Assessing the Elderly:
Getting into the Seven Habits

Darryl B. Rolfson, MD, FRCPC

As presented at the Regional Conference in Geriatrics, Grande Prairie, Alberta

Physicians and other health professionals often confront functional presentations and obscure historic details when dealing with the geriatric patients. Contrary to conventional thinking, the required diagnostic methods to make sense of such cases are available. In its essence, geriatric assessment consists of a proper history, physical exam and mental status exam, followed by a sober and thoughtful formulation.

Despite patient complexity, geriatric assessment does not need to be a cumbersome process. The following seven habits of geriatric assessment will empower front-line clinicians, enhancing assessment accuracy and speed.

#1 *Function as the language of illness in frail geriatrics*

Adults, of any age, usually manifest acute illness with typical signs and symptoms. However, when they have other chronic physical or cognitive conditions, the manifestation of acute illness may be atypical and reflect their underlying vulnerabilities. A short time course of illness suggests an acute process. The language of illness is the functional nature of the

George's case

- George, 87, a retired plumber, presents to the emergency room with a concerned neighbour, Ted, who noticed newspapers collecting outside George's dorr for a week.
- Ted found George on the couch and he seemed to be unusually drowsy and disheveled.
- The home was in disorder with perishable food on the counter and significant clutter throughout the house.
- Ted doesn't know about George's health problems, but did bring a bag of pill bottles.
- George is unable to answer your questions well, though he was more lucid an hour ago. George is unable to tell you about any past medical problems or medications.
- Physical examination is limited by George's poor bed mobility. He is afebrile with a blood pressure of 110/68 mmHg, a heart rate of 90 bpm and normal respirations. You note that he is pulling off bedsheets and trying to climb over the bedrails at times. There is no evidence of abnormalities in the cardiac or respiratory exam. His abdomen is full and his rectal exam reveals fecal loading. No focal neurologic signs are evident and he can only walk a few steps with assistance on each arm.

George's diagnosis is on page 72.

George's diagnosis

George has presented with functional problems, rather than with classic clinical symptoms. Frail, older adults often manifest treatable illness in unconventional ways, such as functional decline. These atypical disease presentations are common in the frail elderly and have an independent impact on adverse hospital outcomes.[1]

presenting symptom itself (cognitive decline, immobility, incontinence, *etc.*), hinting to a system of vulnerability (the weakest link).

#2 Clear the barriers

The frail elderly may present a sequence of barriers that, if anticipated, can be easily cleared. However, if the physician cannot overcome one of these barriers, they should move on to the next.

- ***The attention barrier:*** Remember that pronounced drowsiness fluctuates; this may be due to an underlying delirium that will colour the interpretation of all clinical interactions.
- ***The language barrier:*** Ensure that you consider language proficiency and aphasias before forming conclusions about other cognitive abilities.
- ***The behavioural barrier:*** Rule out frontal lobe dysfunction and other psychiatric conditions if you encounter hostility or socially inappropriate behaviour.
- ***The cognitive barrier:*** Take a collateral history (habit 4) to aid in uncovering major discrepancies between the direct patient history and reality.
- ***The special sensory barrier:*** Attend to the small details; correction of hearing and vision may transform an individual with apparent dementia into a scholar.

Dr. Rolfson is an Assistant Professor of Medicine in the Division of Geriatric Medicine, University of Alberta. He is also the Medical Site Leader for Senior's Services at the University of Alberta Hospital and Program Director for Geriatric Medicine, Edmonton, Alberta.

#3 Use screening tools to your advantage

A number of validated and reliable screening tools (Table 1) identify geriatric syndromes without being cumbersome or time-consuming. Some of these include the confusion assessment method for delirium,[2] the clock test for dementia,[3] the frontal assessment battery for frontal lobe dysfunction[4] and the timed up-and-go test[5] to predict the patient's risk of falling.

#4 Obtain collateral input with permission

Collateral history is time well-spent because it illuminates function and context. It can also expedite solutions to perplexing problems that do not depend solely on the care team.

#5 Expand on the traditional history

The traditional medical history can be enhanced in the frail older adult with a few modifications. The use of problem lists and the habit of rationalizing medications are examples and will be described as habits six and seven.

The cognitive history

A reliable cognitive history will be as helpful as specialized mental status testing. The history should capture time course (onset and progression) and specific cognitive domains.

Common cognitive domains of interest include:

- attention,
- memory,
- language,
- praxis,
- recognition,
- executive functioning,
- visuospatial abilities,
- insight and
- judgment.

There may also be neurobehavioural changes including:

- apathy,
- delusions,
- hallucinations,
- psychomotor changes (retardation or agitation),
- sleep disturbances and
- alterations in appetite, *etc.*

The functional history

The functional history includes the activities of daily living (ADLs) (*i.e.,* dressing, grooming, bathing, feeding, toileting, transfers and ambulation). Instrumental ADLs include meal preparation, shopping, housekeeping, doing laundry, telephone use, yard work, driving, financial management and medication management.

Cover photograph: Clock test representation (Firstlight Images®)

Table 1
Common screening tools for geriatric syndromes

1. The Confusion Assessment Method (CAM)[2]

A positive CAM predicts delirium with good sensitivity, specificity and reliability and can be completed in five minutes. This algorithm depends on a prior review of the history, an interview of capable informants, such as nurses or family, and a brief mental status evaluation of the patient. The presence of four cardinal features sets the stage for delirium:

1. Acute onset and fluctuating course
2. Inattention
3. Disorganized thinking
4. Altered level of consciousness

The presence of the first two cardinal features and either of the latter two constitutes a positive screen.

2. The clock test

Many scoring systems exist, however, front-line clinicians do not generally require a score to obtain a useful screen. In the common modified Shulman method, subjects are asked to add the numbers of a clock face to a pre-drawn, 10-cm diameter circle and to set the hands to indicate the time, 10 minutes after 11.[3] This method allows for scoring on a six-point scale. However, for practical purposes, it is useful to distinguish a normal clock (minor spacing errors only) from an abnormal clock (omissions, duplications, major spacing errors, incorrect time).

3. The frontal assessment battery (FAB)[4]

The FAB can be completed in less than five minutes and is easy to administer. It is reliable and has good discriminant validity. Subjects are scored on a scale of zero to three on each of the following six test items:

- similarities between word clusters,
- lexical fluency (word generation),
- motor programming (luria fist-edge-palm),
- conflicting instructions and inhibitory control by pen-tapping and
- prehension behaviour.

4. The timed up-and-go test[5]

The time required for a patient in a sitting position to stand unassisted, ambulate 3 m and return to the chair is recorded. If that time exceeds 20 seconds, the risk of falling in the future is significantly increased.

The social history

The social history should explore the patient's past personal history, their current home environment and co-habitants and their support network, both formal and informal. It is important to be clear on "who does what" and "for what reason," especially as it relates to ADLs. The presence and "activation status" of medico-legal documents, such as an advanced directive, power of attorney and (in the case of dependent adults) guardianship and trusteeship are important to clarify.

#6 *Rationalize medications*

Medication reviews only require a few extra seconds and can be built into every history. By matching a patient's past medical history or their current problems with medications, you can often spot issues of medication appropriateness, drug interactions and drug-disease interactions. Hence, the medical problems or the medications can be responsible for the patient's abrupt functional decline.

#7 *Start and end with a problem list*

A problem is a clinical, functional or psychosocial issue that has an impact on the current health and well-being of your patient. The first problem list in the history should be descriptive and experiential. The last problem list should condense relevant subjective and objective findings into a formulation that leads to specific plans. It is natural to build this problem list from its basic and acute elements toward more chronic and functional problems and finally to social and rehabilitation issues.

In summary...

The seven habits of geriatric assessment described above may be time-consuming, and even unnecessary, when applied to all older adults. However, in the context of a frail, older adult who manifests their illness atypically (using the language of function and cognition), these modifications to the basic medical assessment should spare the physician the excess time and expense of diagnostic uncertainty and inappropriate referrals. Dx

References
1. Jarrett PG, Rockwood K, Carver D, et al: Illness presentation in elderly patients. Arch Intern Med 1995; 155(10):1060-4.
2. Inouye SK, van Dyck CH, Alessi CA, et al: Clarifying confusion: The confusion assessment method. Ann Int Med 1990; 113(12):941-8.
3. Shulman K, Gold D, Cohen C, et al: Clock drawing and dementia in the community: A longitudinal study. Int J Geriatr Psychiat 1993; 8:487-96.
4. Dubois B, Slachevsky A, Litvan I, et al: The FAB: A frontal assessment battery at bedside. Neurology 2000; 55(11):1621-6.
5. Podsiadlo D, Richardson S: The Timed "Up and Go": A test of basic functional mobility for frail elderly persons. J Am Geriatr Soc 1991; 39(2):142-8.