

THE COMPETENT NOVICE

A quick ward assessment of older patients by junior doctors

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Older people comprise a large proportion of those requiring care in most emergency departments and acute hospitals.¹ Yet acute hospitals can be dangerous and unfriendly places for older people,² and the less time they spend in hospital, the less harm is likely to occur to them. Competent assessment and formulation of an accurate problem list can minimise inadequate or incomplete recognition of problems and inappropriate treatment, which can result in poor outcomes for the older person, including decline in function and increased mortality.³ This paper advises how a quick assessment can inform more detailed later assessment and management.

How best to do it?

Ideally the assessment of an older patient should be comprehensive, extending beyond the standard history and clinical examination. Comprehensive geriatric assessment is multidimensional and interdisciplinary, and includes a full review of the patient’s medical and health issues, and physical, psychological, and social functioning. Systematic reviews have shown the benefits of comprehensive geriatric assessment, with a recent Cochrane review concluding that older people who underwent such assessment had significantly improved chances of being alive and in their own home at up to 12 months after an acute hospital admission.⁴

However, where the assessment of the older patient needs to be quick, such as in an emergency department or on a busy after-hours roster, then this should cover the essential components of geriatric assessment relevant to the patient. Box 1 lists these components, discussed in detail below.

Obtain collateral information

To gather as much information as possible about the patient, obtain collateral information about current and background health problems and previous functional state from a family member or carer, or from the patient’s general practitioner or other healthcare professional. This

Box 1 | Essential elements of the quick assessment

History

Ensure patient has spectacles and hearing aids in place if appropriate. Use a headphone amplification device if the patient is not able to hear you speaking.

Introduce yourself and explain the purpose of your visit.

Seat yourself at the level of the patient and speak slowly and clearly.

Ask the patient what is troubling them (presenting symptoms) and the history of these symptoms.

Ask about other medical conditions including recent illnesses, doctor and hospital visits, and falls.

Check what medication the patient is taking (a current list is preferred), any known allergies, alcohol intake, and smoking status.

Ask about function in activities of daily living, including continence, before the current admission.

Ask about the patient’s home situation, whether they live alone or with someone, if that person provides care to them, or if there are services in place to assist them.

Ask whether they have completed an advance care directive or appointed a proxy healthcare decision maker.

When the patient has significant cognitive impairment, information will need to be obtained from a carer or family member.

Physical examination

Assess general appearance, personal hygiene, nutrition, and hydration. Check vision, hearing, and dentition. Assess swallowing with a small amount of water (20-30 mL).

Perform a brief cognitive screening test to assess orientation, attention, memory, and language. Check ability to follow a two-step command. Briefly assess mood.

Check pulse and blood pressure in both sitting/lying and standing positions.

Assess movement of all limbs, including a brief assessment of tone and power, muscle wasting, and active range of motion at major joints.

While checking limb movement, assess peripheral pulses and presence of oedema, skin integrity, and pressure ulceration (particularly heels and sacrum).

Where possible stand the patient up to check ability to transfer and standing balance, and ask the patient to walk several steps (ensure walking aid is available and provide standby assistance).

Examine cardiovascular and respiratory systems and abdomen, including bladder palpation (and rectal examination if indicated).

THE BOTTOM LINE

- The quick assessment of the unwell older patient can inform more detailed later assessment and appropriate management
- Collateral information from a family member or other health professional provides useful information on current and background problems and function, and may save time
- Focus questions on the current problem and identify chronic underlying conditions
- Check medications
- Assess daily function, current mobility, vision, and hearing to identify a decline and suitable interventions
- Assess cognitive function, as people with dementia or delirium are more likely to have adverse events, and delirium is often unrecognised



LIFE IN VIEW/SPL (CONSENT GIVEN)

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is especially necessary when cognitive impairment is present. Obtain consent for this contact from the patient if possible. Review medical records briefly for relevant information about possible comorbidities and previous admissions.

Focus the history and check medications

Focus patients on their current problem with questions such as, “I know you haven’t been well for a while, but what is troubling you right now?” Where possible, ask if they have a proxy healthcare decision maker (“Who helps you decide what sort of treatment you should have?”), and whether they have an advance care directive or have thought about the future (“Have you thought about what sort of treatment you might want in the future if your health gets worse?”). Check the medication list carefully with the patient and/or family member. Medication errors are common in hospitalised older patients and often occur at admission.⁵

Assess previous function

This is essential, as functional decline (acute or chronic) may itself be the reason for presentation. Such decline often results from acute problems being superimposed on chronic underlying conditions.⁶ It is crucial to identify these underlying conditions, such as heart failure, hypertension, lung disease, diabetes, osteoarthritis, Parkinson’s disease, cognitive impairment or dementia, and frailty. Evaluate pre-admission mobility and function in activities of daily living with questions such as, “Are you able to go out to the shops or to appointments on your own?” and “Do you normally use a walking stick or frame to get around?” and “Do you have someone to help with bathing, housekeeping, or shopping?”

CASE SCENARIO: PART 1

Mrs Brown is an 82 year old woman, living alone, who has been brought into the emergency department after her daughter found her “very muddled” at home. She is apparently normally cognitively intact and manages well independently at home. You are asked to assess her for admission.

CASE SCENARIO: PART 2

You find Mrs Brown to be drowsy and disorientated, and having difficulty answering your questions. You speak with her daughter, who confirms the sudden significant deterioration in her mother’s cognitive and physical condition from her previous independent state. She provides a list of her mother’s medications, which include two antihypertensive drugs and treatment for arthritis, gastro-oesophageal reflux disease, glaucoma, and constipation.

CASE SCENARIO: PART 3

On examination Mrs Brown was disorientated in time and place and had poor attention. She was dehydrated and hypotensive with a further postural drop. She was able to move all limbs but had difficulty standing and walking. Laboratory investigations suggested a urinary tract infection, and the provisional diagnosis was delirium due to urinary sepsis. Antibiotics and rehydration were started, and the dose of her antihypertensive medication was reduced. Her daughter was asked to stay with her while she settled in to the ward.

Physical examination

Assess general appearance, nutrition, and personal hygiene while talking to the patient. Ask them to open their mouth to check hydration and dentition (including presence of dentures or other dental prosthesis). Check vision briefly using a newspaper or magazine, and hearing (whisper a word in one ear while blocking the other). Assess swallowing with a small amount of water (20-30 mL).

To assess mobility and balance, ask the patient to rise from a chair or get out of bed and then (if possible) walk a short distance. Use of a walking aid or standby assistance may be appropriate. This assessment of physical function is essential in gaining an overall picture of the patient’s health and wellbeing, and identification of any decline allows for the introduction of interventions to address this decline.⁷ Other health staff such as physiotherapists or occupational therapists may be involved in functional assessment, and their input should be sought.

HOW PATIENTS WERE INVOLVED IN CREATING THIS ARTICLE

One of the authors is an older person who has experience as a patient and brought these experiences to the topic.

The paper was also reviewed by two older people (aged 85 and 92 years) who have extensive experience in patient and carer roles. Their comments have been incorporated.

The first and second authors work with the Alzheimers Australia Consumer Dementia Research Network, which has provided advice on the importance of appropriate assessment and care of older people with cognitive impairment in the acute hospital setting.

Assess cognitive function

Cognitive impairment is common in older people. In large cohort studies, between 40% and 50% of older people admitted to an acute hospital had cognitive impairment or dementia, some having a delirium.⁸⁻⁹ Screening for cognitive impairment is essential because people with dementia or delirium are more likely to have adverse events (particularly falls).¹⁰ Delirium is a serious medical problem that is common, costly, under-recognised, and often fatal.¹¹ Dementia is a strong risk factor for delirium, and many people with delirium have this superimposed on an underlying dementia.¹¹

Cognitive impairment may have already been documented, or may become obvious during history taking, but it is always useful to ask older patients about their memory. “Can you remember the name of where we are here at the moment?” or “Can you remember what year it is this year?” are simple questions that may indicate the need for more formal assessment later. These are included in the 4A Test (www.the4AT.com), a quick and validated test that can detect most cases of delirium and cognitive impairment.¹² It assesses alertness; orientation to person (age and date of birth), place, and time (year); attention (months of the year backwards); and acuteness of onset. The Confusion Assessment Method¹³ may also be used but does require training.

What are the challenges?

Challenges in communicating with older people may occur, because of cognitive impairment, deafness, impaired vision, dysphasia or dysarthria, depression, and language barriers.⁶ When it is difficult to take an accurate history, it is crucial to obtain collateral information as discussed. A single telephone conversation can save time in the assessment process. A health interpreter may be required when English is not spoken.

Older people can present very differently from younger people with similar medical problems, and findings can often be subtle or undifferentiated. As an example, Mrs Brown presented with a delirium rather than specific symptoms of a urinary tract infection. Older patients often have multiple comorbidities, with polypharmacy and iatrogenic disease. Mrs Brown’s postural hypotension illustrates this problem.

Cultural barriers associated with ageism may also exist, with the tendency to use labels such as “acopia” and “social admission” rather than to look for the real cause for admission with a thorough assessment.¹ Dealing with complex, often interacting medical, physical, psychological, and social problems can be time consuming, but the investment of time is worthwhile with an accurate assessment leading to correct diagnoses, appropriate management and referrals, and a better outcome for the older patient.⁶

ANSWERS TO ENDGAMES, p 35

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STATISTICAL QUESTION

Meta-analyses: what is heterogeneity?

Statements *a*, *b*, and *d* are true, whereas *c* is false.

ANATOMY QUIZ

Anteroposterior radiograph of a barium examination of the oesophagus

- A: Aortic arch impression
- B: Left main bronchus impression
- C: Thoracic aorta
- D: Left atrial impression

PICTURE QUIZ

A rapidly enlarging swelling of the left orbit

- 1 An orbital mass carries a wide differential diagnosis, with three main categories: infectious causes, orbital tumours, and inflammatory lesions.
- 2 The rapid growth of the lesion, superonasal position, and non-response to antibiotics favours the diagnosis of a malignant orbital tumour—the most common primary orbital tumour in children.
- 3 Computed tomography and magnetic resonance imaging of the orbit and surgical biopsy (not fine needle aspiration), followed by staging investigations—computed tomography of the chest, a bone scan, and bone marrow biopsy. Detailed ophthalmological evaluation is advised.
- 4 Management takes into account patient age, tumour size, site, histology, and staging of disease. Presurgical staging (TNM—tumour, node, metastasis), open surgical biopsy, and postsurgical staging are the first steps. Chemotherapy is always needed. Radiotherapy can be added on the basis of the response.
- 5 Five year survival is good (84.3%) in localised orbital disease. Recurrence is seen in about 17% of cases, at a median of 18 months from diagnosis, although it is possible beyond five years.