
- Name team composition, roles, processes and services meeting the specific patient and family needs
- Perform and interpret the functional assessments commonly used in older people
- Describe the processes of assessment and rehabilitation
- List the services available in the community to support older people with physical disability +/- cognitive impairment and carers in their homes and explain the range of residential options distinguishing between them in terms of the level of care provided and the broad criteria used in relation to patient needs.

Teaching and learning in this element starts with a University introductory teaching two days at the start of the COMP2 unit. The teaching is followed by the four-week attachment in the clinical academies (some of the time is spent in dermatology). The University introductory teaching time for Medicine for the Elderly has now been adapted into tutorials and will be timetabled during your attachment.

An introduction to the learning requirements for Medicine for the Elderly will be given at the start of the teaching week through a PowerPoint presentation and a case history.
Extended Clerking Process
At the clinical academy, you will find that compared with your third year units, your tutors will expect a more in depth clerking process reflecting the complexity of the older patient group.

You should carry out a complete history and physical examination for between 5 and 10 patients throughout the attachment as part of the clerking portfolio. Keep these in a clerking file and they will need to be submitted on the last day of the four week attachment.

Try and obtain as much information from your patient as possible by taking a history and performing an examination. Many of the patients you may meet as inpatients may have difficulty giving you an accurate history. Please recognize this early and perform a cognitive assessment to guide your future history taking. After seeing your patient remember to read the notes in depth, look and record results e.g. blood, radiology, ECG. Make copies of the assessments or do your own eg. cognitive and affective tests.

Previous medical history can often be found summarized in the back of the patient’s notes in the consultant letters and on the GP summary print outs.

Remember to summarise the medical problems both acute and chronic. What outstanding investigations are planned? Is your patient undergoing rehabilitation?

Five to ten patients may not seem many. However using the marking schedule, you will see that it is depth of clerking that is required.

With each patient, form a list of differential diagnoses, make a list of investigations specific to the patients presenting problems and management plan. Be able to justify any test or treatment you have chosen. Review all prior records (may be multiple volumes) and check your work with the admitting team’s work. You should learn about the patient’s pre-morbid level of functioning, the impact past and current problems have on family life, their home environment and the level of functioning the patient currently has in hospital. You may also wish to speak with the one of the staff from Primary Care such as the GP, or where relevant, the district nurse. Another contact is the team leader of the home care team.

Talk to the carer (check with the patient), nurses, therapists, dieticians, pharmacists, the social worker and juniors/consultants to get information about your patient.

Check up on your patients frequently to assess progress and detect complications. They may be under another team on a non-care of the elderly ward.

Diagnoses are often not possible in the first few hours of an older person’s admission as insufficient information is available. Sometimes rethinking and changing the admitting diagnosis based on the new information is crucial to forming a correct plan.

Finding out about other health and social problems and responding to unforeseen crises, e.g. an interaction between drugs prescribed by the admitting team is key to formulating a management plan.

Keep your notes on all the patients you have clerked in a file and when you re-visit, write progress notes on your patients from your findings and discussions with the patient and team. If you find it helpful to structure your re-visit notes, use the SOAP plan (subjective,
objective, assessment and plan). Compare your notes with the notes in the medical record. Following up on the patient also includes looking at all test results and interpreting these results.

Read in depth about your patient's medical problems but for your clerking portfolio make sure you keep the cases based around the core medical problems. Use the online facilities such as Blackboard. Google offers a whole wealth of useful medical and patient friendly information. You do not need to add this information to your file but the reflections around the core problems are an important part of the clerking folder review.

Participate in the team’s ward rounds; sit in on one of the nurses handovers.

Many older patients in hospital or attending outpatients are on multiple drugs. Pharmacists are important members of the team caring for older people and provide advice on use of different drugs, suitability of different drug delivery devices for individual patients e.g. inhalers, different aids we can use to improve adherence and how we can minimize drug interactions. When you are on the ward with a pharmacist, ask about the drugs your patients are taking.

At the clinical academy, you will have your own individual timetable where you will be carrying out ward work, taking part on ward rounds, multidisciplinary meetings, home visits, outpatient sessions, and finding out more about what goes on in the Day Hospital. You will also be attending the equivalent of a weekly dermatology session and contribute to a weekly tutorial.

If at any time you are unhappy with the teaching you are obtaining, it is important to discuss it with your lead medicine for Older People tutor. If you feel unhappy doing this contact the Bristol University Course Administrator for this element (Sharon Byrne) and Sharon will speak with the tutor and try and sort out what the problems are. It is very unusual that students have an unsatisfactory learning experience in Medicine for the Elderly. When it does take place, it is usually due to too many doctors being away at once with the result that you are not getting enough teaching or the timetable has not been sorted before you arrive. This is something we can sort out rapidly with the Care of the Elderly tutor so do not delay making contact.

**On-take Commitments**

In Medicine for the Elderly, the patients admitted as an emergency offer excellent learning opportunities. As a student group, it is important to take turns being ‘on-take’ and the richest learning will come from those patients aged 75 years and over, there is no need to stay beyond 19.00 hrs. Each of you should be on-take clerking older people for 2 days during the clinical attachment. It is sensible that when you are on-take, you work with another student so that you can share your findings and also have another student with you when you leave the hospital buildings. Make yourself known to the medical registrar and ask to be allocated to elderly patients. Try and clerk the patients before they have been seen by the medical team (if this is appropriate). Keep these clerkings for your folders to be used for the tutorials. Follow up these patients through the hospital regardless of whether they go to medical wards or not. Keep regular entries as to the patient’s management and progress.

**Clerking Portfolio as part of the Assessment**

The clerking folder will comprise 10% of your overall mark for COMP2.

The clerking folder acts as a link between the clerking folders of years 3 and 5. You will have the opportunity to present and have your clerking folders reviewed during your attachment. Please use this as an opportunity to ask questions about any aspects that are not clear.
How to complete your clerking folder

Please take histories from at least five patients who present to the medical (or orthopaedic take) with these core topics - confusion, falls and immobility. These three common symptoms are the presentation for a myriad of illnesses that range from spinal cord compression to Guillain- Barré syndrome to community acquired pneumonia to metabolic abnormalities.

Please include at least one case where the patient has had a stroke.
Please include at least one case where the patient has had delirium
Please include at least one case where the patient has had a fall

So your folder could comprise of a variety of patients such as

- A patient with dementia
- A patient who has had a fall
- A patient who comes in with immobility on multiple medications
- A patient who has fractured her hip
- A patient who has had a stroke
- A patient who has come in with delirium

The marking schedule is attached. Please have a look at this to see what is expected of you.
<table>
<thead>
<tr>
<th>Marks</th>
<th>0</th>
<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
<th>7-8</th>
<th>9-10</th>
<th>Student self assessed</th>
<th>Tutor mark</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legibility and Use of English</strong></td>
<td>Unable to read and illegible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Comprehensive legible and story easy to read</td>
<td></td>
</tr>
<tr>
<td><strong>History, examination Use of clerking proforma and freehand clerking</strong></td>
<td>Incomplete sections</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Comprehensive inclusion of all information and systems Has used clerking proforma and general history sheets Detailed social and functional history obtained Drug history linked to PMH</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnoses and differential diagnoses stated</strong></td>
<td>No differential diagnoses or problem lists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Full problem list and differential with evidence of For and Against</td>
<td></td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td>Clerking stops at end of examination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clear management plan with task list</td>
<td></td>
</tr>
<tr>
<td><strong>Inclusion of collateral history</strong></td>
<td>No collateral included</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Full collateral histories from different sources eg. GP/Family and carers</td>
<td></td>
</tr>
<tr>
<td><strong>Inclusion of cognitive and affective tests</strong></td>
<td>No MMSE or ACE-R No clock drawing tests No GDS Or BASDEC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Full supporting documentation of cognitive and affective state for every patient. Copies of assessments included in portfolio and reflections around abnormalities detected</td>
<td></td>
</tr>
<tr>
<td><strong>Investigations planned and results included</strong></td>
<td>No Documentation of investigations requested</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Full inclusion of all results requested and results written in. Importance of normal and abnormal results recognized and links to differential diagnoses included</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnoses and differential diagnoses reviewed with updating evidence</strong></td>
<td>No differential diagnoses or problem lists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clear differentials and problem lists which have been reviewed with the investigations and collateral history. For and against information around each differential included</td>
<td></td>
</tr>
<tr>
<td><strong>Follow up of patient through hospital journey discharge planning</strong></td>
<td>No follow up of patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clear detailed records of updates on patients with review of information available. Discharge planning and professionals involved clearly documented</td>
<td></td>
</tr>
<tr>
<td><strong>Reflections on what you have learnt</strong></td>
<td>No reflections on learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Comprehensive reflections on patient cases linking to core problems in MFE and learning objectives. Use of Core problem reflection prompt sheets</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
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<td>/100</td>
<td>/100</td>
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</tbody>
</table>
Passmark

The passmark for the clerking folder is 60/100

Feedback on clerking folder

Your tutor will review your clerking folder in week 2-3 of your attachment to advise you on areas for improvement.

When you receive your folder, your tutor will provide written feedback on three areas that you did well and three areas that you could improve on.

Clerking Folder Hints

Please make sure your clerkings are as legible as possible.

Ensure that if you need to copy information from the notes that this is clearly marked and identified in a separate pen.

For differentials please use a For and Against system of summarizing the evidence for each diagnosis.

Collateral histories—try and obtain these from the patients relatives/carers and GP. You may need to copy these from the notes but to develop the skill, try and obtain as many as possible yourself. See Tips on obtaining a Collateral History.

Try and obtain feedback on your clerkings for your own learning.

Use the reflections below to prompt your learning (one of the key areas to develop as a student and future doctor is to ask Why? Why? Why? This will help you to develop a reflective practice).

Include cognitive and affective assessments on all your patients even if you think your patient is completely cognitively normal (they often will have problems that the assessments reveal) ie. do one of MMSE/MOCA/ACE-R on all your patients (include the clock drawing) and likewise GDS/BASDEC Hamilton score. Evidence shows that these objective tests reveal problems not recognized by nursing and medical staff.

Structure for Reflections

For a patient with dementia consider the following questions:

- How was this diagnosis made or is it a new diagnosis?
- What in the clinical examination supports the diagnosis of dementia?
- Have you spoken to a collateral source?
- What type of dementia is this and why?
- Does your patient have any behavioural or psychiatric features of dementia?
- What blood tests have been performed to exclude an underlying delirium?
- What does the CT head show?
- What do the neurocognitive tests show (MMSE/ACE-R, MOCA)?
- What treatments are being tried or have been tried?
- What do you know about the side effects of these treatments?
- What risks does the dementia present to your patient? (e.g. wondering, kitchen safety, home safety, stairs)
What is your patient's life expectancy with this type of dementia?
What are the legal and ethical issues around dementia?
Is your patient still driving?

**For a patient with a stroke**

- Why is the diagnosis a stroke? (remember the definition)
- What other differentials have you considered?
- How did your patient first present?
- What is the acute treatment?
- What clinical features are there?
- What clinical category does your patient fall into? (remember TACI/PACI/?ACI/POCI)
- What does neuroimaging show?
- Was your patient on appropriate primary prevention?
- Is your patient on appropriate secondary prevention?
- What is the aetiological causation of this stroke?
- What other tests do you need to do to prevent a further stroke?
- What are the common complications of a stroke?
- What are the rehabilitation prospects for your patient?
- What is the risk of your patient having another stroke?

**For a patient with Delirium**

- What are the history and clinical features that suggest delirium?
- What is their admission AMT?
- What features in the PMH make this patient vulnerable to delirium?
- What do the metabolic/endocrine investigations show?
- What do the infection tests show?
- What are the underlying causes?
- How are you going to treat your patient?
- How long will it take them to improve?
- Has an MMSE/clock drawing/ACE-R been completed in the well state?

**For a patient with a Fall**

- What are the precipitating features of the fall e.g. preceding chest pain, SOB, palpitations
- Can your patient remember what happened?
- Has your patient sustained an injury?
- What are the modifiable risk factors for falling again?
- What factors are not modifiable for future falls?
- Does their drug history mean that they are more at risk of bleeding eg. warfarin/dabigatran/apixaban/rivoxaban/asinpirin/clopigogrel?
- Does your patient have a gait and balance problem?
- Has cognitive testing taken place?
- Are all their bloods normal or is there a precipitating cause such as infection?
- Does your patient have a lying and standing BP deficit?
- Has your patient had an ECG? Is this normal?
- What is the physio's impression of your patient?
- Does your patient need OT?
- What is the living environment?

**For a patient on multiple medications**

- What are the medical indications for your patient's treatment?
- What is their PMH?
- What is your patient's functional status?
What is your patient's cognitive status?
Does your patient have a compliance aid e.g. Dosette/blister pack?
What are the common side effects of each of the medications?
What are the risks of each medication?
Is this medication for primary prevention?
Is this medication for secondary prevention?
Is this medication making your patient feel better?
Is this medication life enhancing or life prolonging?
What does your patient think of the tablet burden?
Tips on taking a Collateral Cognitive History

Taking a cognitive and functional history from a carer or relative is an important skill to practice. Try and take as many collateral histories as you can. (see video on blackboard)

Start off by explaining who you are and what you would like to know gaining consent from the carer/relative

1) Ask about duration of symptoms eg. Short Term Memory problems (time frame eg. over six months)

2) Ask about progression eg. gradual or progressive

3) Mood or personality changes

4) Behavioural or psychiatric symptoms of dementia/psychosis eg.
   - Hallucinations/delusions
   - Wandering
   - Sleep disturbance
   - Calling out, screaming, swearing
   - Inappropriate behaviour

5) Ask about risks
   - Kitchen safety such as leaving the gas on
   - Wandering
   - Self neglect
   - Abuse-financial, physical

6) How have the above impacted on your patients Activities of Daily living eg. dressing/bathing/toileting

Ask about depression

7) Check PMH/Family history/head injury/vascular risk factors eg. smoking/drugs

8) Alcohol history

Submission of your Clerking Folder

Checklist

Have you self-marked your clerking portfolio next to the marking scheme?
Have you made sure that entries copied from the notes are clearly identified?
Have you reviewed abnormal tests and written differentials relevant to these?
Have you included cognitive and affective assessments for all your patients?
Have you reflected around your core problems using the reflection checklists?

The clerking folder needs to be submitted to your academy tutor by 3.00pm on the last Tuesday of the four week block.

Failure to submit your clerking folder by this time will result in a 10% reduction in your mark over the next seven days till Tuesday 3.00pm seven days later.
Failure to submit your clerking folder seven days or more after this time will result in 0 marks.
CLERKING ADVICE

Some hints on History taking and Examination of Older patients

Please look again at the intro slides to Medicine for Older People on Blackboard as these notes are in addition to the presentation

Remember the steps of comprehensive Geriatric Assessment (CGA)

Step 1: Get the History
Step 2: Medication Review
Step 3: Functional Inquiry
Step 4: Physical Examination
Step 5: Cognitive Testing
Step 6: Testing for Emotional Problems
Step 7: Targeted investigations
Step 8: Sharing of results with team
Step 9: Team plan, and follow-up

Introduction

A recent questionnaire responded to by fourth year medical students after their care of the elderly attachments indicated that many students found older people difficult to clerk and struggled to complete a history, examination, clinical impression and management plan.

Your learning so far will have taught you how to take a history from someone who is easily able to answer your questions. Many of the patients that you will meet in your first and subsequent years as a doctor will have difficulty with this however for many medical reasons. (twenty five percent of In-hospital beds are occupied by patients with dementia at any one time).

I have outlined some of the ways that as a student you can approach taking a history from a person who is unable to give you accurate answers because of underlying medical illness.

The best way to become good at obtaining a history from patients like this is to practice and learn your own strategies as to what you would do if this person presented as an emergency to the medical or surgical take. Whatever branch of medicine you go into this will stand you in good stead. Clerking is a skill that requires continued rehearsal like any skill.

Why is this relevant to you?

As an F1 doctor working in hospital many of your patients will be elderly with complex medical, cognitive and psychosocial problems. Clerking these patients and obtaining information accurately is vital in order to get an appropriate management plan. I.e. accurate clerking and assessment will determine your management plan.

Your concept of clerking a patient does need to change however. It is not just about asking questions. It is much more than this and bottom line is that clerking is about obtaining information about a patient that will influence your clinical impression and management plan. Always bear this in mind.

It is also about realising that your assessment is one assessment in a point in time. Elderly patients change rapidly and fluctuation in clinical and mental state is commonly seen on the
wards. Your accurate documentation is vital and always remember that what you write needs to be legible to others so they can gain understanding of how your patient was when you saw them.

e.g. An 87 year old lady is admitted via A/E with confusion having been found wandering on the street. She is able to tell you her name and DOB but is not orientated to place or time. She knows that she takes a lot of tablets but does not know what they are. Her examination is normal except for the confusion and some osteoarthritis. All her blood tests are normal. The brain scan is normal. There is no collaborative history as she is by herself.

It is Tuesday 10.30am, the admitting doctor rings the GP surgery for a complete list of her medications. It appears that she was started on tramadol medication three days ago for osteoarthritic knee pain and is normally not confused. She has no relevant medical history other than the OA. The tramadol was stopped and her confusion quickly improved.

The clerking in this case involved obtaining the relevant drug history and PMH from a collaborative source. This is vital information that has influenced your management plan.

Your learning so far will have taught you how to take a history from a patient who is easily able to answer your questions. Through medical illnesses many older people struggle to answer comprehensively. They will often be able to speak about how they are feeling (and it is always important to ask them how they are feeling because it is very revealing) but because of temporal orientation (able to tell you the day, date time, year and month) and spatial orientation (able to tell you that they are in hospital and which ward they are on) problems, will not give an accurate history of previous events.

NB Remember that older people rarely seek to mislead and wish to help the doctor in their enquiries. Cognitive processing may be slowed or impaired. Responses to questions may be inaccurate

It can be quite frustrating when you are under time pressures on the medical take but try and direct your patient gently. Recognise your frustrations and try and be patient because bottom line is that the patient is trying to express themselves and your job as a doctor is to try and sort out how to help them feel better.

It is common for students and junior doctors to feel out of their depth with these sorts of patients. I have tried to outline some strategies for you to follow in order to tackle some of these problems.

Please read and use in your daily clerking on the wards.

In Patients Demographics

The average age of care of the elderly inpatients is rising on a yearly basis and generally around 85 with a 4 to 1 female to male ratio

The case mix of each ward varies but nearly all of these elderly patients have complex health care needs (co-morbidities), which need to be taken into account in making clinical decisions and discharge arrangements. Many will have cognitive difficulties (in a recent ward review 22 out of 26 patients had a reduced MMSE score). These patients are often very vulnerable and frail, mentally and physically and often socially. The acute illness which brings them into hospital tips the balance from them being able to cope at home to sudden dependence. They can become physically de-conditioned and frailer in hospital, often compounded by urinary and chest infections. Rehabilitation takes longer and often involves the community teams.
Out Patients Demographics

Generally Older people seen in out-patients are slightly younger and fitter, more ambulant and less dependent but this is a generalisation!

Many students express that they learn more from the outpatients. This may be true for some illnesses like Parkinson’s disease which is predominantly O/P based but it is important to realise that when you are an F1 your patient base will be inpatients. In terms of being ready to be an F1, the frail inpatients are the group that you need to become competent at assessing and managing.

Common problems encountered with practical solutions

Communication difficulties can be caused by a number of factors:

Reduced hearing or Deafness

Solutions:

Speak slowly and clearly to your patient
Many people lip read
Patients often have a preferred ear, use it to speak into!
Is your patient wearing their hearing aid?
Is the hearing aid on?
Are the batteries working?

Remember that all care of the elderly wards and admission wards should have communicator devices. These are essentially amplifiers that make speaking to a patient much easier. Try and find one when you are on your attachment. General they consist of a set of headphones, an amp and a microphone to speak into. The ward staff should be able to direct you.

Difficulty with answering questions (check it’s not a physical problem with lack of dentures)

The causes of this are multiple and common causes include fatigue and exhaustion, confusion (acute or chronic or acute on chronic-delirium and dementia), pain (a distracter), depression (often unrecognised), mental health illness such as delusional behaviour. Doing a Minimental test (MMSE) is not practicable on the acute take but you need to learn a strategy that rapidly assesses these patients. Remember that patients like this often fluctuate so that by the post take ward round they may be completely different!

Solutions:

Go back to basics - Orientation to person, place and time
Abbreviated mental test score-AMT

1) Orientation to person - your personhood is one of the first things that you learn as a baby. Name and date of birth are often retained by even severely confused and delirious and demented patients. Always ask sensitively - one way of doing this is by saying:

What is your full name including your middle name?

2) Orientation to place - (spatial orientation). Do they know where they are? One way of asking this sensitively is:

Has anyone told you the name of this place that you are in?
Patients are frequently moved around and need re-orientating to the ward so please orientate them gently if they do not know where they are.

*Where do you normally live?*

Remember to check their address as patients will frequently give you an address that they lived in many years previously

3) *Orientation to time* (temporal orientation)

*Do you know what the date is?*
*Do you know what the time is?*
*Do you know what day of the week it is?*
*What year are we in?*
*What month are we in?*

If your patient is temporally disorientated then it is highly likely that they will be unable to give you an accurate sequence of events that led to hospital admission. Remember this, as it is vital to get a collaborative history that is documented. Sources for this include carers, relatives, home care, nurses (if admitted from residential or nursing home), GP intermediate care, etc. Do not hesitate to obtain this information ASAP. It often saves a considerable amount of time downstream!!

Again the importance of this is that it is going to impact on their management plan.
Abbreviated Mental Test Score

This is now incorporated into many of the medical and surgical clerking proformas. It is very useful but only gives a snapshot of someone’s cognitive abilities at that point in time. It incorporates orientation to person place and time as well as a few more items to test different domains. It can be used sequentially over time to illustrate deterioration or improvement with delirium.

It is likely that you will see a few versions of this. Below is a commonly used one:

1. **Orientation to place** 1 mark
2. **Orientation to time** 1 mark
3. **Orientation to year** 1 mark
4. **How old are you?** 1 mark
5. **What is your DOB** 1 mark
6. **Test immediate and short term memory** (give patient three items to remember and tell them you are going to test their memory (or a three item address), e.g. ball, flag and tree. Ask them to recall these items a couple of minutes later 1 mark for immediate ability to say items and 1 mark for short term recall.
7. **What are the dates of World war two?** 1 mark
8. **Who is the monarch?** 1 mark
9. **Count backwards from 20 down to 1** 1 mark

Mark out of 10

**Immediate recall** - this is a test of concentration. Patients who are very sick or who are delirious or sleepy or depressed have difficulty concentrating. They have problems even just repeating back the three items.

**Short term memory loss** is different and many patients with dementia can perform immediate recall easily but not short term recall. Short term recall problems are important to identify because your patients will not remember seeing you or what you have said to them. Prompts (such as writing pads) may be needed. Short term memory loss and problems in another domain of cognition may indicate dementia.

**The dates of World War 2.** This clearly is culturally and generational specific. I recently asked a number of students and many could not give the correct answer to this question!! Annotate the notes to this effect if this is relevant.

**The monarch question likewise.** It is amazing how many people think Queen Mary is on the throne!

**Counting backwards from 20-1.** This again is a test of concentration. Many patients who are sick or delirious cannot perform this task easily and frequently peter out, wandering off the point.

**The importance of the AMT is** that it is essentially a screening tool. You need to have a strategy for patients who do badly on this, i.e. anyone who is scoring less than 10/10. What are the underlying problems with their cognition? Delirium is likely to be the commonest one either with or without dementia but depression is also very common. Use additional screening tools such as the folstein minimental test, the geriatric depression rating scale, the Basdec, the clock drawing test.

It is a common occurrence that patients come into hospital with no formal diagnosis of delirium or dementia yet score badly on the AMT.

As an F1 you need to think about this - What is the diagnosis? What information do I need to distinguish what is going on? Lots of evidence indicates that patients do not get diagnosed with dementia in hospital.
If your patient has cognitive difficulties, REMEMBER this is not normal and requires further evaluation like any abnormal neurological sign. Is your patient suffering from delirium/dementia/depression/psychiatric illness? A full history (with coverage of the previous six months) and examination should be performed. A CAT scan of the head should be done along with B12/folate and TFT’s. CRP should be checked. A drug review should be carried out.

Remember minor illness which is easily tolerated in a younger person can tip the balance in an older person.

Please ask for advice if there is not a clear diagnosis and refer appropriately.

The **Folstein Minimental Test** is used as a standard 30 questions. Again you will see a few versions of this around but generally the same questions are asked and the same domains assessed. It takes longer than the AMT but gives more information. Remember that it does not diagnose but it simply gives you a snapshot of someone’s cognitive state at that point in time. Patterns of illness are seen however, e.g. those patients with dementia characteristically will have short term memory problems and often orientation problems. It is important to make general comments, e.g. if someone is very tired or ill or depressed they will have difficulty concentrating. In order to interpret your results these observations have to be taken into account. The more of these tests you do the better understanding you will have of the illness that you are assessing and how it impacts on your patients function.

When testing attention and concentration – remember that some people are good with words but less are good with numbers – so always check both serial sevens and WORLD backwards.(maximum score five)

If someone scores less than 30 again you need to ask why? Interpret the scoring according to how the patient has answered on each domain.
Mini-Mental State Examination

<table>
<thead>
<tr>
<th>Maximum Score</th>
<th>Score</th>
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<tbody>
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<td></td>
<td></td>
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</table>

### ORIENTATION
5 What is the: (year) (season) (date) (day) (month) (5 points)
5 Where are we: (country) (county) (town) (facility) (floor) (5 points)

### REGISTRATION
3 Name three objects and have person repeat them back. Give one point (3 points) for each correct answer on the first trial. e.g. ball, flag, tree
1. _______ 2. _______ 3. _______

[Number of trials _____]

### ATTENTION AND CALCULATION
5 Serial 7’s. Count backwards from 100 by serial 7’s. One point for each (5 points) correct answer. Stop after 5 answers. [ 93 86 79 72 65 ]
Alternatively spell "world" backwards. [ D - L - R - O - W ]

### RECALL
3 Ask for the names of the three objects learned above. Give one point (3 points) for each correct answer.

### LANGUAGE
9 Name: a pen, and a watch (2 points)
Repeat the following: "No ifs, ands, or buts" (1 point)
Follow a three-stage command: "Take this paper in your [non-dominant] hand, fold it in half and put it on the floor". (3 points)
Read to self and then do: "Close your eyes" (1 point)
Write a sentence [subject, verb and makes sense] (1 point)
Copy design [ 5 sided geometric figure; 2 points must intersect] (1 point)

Score: /30 General comments

______________________________
CLOSE YOUR EYES

______________________________
Sentence
The Clock Drawing test

Patient Name: Date: 

Please say to your patient:

“This is a clock face. Please fill in the numbers and set the time to ten past eleven”

Marking-please circle score

Normal
Mild abnormality
Moderate abnormality
Severe abnormality

Any Comments?
Interpreting the Minimental Test Score (Folstein)

This is similar to interpreting the Abbreviated Mental test score. The clinical context is vital to know. Is your patient medically well? Bloods and radiology normalised? Delirium resolved?

Orientation Section - what is your patients orientation according to person, place and time?

Registration - can your patient remember three objects immediately? This is difficult for patient who are sick, unable to concentrate, depressed.

Attention and Calculation, again difficult for patient who are sick, unable to concentrate and depressed. Generally people find spelling world backwards easier that calculation, Generally men are better on calculation than women
Remember that you can only score 5 points for this. Do both World and Numbers to give each individual a chance to see whether they can concentrate on the task (unless they get 5/5 with the first one)

Recall - this is a test of short term memory. Remember they have to be able to perform immediate memory otherwise they will be unable to do this

Language – Naming - does your patient have any nominal dysphasia?
No ifs and or buts – repetition,
Ability to follow commands
Reading (educationally sensitive)
Writing
Interlocking pentagons - apraxias
Language areas are often affected in stroke disease.

Remember it is not the final score that is important. It is the interpretation of the domains affected within the clinical context of your patient that is important.

Social and Functional History

In your third year you will have been taught about taking a social history. The importance of this is HUGE for older people and this can be quite a complicated area.

What is your patient's functional ability?

Try and divide this into personal Activities of Daily Living (ADL’s), e.g. toileting, washing dressing, eating. Then ask about shopping, cleaning, cooking, etc. If a person has help with these tasks it usually indicates that they are dependent and this is highly relevant to their management plan.

Try and include asking about exercise tolerance at this stage and what they use to mobilise. It is very common that many older people coming into hospital are housebound or only able to walk short distances. If this is the case you need to think why? Musculoskeletal problems are common but so is fatigue and lethargy.

Nearly all of this reduction in exercise capacity has an organic explanation that is relevant to managing your patient.

What is your patient's social history?

Many older people have complex networks of support, families, neighbours, friends, home care, district nurses, community nurses, intermediate care. Ask about frequency of support. Many older people are admitted to hospital because of break down in these support
structures so again it is highly relevant to the management plan. Modifications to the house are also revealing. Does your patient have a stair lift/raised toilet seat/recliner chair/stairs?

One major addition to this is

Asking whether the patient **DRIVES**!

**TO REMEMBER THIS**
Ask whether they **smoke**
Ask whether they drink **alcohol**
*Then (so you don’t forget) Ask whether they drive.*

This is an area that students (and trained doctors) nearly always forget to ask about simply because in the past it has not been part of the routine history taking. Try and remember to make it part of yours!

Add this as part of your standard clerking as it is amazing (and appropriate in most cases) how many older people continue to drive. By and large the majority are sensible about recognising their limitations and tend to drive short distances at quiet times and during the day. However there are a number of older people with cognitive impairment who lose insight into their abilities and can be hazardous on the road.

This is a very sensitive issue for most people but the DVLA guidance ‘At a glance’ (online) is very helpful for advising what medical conditions should be reported to them and the driving restrictions. They offer an advisory service. The disability living centre also offers an excellent assessment and re-enablement service to patients returning to driving, eg. after a stroke.

Remember that when a patient asks about driving that the DVLA advice is standardised. If the patient should not drive for medical reasons then remind them gently that this will invalidate their insurance, document that you have told the patient and let the GP know. The onus is on the patient to let the DVLA know if they are able. If they are unable, then with their permission you may have to recruit family to help out.

**Drug Review**

This is a complex area for many older patients. Accurate history taking is vital. Obtain collaborative information for your patients ie. GP faxed record of what has been prescribed. Pharmacists are invaluable in their help with this but are often not available 24/7 so **DO NOT DELAY**!

Your aim is to try and find out what the PATIENT HAS BEEN TAKING PRIOR TO ADMISSION because it is this that will determine your management plan.

This may and often does vary widely from what the GP has prescribed, what the family think the patient has been taking, and what bottles they come in with.

The first and most important place to start is with the patient. Never just read what is on the boxes. Always give the box to the patient and ask the patient to tell you how many they are taking and for what reason. This illuminates many problems with understanding and compliance. Even simple things like the ability of the patient to read the label on the box. Misunderstandings are frequent. Your role as a future doctor in educating your patient is HUGE. If the patient is not taking the medication it is important to still write this med down but write a note beside it to that effect.

Accurate documentation is **VITAL** as medication **regularly harms and kills patients**. Always find out what the proper name is for the medication as trade names constantly vary.
The BNF is the pharmaceutical reference Bible! USE IT (online or up to date ward copy)

A patient was recently admitted on the medical take by an F1 over the weekend with a stroke, and the drug history recorded: frusemide 40mg OD, omeprazole 20mg OD, marevan 5 mgs OD, gaviscon 10mls OD. The patient was prescribed aspirin and booked for a CT head scan with her drugs continued. When she was reviewed by the SHO it was clear that the F1 did not know that marevan is a brand name for warfarin and knowing this would have changed her management, ie. she would have had an urgent CT head looking for haemorrhage and the aspirin would not have been prescribed till the result known. An INR would have been taken.

There is much evidence to suggest that a combined doctor and pharmacists drug history is superior to that of just a doctor alone. Many hospitals are now recognising this importance and have put admission pharmacists at the front door during daylight week hours. The process is called medicines reconciliation and also encompasses the secondary/primary care interface.

Some hospitals have care of the elderly pharmacists an invaluable resource. Get to know the pharmacists of the wards that you are attached to. They have a huge wealth of knowledge regarding the medicines. **Always ask** if you don’t know what a drug is for and remember to use the BNF. **Accuracy is vital**.

**Review of Symptoms**

This can be rather daunting for medical students as many older people will have multiple problems. It is however important that this is covered *in detail* as you will often pick up info that will not be present in the PMH or presenting complaint. Remember that your patient needs to be cognitively intact to give you a good history regarding ROS. A collaborative history is important in many cases.

Important areas that come up repeatedly are GI problems especially weight loss. Gradual weight loss is usually a sign of illness and frailty. It has important implications for future health so always try and establish whether this has happened.

Another important area is locomotor system problems. This is one of the commonest areas of disability, with OA hips, knees and back being seen frequently. Shoulder problems, often rotator cuff disease are also common.

**Conclusion**

I hope you will find these notes helpful. If you are having problems that these notes do not address please speak to your tutor or e-mail me.

Likewise any suggestions for improvement then drop me a line.

susan.wensley@nbt.nhs.uk

August 2013

P.S. One last point - **Always** read the notes of your patient from the moment they *first* contacted the medical services i.e. GP letter/ambulance sheet/A/E assessment. This is very revealing as events change with time.
**Medicine for the Elderly:**

Please see the additional material in the lectures/handbook/tutorials/case scenarios. The details itemized in the table below are only examples of some of the core knowledge required.

### Essential Core Medical Illnesses

<table>
<thead>
<tr>
<th>Problem</th>
<th>Presentation</th>
<th>Details e.g.</th>
<th>Relevance to Foundation years and frequency seen in Hospital</th>
</tr>
</thead>
</table>
| Dementia                       | “My mum keeps forgetting things and it’s getting worse”                      | See lectures/handbook/tutorials/case scenarios
Know prevalence+age relationship.
Explore pre-disposing factors, duration of onset, patterns of cortical impairment, behaviour.
Know different causes and pathologies, ethical aspects, treatment including multiprofessional team, family impact and support available |
|                               |                                                                             |                                                                                                                                                                                                                                                                                           | Medical take-common
Surgical take common
GP practice common
25% of all inpatients |
| Delirium (acute confusional state) | “My husband’s been confused the last few days and he’s had a temperature” | Know that Cognitive testing should be carried out on all older people admitted to hospital
Understand that identification and treatment of the underlying cause is crux of management
Understand the wide variety of causes that predispose to delirium
Know that an independent history from a carer, GP or relative is often required |
|                               | “The doctor started my dad on some new tablets for his Parkinson’s disease and he’s become confused” |                                                                                                                                                                                                                                                                                           | Medical take common-40% of medical take
Surgical take common
GP practice common on call |
| Dizziness and syncope          | “I keep getting dizzy and finding myself on the floor”                      | Know definitions, prevalences and underlying causes.
Describe important points in history taking and examination, relevant investigations and management plans. Define evidence base for Rx from RCTs. Define factors in the fracture-prevention triangle and role of multi-professional team in management. |
|                               |                                                                             |                                                                                                                                                                                                                                                                                           | Medical take common
Orthopaedic Take- common
Fractured hips/pelvis/wrists/humerus |
| Falls                          | “My father has had 3 falls in the past month”                               | Know causes of falls
Be able to take an accurate history, accurate examination especially musculoskeletal and neurological, gait analysis |
|                               |                                                                             |                                                                                                                                                                                                                                                                                           | Medical take-common
Orthopaedic Take- common
Fractured hips/pelvis/wrists/humerus |
<table>
<thead>
<tr>
<th>Problem</th>
<th>Presentation</th>
<th>Details e.g.</th>
<th>Relevance to Foundation years and frequency seen in Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture neck of femur and osteoporosis</td>
<td>“Now, they tell me, I’ve broken my hip and need an operation”</td>
<td>Know precipitating causes of falls/osteoporosis Complications of surgery Treatment options Rehabilitation aspects National guidance</td>
<td>Medical out patients- osteoporosis very common Orthopaedic take-fractured NOF common GP practice Osteoporosis-common</td>
</tr>
<tr>
<td>Immobility</td>
<td>“I just sit in the chair, it’s too much effort to do anything”</td>
<td>Detect diagnostic indicators in history taking and examination. List common relevant investigations and treatment approaches including role of multi-professional team. Be able to assess cognitive and affective state</td>
<td>Medical take-common GP practice on call-common</td>
</tr>
<tr>
<td>Stroke and TIA</td>
<td>“My right hand went dead and I could not get my words out”</td>
<td>Know definitions, prevalence. Identify cardiovascular risk factors from clerking. Recognise TACI, PACI, POCI, Lacunar from clerking. Describe specific investigations and management plan. Define evidence base for Rx from RCTs. Recognise and discriminate large intracerebral haemorrhages and infarcts on CT scan. (Rehab-see below)</td>
<td>Medical take-common Surgical patients-maybe seen post op</td>
</tr>
<tr>
<td>Drug prescribing problems</td>
<td>“These are all the tablets I am on”</td>
<td>Following clerking, identify common causes for drug interactions and methods by which adherence can be enhanced</td>
<td>Medical take-common Surgical take –common Orthopaedic take common</td>
</tr>
<tr>
<td>Frailty</td>
<td>“My mum has been losing weight over the last few years and has no resistance to infections”</td>
<td>Know the frailty phenotype Recognise poor prognostic indicators</td>
<td>Medical take-common Surgical take-common Orthopaedic take-common Primary care-large numbers of patients esp residential and nursing homes</td>
</tr>
<tr>
<td>End of life issues in frailty and extensive comorbid disease</td>
<td>Mr Smith is deteriorating despite all active treatment</td>
<td>Be aware of NICE quality standards Introduction to DNACPR Understand concepts of futility Introduction to Integrated Care pathway for the dying.</td>
<td>Medical take and wards-common Will cover again in year 5 palliative medicine</td>
</tr>
<tr>
<td>Legal and ethical aspects in Older People</td>
<td>My patient is confused and I don’t know how to discuss this treatment with him</td>
<td>Know about the legal concepts of capacity to make a decision, best interests decision making, IMCA, lasting power of attorney</td>
<td>Medical and Surgical patients -common</td>
</tr>
<tr>
<td>Important problems</td>
<td>Carer strain</td>
<td>Hypothermia</td>
<td>Parkinson’s Disease</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
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<tr>
<td>“I can’t carry on any longer, he will have to go into a home”</td>
<td>Describe predisposing factors and community approaches used to support carers</td>
<td>Give definition. Know importance of low-reading thermometers in diagnosis. Define physiological, environmental and psychosocial factors in causation. Describe acute treatment and 2nd prevention</td>
<td>Identify diagnostic clinical features from history and examination. Give differential diagnosis. Explain pathophysiology and drug and non-drug approaches to treatment including multi-professional team approaches. Define natural history and impact on patient+carers.</td>
</tr>
<tr>
<td>Medical and surgical take-common</td>
<td>Medical take-occasional Acutely Managed usually by A/E, Complications seen on medical take</td>
<td></td>
<td>Outpatients predominantly</td>
</tr>
</tbody>
</table>
## Assessment Tools

<table>
<thead>
<tr>
<th>Assessment Tools</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Folstein Mini-Mental (MMSE)</td>
<td>Standard assessment scores used to assess cognition</td>
</tr>
<tr>
<td>Addenbrooks Cognitive Examination (ACE-R)</td>
<td>See above</td>
</tr>
<tr>
<td>MOCA (Montreal Cognitive assessment)</td>
<td></td>
</tr>
<tr>
<td>BASDEC or Geriatric Depression Scale (GDS)</td>
<td>Objective Validated Standard tests of affect screening for depression Basdec-score out of 21- GDS score out of 15 Hamilton score out of 30 Higher scores indicate more depression Please use and become familiar with applying – note not valid if a patient is demented. Use the Cornell score (observational depression score)</td>
</tr>
<tr>
<td>Barthel Index</td>
<td>Identify clinical situations where functional assessments are utilised, know where use is inappropriate Originally developed for stroke rehab two scales Out of 20 and 100</td>
</tr>
<tr>
<td>Berg balance score</td>
<td>Used by physios to assess how stable someone is, often mentioned in MDMs Score out of 56, lower score, worse balance!</td>
</tr>
</tbody>
</table>

### Processes of care, specialist staff and national standards

<table>
<thead>
<tr>
<th>Specialist nurses (stroke, continence, ortho-geriatric, movement disorders)</th>
<th>Identify roles in Medicine for older people and in conditions listed above, identify appropriate team composition for assessment/rehabilitation and ingredients for effective ‘team-work’ in Medicine for older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapists (physio-, occupational and SALT)</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
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<tr>
<td>Dietician</td>
<td></td>
</tr>
<tr>
<td>Social worker</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Geriatric Assessment</td>
<td>Describe basis for use and main ingredients See week 1 lecture</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Define process in relation to post-fracture neck of femur and stroke. Define evidence-base from RCTs</td>
</tr>
<tr>
<td>Intermediate care</td>
<td>Give an example of community-based rehabilitation and purpose e.g. Hospital-at-home</td>
</tr>
<tr>
<td>Social service and health support in the community for older people at home</td>
<td>List services available to support older people and carers with physical disability +/- cognitive impairment</td>
</tr>
<tr>
<td>Very sheltered accommodation</td>
<td>Explain range of options, distinguish them in terms of level of care/trained nursing staff/ability to manage needs of patient</td>
</tr>
</tbody>
</table>
Practical Procedures for Graduates

Below are a list of procedures listed in Tomorrow's doctors (2009) that you will have an opportunity to learn, perform and be assessed on during your Medicine for the Elderly attachment. Please make the most of the opportunities offered to you during your time as a student and practice the skills below. Eg. every single patient on an elderly care ward will have had an ECG. Many of your patients will need blood tests. Incorporate the results of these tests into your clinical clerkings.

1) Measuring pulse and blood pressure-using manual techniques and automatic electronic devices

2) Venepuncture

3) Managing blood samples correctly

4) Performing and Interpreting 12 lead ECG-competent to read rate and rhythm, identify atrial fibrillation, identify left ventricular hypertrophy, identify right and left bundle branch block, identify bradycardia and tachycardia, identify pauses, ectopic beats atrial and ventricular). Identify first, second and complete heart block.

5) Basic respiratory tests-peak flow and spirometry

6) Nutritional assessment (see MUST score in section-Undernutrition in older adults). Be able to perform and interpret appropriate actions.