



Clinical Practice Guidelines: Other/The older patient

Policy code	CPG_OT_TOP_1024
Date	October, 2024
Purpose	To ensure a consistent approach to the management of the older patient.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
Source of funding	Internal – 100%
Author	Clinical Quality & Patient Safety Unit, QAS
Review date	October, 2027
Information security	UNCLASSIFIED – Queensland Government Information Security Classification Framework.
URL	https://ambulance.qld.gov.au/clinical.html

While the QAS has attempted to contact all copyright owners, this has not always been possible. The QAS would welcome notification from any copyright holder who has been omitted or incorrectly acknowledged.

All feedback and suggestions are welcome. Please forward to: Clinical.Guidelines@ambulance.qld.gov.au

Disclaimer

The Digital Clinical Practice Manual is expressly intended for use by appropriately qualified QAS clinicians when performing duties and delivering ambulance services for, and on behalf of, the QAS.

The QAS disclaims, to the maximum extent permitted by law, all responsibility and all liability (including without limitation, liability in negligence) for all expenses, losses, damages and costs incurred for any reason associated with the use of this manual, including the materials within or referred to throughout this document being in any way inaccurate, out of context, incomplete or unavailable.

© State of Queensland (Queensland Ambulance Service) 2024.



This work is licensed under the Creative Commons Attribution-NonCommercial-NoDerivatives V4.0 International License

You are free to copy and communicate the work in its current form for non-commercial purposes, as long as you attribute the State of Queensland, Queensland Ambulance Service and comply with the licence terms. If you alter the work, you may not share or distribute the modified work. To view a copy of this license, visit <http://creativecommons.org/licenses/by-nc-nd/4.0/deed.en>

For copyright permissions beyond the scope of this license please contact: Clinical.Guidelines@ambulance.qld.gov.au

Most developed countries have defined older people to be over the age of 65.^[1] This cohort represents the fastest growing segment of the Australian population and consequently older patients are an increasing proportion of work for ambulance services.^[2] Older patients now live longer with chronic and often incurable conditions and their health management will commonly require a degree of both medical and social care.

The assessment of an older patient is often more complex than one conducted in younger patients as it focuses on individuals with complex or chronic conditions, and emphasises the patient's functional status and quality of life. With a greater significance placed on autonomy and independence, effective assessment should be broad and consider a varied account of the patient's requirements rather than revolving around crisis management of recurrent or acute symptoms.^[3]

Caring for the older patient can present a challenge for the clinician as assessment needs to consider the patient's physical and mental state, medications, and social circumstances which may complicate the management of an otherwise simple ailment. Clinicians need to maintain a high index of suspicion that seemingly uncomplicated signs and symptoms can be the manifestation of serious underlying pathology.^[3]

Clinical features



The ageing processes are often associated with an increase in the prevalence of chronic disease, the deterioration of organ function and declining physiologic reserves.^[4] An understanding of these physiologic changes is important as they are essential for conducting a thorough assessment and management of the older patient and the related comorbidities and disabilities. The physiologic changes associated with the ageing process can be extensive but are most notable in the cardiovascular, respiratory, renal, and neurovascular systems.^[4]

Respiratory System

- respiratory compliance ↓
- ↓ elastic recoil with alveoli collapse
- ↓ response to hypoxia and hypercapnia
- ↑ prevalence of disease and infection

Renal System

- loss of nephrons, ↓ size and weight of kidneys
- ↓ ability to filter blood
- ↓ ability to clear pharmacological agents
- marked decline in the subjective feeling of thirst
- ↑ prevalence of infection, particularly UTI's

Miscellaneous

- general loss of muscle tone and strength
- ↑ prevalence of undernutrition and malnutrition
- ↑ prevalence of osteoporosis
- deterioration of skin immune system results in increased susceptibility to infection

Neurovascular System

- degeneration of neurons
- ↓ in brain size and weight
- sensory perception declines steadily
- ↓ in hypothalamic function, affects ability to generate and conserve heat
- ↑ cognitive impairment
- changes in pain perception

Cardiovascular System

- most common comorbid condition
- deterioration in conduction system resulting in ↑ prevalence of AF, BBB, sick sinus syndrome
- widespread arteriosclerosis results in hypertension
- thickening of the heart wall with associated cardiac hypertrophy
- ↓ cardiovascular reserve



Risk assessment



General appearance

A strategic assessment of the older patient's general state of health can be obtained by observation. Viewing the patient's interaction and movement can provide the clinician with valuable information about the patient's level of consciousness, mobility and gait, muscle strength, social interactive ability, hygiene, colour, and obvious discomfort. It is important to note that in the older patient, the first sign of a medical problem can commonly manifest as a change in functional status.^[3]

Medications

Older patients can suffer from chronic disease states which require multiple medications for their management. This polypharmacy combined with risk factors of physiologic aging processes, increased number of physicians involving the patient, and concurrent use of drugs that cause additive hypotension, sedation or anticholinergic effects, can render older patients particularly susceptible to adverse drug effects and drug-to-drug interactions.^[5]

Mental status

Assessment of mental status is a critical part of the older patient's assessment. The older patient's mental status may be influenced by cognitive impairment such as dementia or Alzheimer's, current illness or injury, current medications, or relative familiarity with their surroundings. Impaired cognition, even if normal for the patient, may have a significant bearing on the type and direction of medical care.^[6]

An acute change in the mental status of older patients may be the result of Delirium. Delirium is characterised by an alteration of consciousness, cognition, or perception that develops over a short period of time (hours to days).

Risk assessment (cont.)



Patients presenting with delirium may be agitated and restless, quiet and withdrawn, or move between these two states. Delirium is often associated with poor outcomes in patients with increased risk of falls, mortality, and a higher dependency of care. Key risk factors for delirium include: Age greater than 65 years, known cognitive impairment/dementia, severe medical illness and current hip fracture. Any patient presenting with one or more risk factors should be identified upon presentation to hospital for further screening and assessment.^[7]

It is important to note that the absence of adaptive devices such as hearing aids or eye glasses can functionally disable patients and may be a contributor to altered mental status by limiting their ability to interact with their environment.

Dementia

Dementia is a clinical syndrome that can be caused by several underlying diseases, including Alzheimer's. Although dementia can occur at any age, it is far more prevalent in older people. Approximately 9 percent of people over the age of 65, and 30 percent of people over the age of 85 have a diagnosis of dementia.^[8]

People with dementia are entitled to the same legal rights and ethical considerations as any other person. Health professionals must keep the following points in mind when interacting with a person with dementia:

- Valid informed consent should always be sought from the person with dementia for health care decisions. If the person lacks the capacity to make a decision, the relevant state law in respect of substitute decision making for health matters must be followed.



Risk assessment (cont.)

- Information provided by the person with dementia should be treated in a confidential manner. Confidential information should only be disclosed without the person's consent in exceptional circumstances, e.g., where the clinician has a duty of care.

Health professionals should provide person-centred care, by identifying and responding to individual needs and preferences of the person with dementia, their carer(s) and family.^[4] Health professionals should use language that is consistent with the 'Talk to me' good communication guide for talking to people with dementia:^[8]

- Talk to the patient and don't prejudge their level of understanding.
- Make eye contact and speak clearly in short sentences, avoiding jargon.
- Use clear and simple language and use repetition if required, but sensitively.
- Avoid patronising; treat the patient with respect and dignity.
- Use empathy, don't minimise the patient's feelings.
- Try to avoid distractions to help keep their focus.
- Be patient & allow plenty of time for them to respond to questions.
- Provide information in small chunks.^[9]



Risk assessment (cont.)

Trauma

Traumatic injuries in older patients are associated with significant morbidity and are one of the leading causes of death. The physiologic changes combined with disease processes significantly diminish the ability of older people to respond to the physiologic stress of trauma, with shock progressing much more rapidly in this population than any other age group. Falls are responsible for over half of all accidental deaths in the older population and particular attention should focus on assessment of the head, chest, abdominal, and fractures of the hip, spine, femur, hand, forearm and shoulder.

Additional information

Grasp reflex

Transferring of the older patient e.g. from chair to stretcher, can present a risk to the attending clinician. With normal neurodegeneration and/or cognitive impairment the brain can lose its ability to override reactions such as the grasp reflex. When an older patient won't release an object, it is not adverse behaviour but rather a primitive reflex to a fear of falling and injury. Clinicians should be aware of this risk and where possible avoid situations, such as hand holding, when moving or transferring the geriatric patient, which may trigger this reflex. Clinicians should consider alternate aids such as walk belts to assist in this process. Once a patient is exhibiting signs of grasp reflex, reassuring them and prompting the patient to open their hand is often effective. Prying the hands of the patient open will often only result in an increased reflex response and an increased risk of potential injury to the patient and the clinician.

Skin tear

The degeneration of the skin associated with the older patient can predispose these patients to significant and painful skin tears. Caution should be applied when applying or removing any adhesive tape, dressing or ECG electrodes to these patients. To facilitate the removal of such items, apply careful counter-pressure to the skin near the adhesive fastener as it is slowly rolled off.

CPG: Clinician safety
CPG: Standard cares

Consider:

- **Clinical Frailty Scale®**
- **Fall Risk Assessment Tool (FRAT)**

Manage as per CPG:

Specific to pathology

Transport to hospital
Pre-notify as appropriate

Note: Clinicians must only perform procedures for which they have received specific training and authorisation by the QAS.