COLLEGE OF GENERAL PRACTITIONERS OF SRI LANKA

Print CPD Programme
August 2013

CARE OF THE ELDERLY IN GENERAL PRACTICE

Author
Dr. Ruvaiz Haniffa

Edited by
Dr. Jayantha Thambar

Care of the elderly in General Practice

Dr Ruvaiz Haniffa, MBBS., DFM., PGDip., MSc., MD(Col)., MCGP(SL)., MRCGP (INT)
Lecturer, Family Medicine Unit, Faculty of Medicine, University of Colombo

Edited for print CPD by Dr Jayantha Thambar
Original document is available at the College office and is recommended for those interested in elderly care

The total number of general practice consultations in Sri Lanka is estimated to be around 12.7 million consultations per year. Of this 32 – 50% of the elderly population in Sri Lanka use medical services with more females using the services than males [2]. In Sri Lanka the percentage share of the over 60 years population is expected to more than double from 10% in 2001 to 22% in 2031. In absolute terms, the number of elderly would treble from 1.9 million to 5.1 million [3]. This scenario reflects global trend in demographics.

With rapid changes in demography, family dynamics, socio-economic status and cultural values in Sri Lankan society, family physicians have a unique opportunity to participate in the lives of the elderly as the qualities a general/family practice have, make them uniquely tailored for the care of elderly patients. A family physician/general practitioner would therefore be the ideal health care provider and healthcare coordinator for the elderly patient in the current context and for the foreseeable future in Sri Lanka [1].

Definition of elderly

For practical purposes the following criteria are use to define and classify the elderly population.

- Young old – 65 years to 74 years
- Old - 75 years to 84years
- Old-old - 85 years to 94 years
- Extremely old - ≥95 years

Ageing

Ageing is an inevitable process associated with anatomical, biochemical, physiological and psychological decline which leads to and results in functional decline of the individual. The decline in each system has a unique physiological and/or pathological process which results in a myriad of signs and symptoms.
The optimal application of the basic principle of geriatrics is *the preservation of function and the improvement of quality of life.*

Assessment of the Elderly in General Practice

The World Health Organization recommends *"health in the elderly is best measured in terms of function"*. As ageing leads to a functional decline in the individual proper and accurate

assessment of function in terms of anatomical, biochemical, physiological and psychological parameter becomes important in the elderly for;

1. Problem detection
2. Planning to overcome limitations
3. Prevention
4. Monitoring of progress and/or decline over time

Proper and accurate functional assessment has the following benefits;

1. Improves diagnostic accuracy and hence optimal management
2. Improvement in functional status
3. Improves affective and cognitive function
4. Decrease hospital use and medication which results in decreased health cost to individuals and the state
5. Increases rate of survival with better quality of life.

The care of the elderly requires management of a broad range of information derived from the person's medical condition, psychological makeup, social circumstances and living environment.
The assessment of the elderly can be done in many ways using a variety of methods.

1. System based approach i.e.- examination of cardiovascular system,
2. Systematic functional based assessment of region/organs (ie- vision, hearing, Upper limb for movement, power and sensation etc)
3. Nutritional assessment
4. Mental State assessment

In actual general practice a tool/s which combines the salient feature of each of these parameters is widely used. (Please see Annex 1)

If the patient presents with non specific symptoms, unexpected deterioration in health and/or inability to cope with Activities of Daily Living (ADL), it is useful to consider the following check list in the assessment;

1. Mental state - confusion/ dementia, Depression, Bereavement

2. Eyes- visual acuity ,Cataract / glaucoma

3. Ears- deafness, Tinnitus

4. Mouth - Dentition,xerostomia, malnutrition

5. Medication- Polypharmacy, Adverse drug reaction

6. Bladder / Bowels- Incontinence, retention, urinary tract infection

7. Locomotion - Gait, movement disorders ,arthritis, circulation

In the process of assessment the GP must remember that the elderly patient requires considerable support, understanding caring and attention.

Home visits

A Home visit is an important component in the overall assessment of an elderly patient, serving as a 'security gesture' to the patient and evidence of support for the desire to remain independent for as long as possible in their place of residence. It also helps strengthen the doctor-patient relationship which is of particular importance to the frail elderly patient feeling increasingly insecure and threatened. Home visits allows the physician to gather information that may not have been uncovered in the office visit, such as confirming medication and assessing compliance, assess care giver capabilities and facilities available, assessing incontinence, neglect and activities of daily living and instrumental activated of daily living.

Home visits can be considered under three categories;

1. An 'unexpected visit' – especially to a new patient
2. A patient initiated but routine request for a 'check up'
3. The regular call – at a predetermined frequency at the convenience of the doctor, patient and care giver/s

Physicians who make home visits are looked upon as more caring and patients show a preference towards clinics, hospitals and medical centers where such programmes are based.

Special aspects of Geriatrics in Family Medicine/General Practice

One of the most challenging clinical situation in the elderly is that certain common conditions occur without the accepted features of the illness or take a different form obscuring the diagnosis or problem definition. In addition some illnesses will present differently when they occur in the elderly. The practitioner has to be mindful of this fact have a very high degree of clinical suspicion and vigilance when dealing with elderly patients.

A combination of anatomical, biochemical, physiological and mental factor may present as a single of combination of social, situational and behavioral changes with or without clinical signs and symptoms. A well recognized combination of presentation of the elderly primary care known as the 'Classical Triad' is shown below.

1. Frailty

Frailty is defined as dependence on others for Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). It is a multidimensional concept that considers the complex interplay of physical, psychological, social and environmental factors. Frailty is different from disability. It may be the cause of and/or consequence of disability or co morbidities.

Like all physicians, general practitioners too have been trained to focus on specific medical diseases when approaching patients. Frailty however, does not fit in this approach because there is almost never a chief complaint. It is a distinct entity which must be recognized by the primary care physician in order to provide efficient, relevant and cost effective care in a

holistic manner. Identification of frailty provides a conceptual model for moving away from the organ and disease based medical approach towards a more health based integrated approach [4].
In actual practice terms, frailty is recognized in the presence of the following core elements.

1. Weakness
2. Tiredness
3. Poor endurance
4. Weight loss
5. Low levels of physical activity
6. Slow gait speed

Presence of 3 or more core elements – Frailty
Presence of 1 or 2 core elements – Precursor state
No core elements – No frailty

Frailty is measurable and a number of tools/instruments with different parameters have been developed for use in general practice. E.g. Groningen Frailty Indicator, Frailty and Autonomy Scoring, Instrument of Leuven (FRAIL), Edmonton Frail Scale and Frailty.

2. Mental Health Problems

In the elderly there are five categories of mental disorders that are of particular importance. There can be easily recalled as the 5 Ds. They are [5].

1. Delirium – A syndrome of acute cognitive impairment occurring in the context of physical illness.
2. Dementia – Is an acquired syndrome due to disease of the brain resulting in progressive or chronic impairment of several domains of higher cognitive functioning, including memory, language, visuospatial ability, praxis, gnosis executive function and calculation.
3. Depression – It is reported that 6% of the elderly population suffers from depression. These patients are very likely to present to primary care physicians rather than psychiatrist
4. Delusion (Psychosis in the elderly) – Persistent hallucinations and delusion are cardinal signs of psychotic illness
5. Distress (Anxiety and stress related disorders)
   Anxiety that is inappropriate or disproportionate to events is considered pathological and may cause considerable functional impairment.

3.Atypical presentations of common problems

1. *Infection without fever* [1]

Elevation in the body temperature is a universally accepted sign of an acute change in clinical status. The febrile response may be absent or blunted in infections in the elderly. There may indeed be appropriate rise in temperature due to infection but it may not be detected because the baseline normal temperature in the elderly is lower. Significant leucocytosis occurs less

frequently in the elderly rendering interpretation of routine hematological screening tests and screening tests on other body fluids for infections difficult to interpret.
The clinician's suspicion of infection may be reduced when abnormal physical findings or complaints are erroneously attributed to pre morbid conditions or ageing alone. This early misjudgment leads to biased subsequent interpretation of information, which in turn leads to delay in appropriate treatment, unnecessary testing, and eventually long and unnecessary hospitalization.

2. *Noninfectious causes of fever*

The most common non-infectious cause of fever is mechanical blockage of a hollow viscous causing a local inflammatory response ie (fecal impaction or blocked urinary catheter), atelectasis or mucus plugs in the bronchi and phlebitis, with or without thrombosis
.

3. *Bowel problems*

Complaints of constipation are common in elderly. Constipation is defined as having two or less bowel movements per week, straining at stool on more than 25% of occasions and finding of large amounts of faeces in the rectum on digital rectal examination or abdominal radiography.
A reduced intake of dietary fiber, dehydration, cognitive impairment, co morbidities (diabetes, strokes, Parkinson's disease, depression, dementia), electrolyte imbalance (hypokalemia and hypercalcemia) and certain medications (diuretics, NSAIDS, angiotensin-converting enzymes inhibitors, narcotic agents and aluminum containing antacids) play important aetiological roles in constipation in the elderly.

4. *Pain*

Pain perception and pain reaction thresholds are decreased in the elderly. The inability to describe accurately and/or localize pain and associated symptoms, particularly in the gastrointestinal system plays a significant role in the high morbidity and mortality associated with gastrointestinal diseases in the elderly.

5. *Breathlessness*

Changes in mental status may mask the sensation of dyspnoea although tachypnoea may be evident. This presentation is most evident with acute congestive heart failure, pulmonary emboli and intestitial lung disease in which symptoms other that breathlessness, such as chest pain, lower limb swelling and dizziness may be the patient's chief complaint.

Falls

About one third of community dwelling persons over the age of 65 years fall each year. A serious outcome of falling which often not addressed by doctors is the development of fear of falling, which has a serious impact on the quality of life of the patient, causing a radical and dramatic change in the patient's outlook on life and living.
The etiology of falls as with most geriatric syndromes tends to be multi factorial.
The causes of falls can be categorized in to three categories.

1. *Intrinsic factors* – conditions that impair central processing, neuromuscular control, sensory input and musculoskeletal activity.

2. *Extrinsic factors* – e.g. darkness, wet floor.
3. *Situational factors* – factors that create conditions which makes falls more likely. e.g. walking to the washroom in the dark.

In evaluation of falls it is important to determine if the patient had any premonitory symptoms, such as chest pain, palpitations, light headedness, shortness of breath or dizziness, before the fall because a more serious and condition such as myocardial infarction may be masked by the fall.

Sleep

Approximately 50% of the population over the age of 65 years or older have problems with sleep. The most frequent sleep complaint in older adults is *sleep maintenance insomnia* which is a difficulty in staying asleep. It is characterized by having normal sleep in the early phase with early morning awakening and frequent nocturnal awakenings.

Sleep related breathing disorders are probably the most serious of the sleep disorders. *Obstructive Sleep Apnoea (OSA)* which is due to cessation of airflow caused by a complete or partial upper airway collapse at the level of the pharyngeal airway is characterized by episodes of breathing becoming shallow and stopping. A history of snoring, gasping for air, witnessed sleep apnoeas and excessive daytime sleepiness may be present.

Non recognition and non treatment of sleep disorders in later life may result in deterioration in the quality of life, the development of affective disorders, worsening of cognitive impairment and increased risk of morbidity and mortality.

Failure to Thrive

Failure to thrive is defined *as unintentional weight loss with metabolic*. The cause of weight loss remains unexplained in the elderly. The spectrum ranges from medical conditions (such as cancers, endocrine disorders, chronic infections or inflammation) to psychosocial problems such as depression, dementia, neglect, isolation and loneliness.

The assessment of unexplained weight loss requires careful evaluation of the patient's medical condition, psychological status and economic circumstances. The extent and severity of the condition must be measured by the degree of documented weight loss and laboratory assessment for anaemia, hypoalbumineamia, lipid status, lymphopenia and thyroid status. An accurate dietary history should be obtained and medications reviewed as certain medication alter taste and/or reduce appetite.
Unexplained weight loss and failure to thrive may progress to such an extent that irreversible loss of muscle mass, physical weakness and impaired immunity results in inevitable decline towards death.

Pre and Post Operative Care

Age is a risk factor for surgery and poor surgical outcomes. Much of the risk comes not from advanced age *per se* but from co morbid diseases and conditions associated with advanced

age. Due to limited availability of hospital beds and the increasing cost of pre, peri and post operative care more of the pre and post operative care tends to take place in primary care settings.

The pre operative assessment should include the following.

1. Cognitive assessment – To have a base line mental status. This allows the physician to recognize delirium which is common in the elderly, earlier in the post operative period.
2. Functional assessment – Knowing base line functional status allows prediction of potential problems in the peri and post operative periods and helps plan for preventive interventions. Poor functional status is a marker of high surgical risk.
3. Nutritional assessment – Poor pre operative nutrition contributes to poor wound healing, higher infections and pressure sores and loss of functional capacity.

Once the patient has been discharged from hospital, community based post operative care is usually undertaken by the general practitioner. There are a number of issues which must be addressed in the post operative period to optimize recovery.

1. Pain management – Good pain control facilitates early mobilization and recovery.
2. Mobilization – Patients should be ambulant as soon as practically possible. Prolonged bed rest puts the patient at risk of atelectasis, pneumonia, deep vein thrombosis, loss of muscle mass, orthostatic hypotension, urinary retention, constipation and pressure sores.
3. Maintenance of function – It is common for older patients to suffer a decline in functional status in the post operative period. Encouraging patients to attend to their activities of daily living as soon as possible is important. Care givers must to educated on the need to foster patient independence.

Loneliness

It is estimated that at least one in three elderly people feel lonely. It is more likely to affect the 'old-old', widows and widowers and those affected by disability. They tend to stay indoors, are often troubled by depression, agoraphobia, social phobia, sensory impairment and urinary/faecal incontinence.

Possible signs of loneliness include:

- verbal outpouring
- drab clothing
- dependence on radio/television
- body language with a 'defeated' demeanor
- prolongation of visit at consultation including holding on to one's hand

Maltreatment of the elderly

Maltreatment of the elderly is of special significance to the family physician as they are in a unique position to detect abuse and neglect in the elderly. It is a problem of unknown magnitude possible affecting 1-10% of the elderly population. There is no universally

accepted definition for maltreatment of the elderly. It may be described under the following domains;

1. Type of abuse – physical, verbal, financial
2. Relationship to perpetrator – family member , paid care giver
3. Location – home, nursing home, hospital or other institutions

Physicians who ask their elderly patients direct questions about mistreatment are more likely to recognize it.

Sexuality

In the US over 50% of adults over the age of 60 years and 24% over the age of 75 years reported having sexual relations at least once in the preceding month.
Older adults experiencing sexual difficulties often do not seek medical assistance and are rarely asked about sexual function by their physicians. Elderly patients are more inclined to discuss issues of sexuality with their GPs with whom they have a long standing relationship

Drugs in the Elderly

A major challenge faced by family physicians in caring for the elderly is the quantity of medication used by them. Reducing the quantity of medication the patient takes can be done by avoiding prescribing a medication for each symptom.
Some experts however, have expressed concern that too great an emphasis is placed on limiting drug use and quantity in older persons. They believe that efforts should focus on monitoring, patient education and gaining maximum benefit from drugs that are prescribe as focusing on reduction and simplification may lead to under prescribing of appropriate drugs.
For example, despite good evidence of benefit, older patients are less likely to receive β-blocker therapy after acute myocardial infarction.

The use of herbal and dietary supplements in the elderly is becoming very common. The family physician needs to have a working knowledge of appropriate supplements to use in practice with a particular reference to elderly patients. Patients should be encouraged to bring with them the supplements they are taking to the clinic.

The types of supplements commonly encountered in general practice may be classified as follows;

1. Herbal remedies
2. Vitamins and minerals
3. Nutraceuticals – supplements which are not herbal, vitamins or minerals. E.g. – enzymes (Trypsin), hormones (dehydroepiandrosterone, melatonin), nutraceuticals which the body can synthesize which are available commercially – phosphatidylserine, methylsulpfonylmethane (MSM), *S* adenosylmethionine (SAMe), substances not synthesized by the body but which are believed to play a useful physiological role – citrus bioflavindoids and fructo-oligosaccharides
4. Combination products (most encountered in the elderly)

In discussing the issue of supplements it is not appropriate to make a generalization about supplements being dangerous or having unknown effects any more than it is to assume that all supplements are safe because they are 'natural'.

In geriatric prescribing the main goal is to maintain or improve functional ability of the patient which should result in an improved quality of life.

Health Promotion and Disease Prevention

Health promotion and disease prevention in the elderly are often neglected. This seems to be based on the notion that increased risk of illness in the older person reflects 'normal' ageing which is inevitable and probably determined genetically and hence will not respond to life style changes.
Adoption of a healthier lifestyle even in late life can lead to an increased active life expectancy with reduced disability and reduced healthcare expenditure. This requires empowering patients to take a more active role in identifying risk factors and encouraging them to take steps towards modifying disease risks.

> The focus on preventive strategies in the elderly is more on preventing decline in the quality of life and preserving independence, vitality and functional status. This requires a highly individualized programme taking in to consideration the older persons preferences, functional status, co morbidities, affordability and practicality.

Primary preventive interventions are designed to reduce the risk of onset of disease. Primary preventive strategies such as immunization (for pneumonia, influenza and tetanus), proper nutrition, physical activity, and avoidance of substance abuse (cigarette smoking and alcohol abuse) should be implemented and re emphasized in the elderly. Programmes to prevent unintentional injury which is a major cause of morbidity and mortality should be encouraged.

> *Secondary prevention* refers to strategies aimed at identifying and improving outcomes of persons with preclinical or asymptomatic disease. Early detection through screening is the most common method of secondary prevention. Screening for heart disease, hypertension, dyslipidemias, cancers (colorectal, breast, cervical and prostate), hearing and visual impairment should be under taken at primary care level.

Life Care in a Community

The number of frail older people in need of care is increasing and the family's capability to provide even the needed minimum care is decreasing. This creates the need for organized short and long term care for the elderly.
Short stays for rehabilitation and convalescence are appropriate following an acute illness or exacerbation of a chronic illness. Short term respite also maybe indicated when the stress of care giving threatens to overburden the family or sometimes as in terminal care, when emotional and physical burdens are overwhelming. In Sri Lanka this type of short term care is classically provided for the older person by rotating his/her stay among siblings or children.
The family physician is often involved in the decision making process and usually can offer one of three options- home care, nursing home care or life-care in a community (home for the elders).

The goal of long term care is to maximize function and quality of life in the given setting. Long term placement may be one of the most momentous decisions for the individual and family. Long term care covers the continuum that spans from occasional assistance to complete care of every aspect of a persons life. The nature of the location of care will primarily depend on the intended outcomes and on the expected length of stay.

In assessing a person for institutional care or life care in a community, levels of function, psychological impairments, presence of chronic illness, available support services at the institution, patient and caregiver/family preference and economic status of the individual and family must be considered. Although the primary care giver usually provides the bulk of the support, once institutionalized, secondary care givers contribute significantly to the support system.

Palliative and End of Life Care

Palliative Care is an approach that improves quality of life of patients and their families facing problems associated with life threatening illness. This is done through prevention and relief of suffering by means of early identification, impeachable assessment and treatment of pain and other problems - physical, mental, social and spiritual.

The designation of end of life connotes an expectation of death within the foreseeable future from an illness that is generally not amenable to medical interventions. The definition may also include consideration of functional incapacity and unremitting symptoms attributed to progression of the illness.

It is important for physicians to recognize when the conditions of terminal illness have been met so that the medical care plan can be reconsidered appropriately.
There are several salient features of a terminal care plan that should be reviewed as part of the reconsideration of the medical care plan.

1. Symptom control – Especially control of pain. Other symptoms such as breathlessness, nausea, itching and diarrhea should also be controlled.
2. Long term side effects of medications no longer hold the same relevance. E.g. – addiction to opiates, Parkinsonism due to major tranquilizers
3. Balance between aggressive medical interventions and with holding certain therapies E.g- Cardiopulmonary resuscitation, provision of feeding tube. These should be discussed with patient and care givers in advance and clear decisions made.
4. For patients being cared for at home, nursing home or institution the decision to seek hospital care

In provision of terminal care the health needs and comfort of the care givers (especially if family members or friends) must be considered and accommodated with equal importance.

End of life issues must be discussed with patients and care givers to ensure that medical care is delivered in keeping with the desires and wishes of the patient respecting patient autonomy when patient is incapable of decision making. Patient autonomy may be expressed through a living will or a durable power of attorney for health care.

Care of the care giver

Delivery of elderly care is physically, mentally, socially, spiritually and financially a exhausting process for the care giver be it for short or long term. The doctor must appreciate and recognize the consequences on the care giver. The care giver can be supported in the following domains

- Physical care and medical treatment
- Psychological care and support
- Social Care
- Economic care

Successful Ageing

Successful ageing refers to modification of behavioral process to achieve the best possible outcome of ageing- i.e. to maximize disability free life span. This concept emphasizes that if the risk factors can be eliminated, there is potential for reduction of age associated diseases and better ageing outcomes. The concept of successful ageing has three main components. These are;

1. Lowering the probability of disease and disease related disability
2. Strengthening cognitive and physical functional capacity
3. Encouraging active engagement with life

There is a "rule of thirds" with respect to functional decline. It is believed that of the decline in function, only a third is due to actual ageing, another third is attributable to disease and the remaining third is due to disuse. This has important implications. It means that we can intervene substantially by reducing disease risk and encouraging active engagement with life to bring about optimal outcomes of ageing.

The adoption and maintenance of a healthy lifestyle requires considerable understanding and effort by an older person and care givers. It will also require an environment which is conducive to adoption and maintenance of such lifestyle. This would need in puts from the community at large by way of community initiated programmes, e.g. facilities for recreation and exercise, training of care givers in initiating and maintenance of 'healthy' eating habits, identifying resources and talents in the elderly and getting them involved in community based social welfare progrmmes.

Conclusion

The elderly segment of the population the world over is growing. Their demand for better quality of life will be inevitably reflect on more demands on healthcare providers – mainly primary care physicians. Hence, in the interest of provision of good quality care to our patients we as family physicians should increase and update our knowledge and skills to handle health related problems of the elderly. In the Sri Lankan context where there will be no Geriatricians for at least the next 2 decades in it incumbent upon us Sri Lankan Family Physicians to develop a special interest in Elderly Medicine.

References

1. Haniffa R. Care of the elderly in general practice. In: Goonaratna C and Balasuriya A , eds. Medicine in the elderly Vol I. First edition. Colombo, Sri Lanka: Ananda Press, 2011:323-347.
2. Annual Health Bulletine. 2007. Ministry of Health Sri Lanka.
3. Dept of Census and statistics 2007. Sri Lanka
4. De Lepeleire J, Degryse J, Iliffie S and Mann E. Frailty: an emerging concept for general practice. *The British Journal of General Practice* 2009; **59(562)**:364-369
5. Hanwella R. Care of the elderly in general practice. In: Goonaratna C and Balasuriya A , eds. Medicine in the elderly Vol I. First edition. Colombo, Sri Lanka: Ananda Press, 2011. 91-134.

Annex 1

GERIATRIC FUNCTIONAL ASSESSMENT FOR THE BUSY CLINICIAN

Guiding formula: (If deficit in) **F**unction = (Assess) **A**bility + **M**otivation + **O**pportunity (**I & S**)

Function = Activities of daily living (ADL)
Basic ADLs: Mobility, bathing, dressing, grooming, transferring, toileting, continence, eating
Instrumental ADLs: Using telephone, driving, using public transportation, shopping, preparing meals, housework, taking medicine, managing money

Ability: Physical assessment

6 maneuvers task (function tested)

1. Both hands behind head (hair combing, washing back, etc)
2. Both hands together in back of waist (lower extremity dressing, hygiene)
3. Sitting, touch great toe with opposite hand (lower extremity dressing, hygiene)
4. Squeeze examiner's two fingers with each hand (opening jars, doors, etc)
5. Hold paper between thumb and lateral side of index finger while examiner tries to pull our (picking up objects)
6. Stand from chair with hands crossed over chest (transferability)

Ability: Cognitive assessment

Mini-mental state Folstein et al, J Psychiat Res 12:189-198, 1975

Make pt. comfortable, establish rapport, praise success, avoid pressing for answer. Do initial and serial measurements.

	Orientation
5	What is the (year) (season) (date) (day) (month)?
5	Where are we? (state) (country) (town) (hospital) (floor)?
3	Registration: Name 3 unrelated objects. Ask for all 3. Repeat until patient learns all 3. Record number of trials
5	**Attention and calculation**: Serial 7's (93,86,79,72,65). Stop after 5. OR spell "WORLD" backwards D L R O W
3	**Recall:** Ask for 3 objects above
	Language:
2	Naming: pencil and watch
1	Repetition: "No ifs, ands or buts"
3	3-stage command: Take paper in your right hand, fold it in half, and put it on the floor
1	Reading: "Close your eyes"

Other assessment tools: **6 meter walk** **1 foot stand**	1	Writing: "Write a sentence:
	1	Coping: Intersecting pentagons
	Scoring: ≤ = dementia	
	Other assessment tools: clock drawing, trail making	

Motivation: Assess depression – Single question: "Do you often feel sad or depressed"
Short geriatric depression scale Sheikh & Yesavage, Clin Gerontol 5:165-172, 1986.

Choose the best answer for how you felt over the past week (Yes or No)

1. Are you basically satisfied with your life **Y**
2. Have you dropped many of your activates of interests **N**
3. Do you feel that your life is empty **N**
4. Do you often get bored **N**
5. Are you in good spirits most of the time **Y**
6. Are you afraid that something bad is going to happen to you **N**
7. Do you feel happy most of the time **Y**
8. Do you often feel helpless **N**
9. Do you prefer to stay at home rather than going out and doing new things **N**
10. Do you feel you have more problems with memory than most **N**
11. Do you think it is wonderful to be alive now **Y**
12. Do you feel pretty worthless the way you are now **N**
13. Do you feel full of energy **Y**
14. Do you feel your situation is hopeless **N**
15. Do you think most people are better off than you **N**

"Normal" answers indicated in bold **(Y/N)** - > "Depressed" answers = positive screen

Opportunities: Existing or needed

Individual opportunities: Personal resources	**Societal opportunities: Community resources**
Health habits/lifestyle: screen for nutrition, alcohol and tobacco use, medications taken, vaccinations Family structure and social support Adequacy of living quarters Assistive devices: Hearing aids, eyeglasses, walking aids, etc Assessment tools: Nutrition health screen, home safety checklist	Health insurance Transportation Access to social support networks Know your community resources for geriatric patients: Transportation options Meals on wheels and home Health Disease-specific support groups OT, PT, social work, etc