Geriatrics for Inpatient Medicine

THE BIG PICTURE : AGE ADAPPTT

A = ADLs/ IADLs (function)
G = goals of care/prognosis
E = evaluate/eliminate meds
A = advance directives, identify surrogate
D = delirium, dementia, depression
A = activity, avoid bed rest
P = pain
P = pressure ulcers
T = tubes and tethers (foleys, IVs restraints)
T = transitions

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Supported by a grant from the Donald W. Reynolds Foundation and with ongoing support from the UCSF Geriatrics Division Center on Aging

ON ADMISSION HX REMEMBER TO DOCUMENT:

ADLS (bathe, dress, toilet, transfer, continence, feeding)
IADLs (telephone, shopping, food preparation, housekeeping/ laundry, transportation, taking medicine, managing money)
Living situation, caregiver
Advance directives (are there any?) and goals of care
Geriatric ROS: falls, incontinence, mood, weight loss, cognition, change in function

ON ADMISSION PE REMEMBER TO DOCUMENT:

- Consider orthostatic blood pressure and pulse
- Mini-cog (MOCA AND CAM if abnormal)
- PHQ-2 for mood
- Gait assessment
- If patient not walking, full exam for pressure ulcers

EVERY DAY CONSIDER THE FOLLOWING AREAS:

Assess Function: Know patient's **physical** & **cognitive** function for discharge planning; include **bowel** & **bladder**. Has function changed since admission? 1/3 patients decline

Evaluate/eliminate high risk meds when possible: Always perform **medication reconciliation** prior to discharge

Goals of Care: Know patient's **goals** (comfort, life prolongation) and likely prognosis (yrs) to help guide therapy. Validated prognostic indices can be found at **eprognosis.org**

Advance Directives: With or without formal advance directive, **identify a surrogate** if at all possible.

Dementia/depression/delirium: Screen with Mini-cog/CAM/ 2 - item depression screen

Activity: Bed rest is toxic to elders and can cause severe functional decline. Encourage staff to **walk patient daily** and minimize time in bed. If unable, get **PT** to prescribe **exercises in bed** until patient able to walk

Pain: Assess daily; for uncontrolled pain or if patient has dementia try to use **ATC** analgesia rather than PRN

Pressure Ulcers: Preventable with turning, appropriate mattresses in highest risk patients; call wound RN early on

Tubes: Tubes, lines and catheters acts as one point **restraint** and are possible sources of **infection**. **Get all out quickly**.

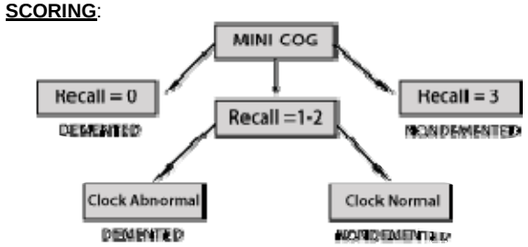
Transitions: Consider discharge issues **from day one**. If patient to go home is help w/ADLs/ IADLs needed? Available? Finances? If may go to SNF, is PPD placed? Is follow-up in place? **Communicate w/ PCP.**

DEMENTIA

MINI COG - A Quick Dementia Screening Tool

1. Ask patient to remember 3 words after you say them (ex. ball, flag, tree) and then repeat the words back to you
2. Instruct patient to draw face of a clock on a pre-drawn circle with the hands to read a specific time (e.g. 8:10). Instructions can be repeated. If the patient cannot complete task in ≤3 min, move on to the next step.
3. Ask patient to repeat the 3 previously presented words

SCORING:



If patient has a positive mini-cog, screen further to try to determine if patient has delirium, dementia, or both

DEMENTIA PEARLS:

- Patients with dementia have high risk of delirium so implement delirium prevention (**see delirium on reverse side)**
- Document degree of dementia and be certain patient has a safe discharge plan
- Many patients with dementia have capacity to make decisions; capacity is decision specific - able to communicate a choice, understand the relevant information, appreciate the situation and the consequences of their choice, and reason about treatment options
- If competence/capacity an issue, get social work/geriatrics/ psychiatry involved early especially if **5150** may be necessary; consider KELS evaluation with OT; consider APS referral at the time of discharge *if indicated*

*From: Borson et al. International J of Geri Psychiatry 2000; Grisso, Appelbaum. Assessing competence to consent to treatment:a guide for physicians and other health professionals.*1998

DEPRESSION

PHQ-2: OVER THE LAST 2 WEEKS, HAVE YOU BEEN BOTHERED BY:

1. Little interest or pleasure in doing things?
2. Feeling down, depressed, or hopeless?

⇒ If yes to either, complete PHQ-9

From Whooley et al 1997; www.depression-primarycare.org;

PRESSURE ULCERS

SUSPECTED DEEP TISSUE INJURY:

- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear
- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue

STAGE I:

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence.

STAGE II:

- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough
- May also present as an intact or open/ruptured serum-filled blister.

STAGE III:

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed.

STAGE IV:

- Full thickness tissue loss w/ exposed bone, tendon or muscle
- Slough/eschar may be present on some parts of wound bed.

UNSTAGEABLE:

- If slough and/or eschar obscures wound, true depth/ stage cannot be determined
- Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed

From: www.amda.com Pressure Ulcer Therapy Companion, Clinical Practice Guideline.

DELIRIUM

DIAGNOSIS: CAM (Confusion Assessment Method)

1 + 2 + (3 or 4)

1= Acute Onset & Fluctuating Course
PLUS
2= Inattention
AND EITHER
3= Disorganized Thinking
OR
4= Altered LOC
(Most Common = HYPOACTIVE Form)

DELIRIUM VERSUS DEMENTIA:

Feature	Delirium	Dementia
Onset	Acute	Insidious
Course	Fluctuating	Constant
Attention	Disordered	Gen Preserved
Alertness	Disordered	Gen Preserved*
Hallucinate	Often Present	Gen Absent*
Psychomotor changes (hyper or hypo)	Often Present	Gen Absent*

* variable in advanced dementia

DELIRIUM PREVENTION:

1. Encourage hydration (elevated BUN is delirium risk factor)
2. Frequent orientation with family, friends, clocks, calendars, and white boards
3. Minimize medications, particularly anticholinergic, sedatives, hypnotics, opiates
4. Treat pain, try to use ATC rather than PRN; match level of pain medications to level of pain; attempt use of non-opiates
5. Keep room light during the day, keep room quiet and dark at night and try to minimize sleep disruptions
6. Encourage daytime activity; consider specific written order like ambulate 3x/day
7. Try to make certain that glasses/magnifier and/or hearing aids/ "pocket talker" available
8. Minimize restraints, unnecessary catheters/tubes/lines
9. Look for impaction and urinary retention if medical workup for usual causes (MI, infection, etc.) is negative

DELIRIUM TREATMENT:

1. Use drugs only as last resort for safety of patient/ staff; seek psychiatry/neurology consult as needed; document discussion of risks /obtain informed consent (pt or family)
2. Use sitters and/or family for safety and orientation
3. If drugs needed, use typical antipsychotics if possible (e.g. haloperidol 0.5mg-1.0 mg nightly or BID) or atypical antipsychotics; **start w/lower dose than young adult**; wean down/off as delirium clears; beware prolonged QTc, check ECG; beware EPS
4. Avoid benzodiazepines (unless ETOH or benzo withdrawal).
5. Also consider whether patient has dementia, PD, LBD

From: Inouye et al. Ann Intern Med 1990.

MEDICATIONS

APPROPRIATE PRESCRIBING:

- Is there an indication for the drug?
- Is the medication effective for the condition?
- Are the directions and dosage correct?
- Are the directions practical, given this patient's situation?
- Are there clinically significant drug-drug, drug-disease, or drug-condition interactions?
- Is there unnecessary duplication with other drugs?
- Is the duration of therapy acceptable?
- Is this drug the least expensive alternative?
- For **psychoactive** drugs carefully consider risks and document **informed consent.**

MEDICATIONS TO AVOID IN ELDERLY:

- Diphenhydramine (Benadryl)
- Metaxolone (Skelaxin) and cyclobenzaprine (Flexeril)
- Amitriptyline; fluoxetine (Prozac); other SSRIs better
- Hydroxyzine (Atarax); promethazine (Phenergan); metoclopramide (Reglan); anticholinergics
- Benzodiazepines, especially long-acting (Librium, Valium)
- H2 blockers (increase delirium risk)
- Toradol; long term use of long acting NSAIDs (like Naproxen)
- Insulin sliding scale: high risk of hypoglycemia
- Avoid antipsychotics for behavior problems of dementia.

Also see American Geriatrics Society Updated BEERS Criteria (2012): www.americangeriatrics.org

FOLEYS

APPROPRIATE INDICATIONS FOR INDWELLING URINARY CATHETER USE IN HOSPITALIZED PATIENTS:

1. **Bladder outlet obstruction**
   - ⇒ Temporary relief of anatomic or functional obstruction
   - ⇒ Longer-term drainage if surgical correction is not indicated
   - ⇒ For patients with BPH, consider initiation of alpha antagonist and/or finasteride therapy
2. **Urinary incontinence (without obstruction)**
   - ⇒ In a patient with an open sacral or perineal wound
   - ⇒ At a patient's request (primarily for patients at the end of life)
3. **Urine output monitoring required**
   - ⇒ When frequent or urgent monitoring is needed, e.g., in critically ill patients
   - ⇒ When a patient is unable or unwilling to collect urine
   - ⇒ During prolonged surgical procedures with general or spinal anesthesia

From: Saint, Lipsky. Arch Intern Med 1999.

FALLS

RISK FACTORS FOR A FALL:

- Poor vision
- Delirium; dementia
- Diarrhea; incontinence
- Orthostasis; weakness; impaired gait
- High risk medications, especially for sleep
- Environment

PRACTICAL STRATEGIES FOR FALL PREVENTION:

- Address risk factors and readdress risk daily; consider risk of injury (e.g. warfarin, osteoporosis)
- Review medications daily
- Non-pharmacologic sleep protocol best
- Nursing plan = low bed, bed alarm, etc.
- Educate patient/family, especially with new risks

PROGNOSIS

A SIMPLE PROGNOSTIC INDEX:
For 1 year prognosis in patients age 70 and older

Factor	Points
Male Gender	1
ADL dependence at discharge	
in 1-4	2
in all	5
Congestive Heart Failure	2
Cancer	
Solitary	3
Metastatic	8
Createnine > 3.0	2
Albumin	
3.0 – 3.4	1
< 3.0	2
Total	

1 YEAR MORTALITY:

1-4 points	4%
2-3 points	19%
4-6 points	34%
> 6 points	64%

HOW TO USE THIS INDEX:

For patients in the highest risk category, consider hospice or preparing for end of life care. Also consider omitting interventions that only have long term mortality benefit (like cancer screening).

Also consider hospice/palliative care in patients with advanced dementia, CHF, and COPD.

From: Walter et al. JAMA 2001.