Educational Objectives

Students will be able to:

1. Demonstrate appropriate etiquette for interacting with an elderly person in his/her home.

2. Take a history and perform a screening examination for dementia.

3. Compile a medication list based upon observation.

4. Describe services available to seniors in the high-rise setting.

5. Perform a home-based assessment of safety.

6. Perform an assessment of function, based upon both history and observation.

7. Obtain information about a senior’s life history, social interaction, and spiritual connections.

8. Perform an assessment of a senior’s health promotion behaviors.

Home Visit Etiquette

- Knock on the door (loudly)
- Thank the senior (by last name) for the opportunity to visit
- Introduce yourself
- Ask where you should sit
- Try to sit as close as possible, facing the senior
- Explain the reason for the visit
- Inform the senior of the amount of time to be spent
- Describe some important aspects of your life history
Life History

The life history is an important part of the medical history for a senior because it:

- Creates rapport between the patient and provider.
- Provides insight into major life choices that could predict current or future healthcare choices.
- Describes educational background.
- Describes social resources.
- Provides insights into stress experienced and coping mechanisms.

Typical questions include:

Tell me about yourself.

Where were you born?

What brought you to the Twin Cities?

Do you have children?

What kind of work did you do?

Where did you live before moving here?

How long have you lived here?

What memories/events in your life are you most proud or fond of?

What are the key lessons life has taught you?
Self-Reported Functional Assessment

The functional assessment is one of the most important aspects of a history and physical of a senior. Function is the “final common pathway” of disease and injury. Function can be assessed by history (self or caregiver) or directly observed. It is common for there to be differences in information obtained by these three methods. Direct observation of activities in the usual setting (ie, at home) is the “gold standard” and will be covered later.

Typical questions include:

What do you do in a typical day?

Do you leave your apartment every day?

How often do you go out of the building?

How often do you talk on the phone?

What have you stopped doing that you used to do? Why?

Do you need help with: grocery shopping, cleaning your apartment, paying bills, making meals, bathing, getting dressed? Who helps you?

Are there things you could do but don’t because of fear (ie, of falling)?
Mental Status Assessment

A number of formal tools exist to quickly assess mental status. The most common of these is the Folstein Mini-Mental Status Examination, a 30 point test of orientation, memory, attention, and ability to draw, read, and follow directions. Orientation and memory account for over half of the points on this examination.

Because many patients are sensitive about loss of memory, it is important to preface tests of mental status with a brief explanation of the routine nature of this part of the examination. For example, you may say:

Now I'm going to ask you some questions to test your thinking. This is routine; I do this for all of my patients. If a patient has trouble with this some time in the future, I can know that things were OK at this time. Some of the questions may seem silly, some might be hard for you. Let's start with . . .

Repeat and remember these three words: ball, tree, flag

_________________        _______________        _______________

Now remember those words. Next, where are we located?

   Name of building/Street Address ____________________________
   Floor/Apartment # ______________________________
   City ___________________________
   State ___________________________
   County ___________________________

   What day of the week is this? ____________________________
   Month ___________________________
   Date ___________________________
   Year ___________________________
   Season ___________________________

Now, what are those three words I asked you to remember?

_________________        _______________        _______________
Medication Review

A review of medications is essential for every patient. Unfortunately, many patients provide inaccurate or incomplete lists of medications. Looking at pill bottles can reveal duplicative medications or “forgotten” medications. Even rough estimates of pills remaining in a bottle relative to the date of dispensing can help determine actual usage. Some patients have their pills dispensed into pill boxes to improve compliance. In these cases it can be difficult to determine the names of the medications.

Count prescription and over-the-counter drugs prescribed and present in the home.

____________ Total Medications

Add up the number of medications taken on a typical day.

____________ Medications/Day

Describe ways the senior remembers to take medications: pill organizers, location of pill boxes, etc.

How often does the senior miss doses? Why?

What does he/she do when missing a dose?

Comments:
Spiritual Assessment

Questions about patients’ spirituality are becoming increasingly common in health care. Physicians can find information about a patient’s connection to a spiritual community helpful in determining the patient’s resources to cope with ill health, in the past and in the future. Spirituality includes how people find strength and comfort.

**Typical questions include:**

Are you or have you been part of a religious or spiritual community?

If yes, have you been able to stay connected to that community since you moved here?
Health Promotion

Three types of health promotion activities should be included in assessment of the elderly: disease prevention, cancer screening, and health maintenance. The value of these activities remains significant or even increases as a person ages. Preventable diseases such as influenza or pneumococcal pneumonia can lead to death in the elderly. Over 50% of most common forms of cancer present in the elderly. Losses in health due to poor maintenance have relatively large impacts on quality of life for the elderly.

**Typical question for disease prevention:**

Did you receive a flu shot this winter? If not, why not?

**Typical question for cancer screening?**

Have you ever been tested for colon cancer, where they look inside with a lighted tube?

**Typical question for health maintenance?**

Have you visited a dentist in the past year?
Environmental Assessment

The surroundings in which a patient lives can impact health, in both positive and negative ways. The environment can be the source of disease (ie, from pets, mold, etc) and can cause injury (ie, loose throw rugs, poor lighting, clutter, or a chair that is too low). Environmental safety features (ie, bath rails, call lights) can reduce frequency or severity of injury. The bathroom and the kitchen are key locations to assess both risk and function. Incontinence can be obvious on a bathroom floor. Poor memory or cooking and housekeeping skills show up in the refrigerator. A history taken in the office or hospital is of limited value in environmental assessment.

Take a tour of the apartment. Examine and describe the following:

- Typical chair - Note the height of chair relative to the senior’s height, whether arms are present, and whether the base is open in the front or closed like a recliner.

- Bathroom - Note rails, arms for toilet, and ease of entry into the tub or shower.

- Bedroom - Note bed rails.

- Call lights - Note location, button versus string, and two-way communication versus one way.

- Refrigerator and cupboards - Note reach, types of food present, freshness of foods, and cleanliness.

- Other - Note loose rugs, extension cords, space heaters, garbage, clutter, and overall organization.
Observed Functional Assessment

Ask the patient to show you how he/she would get a glass of water. Describe some or all of the following:

- Ability to get up from the chair

- Steadiness and pattern of gait

- Ability to reach for a glass from the cupboard

- Ability to remember the task requested

- Ability to turn the water on and off
Physical Examination

The purpose of this experience is not to practice a complete history or physical examination. There are two features of the physical examination that are relatively easy and are very important parts of a geriatrics assessment.

1. The general appearance of the patient gives a picture of condition of the patient and the circumstances of the visit. In the office, the patient will almost always be seen on the exam table, and in the hospital, the patient is in a bed. During a home visit, the patient may be in a chair, in bed, or restlessly walking around. The patient may be dressed in clothes appropriate for the season, night clothes, or semi-undressed. Record the level of patient cooperation to enable other providers to assess the reliability of the information obtained. For similar reasons, also record the general comfort of the patient.

2. Examination of the feet can provide many kinds of clues to disease and disability. Poor nail care suggests a physical, cognitive, or psychological inability to do (or arrange for) care of the feet. Lack of any callus formation may suggest the patient is rarely walking. Clubbing, cyanosis, or edema suggest a number of specific diseases. Skin breakdown may be due to pressure from immobility or poor fitting shoes. In addition to these foot-specific issues, organ system-based examination of the feet include cardiovascular (pulses), musculoskeletal (range of motion), and neurological (strength). Do not do all of these today.

General Appearance

- Where is the patient (sitting in a chair, in a wheelchair, lying down in bed, on a couch)?
- How is he/she dressed?
- Is the patient cooperative?
- Does he/she appear comfortable?

The Feet

- Nails
- Color
- Edema (on a scale of 0-4)
- Skin breakdown
- Corns and calluses