



### Assessment of the Older Adult: the Importance of Function

Consider these two versions of an admission:

*“Mrs X came in after developing a pain in her chest last night...”*

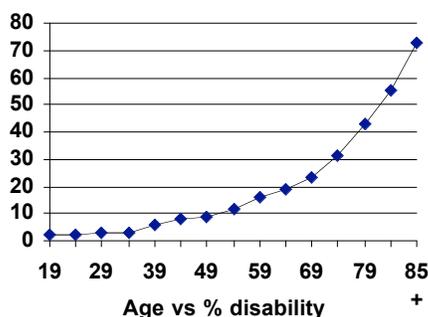
*“Mrs X is an 83 year-old widow who is a retired machinist. She lives alone in a council house with the bedroom and bathroom upstairs, and one of her daughters does her shopping and cooking. She came in after developing a pain in her chest last night..”*

As well as serving as useful ‘warmer-up’ information for the clinical interview, these two extra sentences give a wealth of information. They describe:

- Mrs X as a person, rather than as an appendage to a symptom
- Her socio-economic grouping: SEG has major implications on disease susceptibility, type and presentation
- Her former occupation - implications for occupational diseases
- An indication of family structure and support
- A reminder of her house design: climbing stairs is central to full independent living
- A marker that she has a **disorder of function**

#### Function and ageing

Although the majority of older adults are fit and healthy, the prevalence of disability increases with age



Therefore it is all the more important that we diagnose disability and loss of function in older patients. This is important because :-

- Loss of function always means disease(s) that will need to be diagnosed and treated.
- Loss of function is in itself important to the older person and his or her family.
- Loss of function may lead to other diseases e.g. swallow disorder can lead to aspiration pneumonia, delirium can lead to sedation, immobility etc.

Loss of function is associated with higher: mortality, morbidity and institutionalization, and therefore should be a marker for increased medical vigilance

At it's most basic level, if cognitive function (see below) is normal a simple question such as

#### who does your shopping and cooking?

is a good guide to high level function as it tests a range of functions.

We will discuss overall function, and subdivisions of function (cognitive, social, affective and balance/gait). Some disciplines have more considerable expertise than others in certain areas, ie

*Specialist Nursing: Overall function, continence, skin integrity, behaviour*  
*Occupational therapist: cognition, overall function*  
*Physiotherapist: gait/balance*  
*Speech therapy: swallow, language*  
*Social worker: social, psychological well-being*

but to refer appropriately and work together, all healthcare workers need to understand the elements of functional assessment.

**Overall function** is usually broken into 2 groups:

*Activities of Daily Living. (ADL)*  
*Instrumental Activities of Daily Living. (IADL)*

Activities of daily living are tasks of self-care and are generally rather basic: the most common index used is the Barthel (laminated card). Although it may seem self-evident that a patient who has a disability in one of these areas has got a problem, research from our hospital shows that only 9% of doctors and 27% of nurses will notice these problems. This may be a reflection on a non-holistic tradition of healthcare education, or unconscious ageism (AgePage 1).

Instrumental activities of daily living are equally important to most people and include more sophisticated tasks such as shopping, cooking, driving, managing finances. Although there is no widely agreed simple scale for use by health workers, very often this aspect is tackled by asking about safety issues e.g. particularly with regard to cooking and driving. Other sub-scales of function and performance are described below:-

#### 1. Cognitive impairment

Dementia and delirium will be dealt with in a later AgePages: however up to 40% of older people attending the General Hospital will suffer from a degree of cognitive impairment.



**Cognitive function is the means by which we analyze, interpret and use information from the environment:**

ie this includes perception, intellectual processing and praxis. Cognitive impairment is often referred to as confusion in lay man's terms. This phrase in itself is extremely unhelpful in the clinical setting.

Cognitive dysfunction is often missed by healthcare workers. There are a number of screening tools which may be used. In ARHC and TCD we use the **Mini-Mental State Examination**: this reckoned to be one of the most useful scores (copy in your Oxford Handbook of Clinical Medicine). It is a screening tool and has an 85% specificity and sensitivity for the presence of cognitive impairment. It does **not** diagnose dementia or delirium but is highly suggestive of the presence of either of these conditions. There is a degree of skill attached to using this questionnaire as patients may feel insulted if they are asked about their memory function in an insensitive way. It is important to ensure maximum privacy and to warn the patient that you will be testing for memory.

Patients with cognitive impairment are good at circumventing questions! Any question which is not answered should be taken as a negative score. A score of 23 or less raises suspicion of cognitive dysfunction, but education, literacy and other factors affect the score. Another scoring system is that score of 26 or more indicates a low probability of cognitive impairment; 20 - 26 intermediate probability and below 20 a high probability of cognitive impairment in a hospital setting. The Mini-Mental includes sections on orientation, memory, attention and calculation and language and parietal skills. This is helpful because it emphasizes the relatively global nature of most cognitive impairment. OT testing will give a fuller picture of cognitive function.

#### 2. Affective disorder

Mental health also needs to be measured from the point of view of affective disorders. In ARHC we would either use the Geriatric Depression Scale. This is a simple and effective screening instruments and the major limitations is be that it is not sensitive to patients with severe cognitive impairment.

#### 3. Balance and gait

These need to be looked at as many patients will suffer from problems and many patients are admitted with fractures post falls without anyone asking why the fall occurred in the first place. In the first instance get the patient to sit out of bed or the chair and walk – the **Timed Get up and go! test**. Unless clearly unstable or unable, you should not assist them. Anything less than the stability and mobility of fit people should be considered as abnormal. The Tinetti Scale is

very useful as it breaks down the actions of standing and walking into components which can be assessed and acted upon.

#### 4. Social Assessment.

The important issues to be assessed are social relationships, social support, subjective well being, care-giver burden and personal autonomy, preferences and values. Interview with both patient and family/carers are critical. Check for signs of neglect, poor hygiene, poor nutrition.

#### 5. Swallow assessment

Swallow disorders are common and complex: speech therapists have a mastery of assessment. Disorders of swallow occur in up to 45% of patients with stroke. Increasingly, patients with neurodegenerative disease and with recurrent respiratory infections are noted to have swallow disorders which may compromise their health and function. Appropriate therapy can be life-improving/saving. In ARHC, we use the Meath Swallow Screen, a very simple screening test (distributed with Stroke AgePages). NB the gag reflex is irrelevant in terms of integrity of the swallow mechanism!

#### 6. Nutrition

There is as yet no valid simple screening test, but have a high index of suspicion for nutritional disorders which are common. Currently we are looking into the Mini-Nutritional Assessment which may be helpful.

#### 7. Skin integrity

One in 8 general hospital patients will have decubitus ulcers: see pressure sore/venous ulcer AgePage

#### General note

**We learn not only from our patients but also especially from working with the other assessment/rehabilitation disciplines**