Making the Rounds on Elderly Patients

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BY CHRISTINA CHASE

PHILADELPHIA — Eight basic rules for making the rounds on older, hospitalized patients can help identify problems that the house staff may not focus on, Dr. Evelyn C. Granieri said at the annual meeting of the American College of Physicians.

It takes only 10 minutes to complete all eight assessments, said Dr. Granieri, a geriatrician at Columbia University, New York, who said she has been doing inpatient rounds almost daily for 17 years.

The eight rules are as follows:

 ► Review all medications. Do this every day you visit the patient. Consider how changes in body weight and renal function may affect the appropriate dosage. “Older adults in the hospital are very dynamic in terms of their status,” she noted.

 Also, you should keep in mind that medication changes are a major precipitant of delirium in older adults. On average, patients go into a hospital on about eight drugs and leave on about nine, and five of those medications are new, Dr. Granieri said.

 Given the 70% rate of cognitive impairment in hospitalized elderly patients over age 70, the discharge plan for medications needs to be “as simple as possible,” she said. Complex drug regimens are bound to fail, and may even precipitate an emergency department visit or rehospitalization.

 “Don’t send patients home on b.i.d., t.i.d., and q.i.d. regimens. Try and do a q.d. or b.i.d. at the very most. This is very important,” she advised.

 ► Perform a cognitive assessment. The best screening test is simply asking the elderly patient to draw a clock showing a specific time, such as 2:45. Give the instructions just once, and be relentless in judging the results. “It’s either right, or it’s wrong,” Dr. Granieri said.

 She related the story of a patient, who happened to be a practicing physician in his 70s, who drew and numbered the clock correctly but then added three hands pointing at 2, 4, and 3 and circled those numbers to indicate 2:43. As a physician, she said, “he had perfected the art of being vague.”

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 The clock test is a good early screen, but “it’s not a diagnostic, it’s an unmasking tool,” she noted. It’s critical to unmask the impairment because a patient who can’t draw a clock won’t be able to take medications correctly or drive a car.

 ► Look for pressure ulcers. Check the skin daily because a pressure ulcer can develop in as little as 2 hours. With the current shortage of hands-on nursing care, doing this screen faithfully has become more crucial. On admission, 2%-10% of patients have pressure ulcers, but 10%-20% have them on discharge, Dr. Granieri noted.

 ► Check functional status. “One of the first things that I now do on a frail older people or people over the age of 75 is immediately get a physical therapy and occupational therapy consult. This guarantees that the patient will get out of bed and be checked for ambulation. Also, the therapists often notice skin breakdown, incontinence, and problems following directions.

 In bedridden patients, significant loss of muscle mass starts after 5 days, but it takes 9-12 days to begin rebuilding muscle with help from physical therapy. But even without a consult, “you can look at them and see. You can tell if someone is getting out of bed. You can ask them to swing their legs around and stand,” she said.

 ► Assess for gait dysfunction and fall risk. “It’s incredible that many patients are discharged from the hospital without any test of their gait and ambulation,” Dr. Granieri said.

 To prevent falls in the hospital, get rid of the Foley or Texas catheter. These are seldom needed but often overused, potentially causing falls as well as increasing the risk of urinary tract infections and resistant bacteria.

 There is little that can be done to prevent falls in the hospital. “At the risk of sounding pessimistic, it’s tough—there’s no good answer.” A few environmental changes may help. Make sure that the beds are lowered, that there’s enough light, and that each patient has a bedside commode.

 ► Determine if your patient is eating and drinking. If a patient is malnourished upon admission, this can’t be cured during a 3-day hospital stay. But during rounds, be sure the patient’s food tray is close enough to reach, use a feeding program if one is available, and check swallowing ability at least once (or be sure that nurses check).

 ► Aspiration pneumonia—especially for people who are hospitalized who may be delirious or have cognitive impairment or infections—is deadly, she noted.

 Calorie counts are a waste of time, said Dr. Granieri, who used to be a dietitian and did many such counts herself. “If you think your patient is malnourished and they’ve lost weight, [they have]. Get them to eat by any means possible.”

 For those patients who will not or cannot eat, don’t use tube feedings, she advised, “unless it’s time limited, or unless they have only one organ system that’s problematic.

 Tube feedings in people with dementia do not keep them alive longer, but do increase complications. And studies have shown that people at the end of life don’t necessarily sense hunger and thirst. “Once someone stops eating, that’s it,” she said. It’s important to talk with families early about the issue of tube feedings, she added.

 ► Be sure patients have their glasses, hearing aids, and walking devices. If a patient doesn’t have glasses on, chances are they are somewhere nearby such as in a drawer, since almost all older people have some visual impairment. Likewise, a patient who used a walker at home should have one accessible in the hospital or nursing home.

 ► Use the team of clinicians that is available to you. Get consults, especially for home care. Take advantage of all the services available, such as physical therapy and nutrition services. Don’t take care of a frail older patient alone, she emphasized.

 Finally, keep in mind that all eight of these issues form an interrelated matrix. A patient with cognitive impairment cannot manage a complex medication schedule after discharge, and a patient who can’t reach his glasses might not eat his meals.

 “One of the goals is ... to try and get you to think in a matrix way, as opposed to a linear, or algorithmic, way,” Dr. Granieri said.

 Elderly Face Grief and Loss Differently Than Do Others

BY MITCHEL L. ZOLER

PHILADELPHIA — Loss is inevitable for the elderly, and with loss comes grief. Losses are not just the deaths of loved ones, friends, and acquaintances. The elderly also experience loss and grief as they begin to have diminished ability in activities of daily living. This then can cause the elderly to lose a sense of purpose.

 Many elderly also have difficulty when they can no longer live independently. They struggle with the loss of their homes, their possessions, their health, body parts, their vocations, not to mention their independence, Vicki L. Schmall, MD, PhD, and Patrick Arbore, EdD, said at a conference sponsored by the American Society on Aging.

 “Anything lost in which a person has invested, invested ... time, energy, or dreams” leads to grief and mourning, said Dr. Schmall, president and gerontology specialist at Aging Concerns, based in West Linn, Ore.

 “The psychologic context of loss is different for the elderly, compared with that for younger people,” said Dr. Arbore, director of the Center for Elderly Suicide Prevention at the Institute on Aging in San Francisco. In younger people, losses tend to be sudden and unexpected. For the elderly, losses are not unexpected. And though they are perceived as inherent to living a long life, the accumulation of loss can lead to “bereavement overload,” Dr. Arbore said.

 Grief is a natural and expected reaction to any loss, not just another person’s death. It is the process of experiencing the psychological, behavioral, social, and spiritual meaning, but it’s hard to get a time frame on grief. Periods of sadness should not be diagnosed as depression unless they are unusually prolonged, severe, or cause clinically significant impairment.

 Normal reactions that individuals experience after the loss of a loved one include denial, confusion, lack of concentration, fatigue, forgetfulness, irritability and anger, sadness and anguish, anxiety, and horror.

 Health care workers should not make the mistake of giving patients agents that sedate the pain of grieving, said Dr. Schmall, former director of the program on gerontology at Oregon State University in Corvallis. This prevents people from talking about their loss, an important part of grieving.

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 In contrast, depression is a state where pain is experienced as being useless and meaningless.

 In general, after the loss of a loved one, symptoms of depression usually last for up to 10 weeks. Then it’s hard to get a time frame on grief. Periods of sadness should not be diagnosed as depression unless they are unusually prolonged, severe, or cause clinically significant impairment.

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 A person needs an outlet for their pain by grieving. He or she also needs to be able to work through grief and pain, Dr. Schmall said.

 The most effective ways to help someone who is grieving is to be empathic, acknowledge the person’s loss, and help the patient experience the event at his or her own pace.