ELDERLY PATIENT CARE

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MBChB: Bachelor of Medicine and Bachelor of Surgery, UoN • MSc: Master of Science (Clinical Management of Pain), UoE
CCFP: Certification in the College of Family Physicians of Canada, UBC

PRESENTER DISCLOSURE

Conflict of interest

I have no conflicts of interest to declare.

Remunerated professional work

Medical Services Plan (MSP) — clinical work

Fraser Health Authority (FHA) — leadership work

University of British Columbia (UBC) — teaching work

Our 120 minutes

00–15 Assessment and frailty

15–33 Falls and medication decisions

33–51 Delirium

51–62 Depression

62–67 Break

67–89 Community care, driving and consent

89–105 Goals of care and prognosis

105–120 Assisted dying and synthesis

Clinical Field Assessment (CFA)

Prioritize immediate risk and the patient’s goals.

Explain your reasoning and document the decision.

Use local teams, consultation and reliable follow-up.

Recognize the limits of your authority and scope.

Opening round: which BC process feels least familiar?

Mr. Ng: the first visit after a fall

82, living in his daughter’s basement suite. His legs “gave out”.

Two admissions this year, including a 10th thoracic vertebral compression fracture.

10 lb weight loss. Furniture walking. More daytime fatigue.

His daughter manages meals, medications and finances.

What must happen today, and what can wait for a planned second visit?

Assessment that changes the plan

TODAY

Injury, syncope or acute illness?

Postural blood pressure (BP), pulse, gait and medication exposure.

Can he mobilize, eat and obtain help safely tonight?

PLANNED FOLLOW-UP

Activities of daily living (ADLs); instrumental activities of daily living (IADLs).

Cognition, mood, nutrition, pain and sensory function.

Caregiver capacity, home safety and patient priorities.

What finding would change your decision to send him home?

Frailty: baseline function guides interpretation

Reduced physiologic reserve increases vulnerability to illness.

Clinical Frailty Scale (CFS): baseline fitness and frailty, using judgement.

FRAIL is a brief screen: fatigue, resistance, ambulation, illness, weight loss.

A score supports assessment. Acute deterioration still needs a cause.

Would today’s post-fall function represent his usual baseline?

Mr. Ng: a shared care plan

Patient goal: safer mobility and remaining at home.

Address reversible contributors and reconcile medications.

Arrange strength/balance support, gait-aid review and nutrition assessment.

Name the clinician who will review symptoms, referrals and function.

Write one sentence that makes the follow-up plan actionable.

Ms. Lai: treatment burden after admission

88, newly admitted to long-term care (LTC); moderate Alzheimer’s dementia.

Falls, 10 lb weight loss, poor intake, anxiety and radicular pain.

BP 104/50 mmHg. Pulse 55/min. Glycated hemoglobin (HbA1c) 6.8%.

Sodium (Na) 131; potassium (K) 3.1 mmol/L. Creatinine clearance (CrCl) 40 mL/min.

Which risk has priority before you redesign her long-term regimen?

Ms. Lai: original medication list

Metformin 1 g twice daily

Isophane insulin 5 units twice daily

Semaglutide 0.25 mg weekly

Hydrochlorothiazide (HCTZ) 25 mg daily

Amlodipine 5 mg daily

Ramipril 5 mg daily

Acetylsalicylic acid (ASA) 81 mg daily

Venlafaxine 150 mg daily

Bupropion extended release (XL) 150 mg daily

Buspirone 5 mg twice daily

Quetiapine immediate release (IR) 50 mg nightly

Gabapentin 300 mg nightly

Acetaminophen 325 mg twice daily

Vitamin D_3 1000 units every 2 days

Levothyroxine 88 micrograms daily

Reference list for the discussion, not a recommended regimen.

Ms. Lai: which medicines need attention first?

Exposure	Reason to review	Information before action
Isophane insulin + metformin + semaglutide	Low intake and treatment burden	Glucose pattern, symptoms, renal function
Hydrochlorothiazide + amlodipine + ramipril	Low BP, Na 131, K 3.1	Orthostasis, volume status, indication
Venlafaxine + bupropion + buspirone	Benefit, interactions, withdrawal	Original indication and prior response
Quetiapine + gabapentin	Sedation, gait and pain control	Behavioural indication and observed benefit

Choose one immediate action and one change to stage over time.

Deprescribing with a monitoring plan

IMMEDIATE SAFETY

Assess symptoms and reversible causes.

Consider holding hydrochlorothiazide; address volume and electrolytes.

Reduce hypoglycemia risk using actual glucose data.

STAGED CHANGES

Review each indication and time to benefit.

Taper relevant psychotropics with symptom monitoring.

Agree on restart criteria and a review date.

What would the nurse need to monitor after your first change?

Mr. Simon: three falls in his first month

90, new to LTC, with dementia and chronic kidney disease (CKD).

BP 105/65 mmHg. Hemoglobin (Hb) 90 g/L. HbA1c 5.4%.

Zopiclone, quetiapine, antihypertensives and empagliflozin.

Slow, wide-based gait; reduced sensation in his feet.

Rank your first two actions. What important diagnosis could a “falls” label hide?

Timed Up and Go (TUG) test

Use a standard armchair, usual footwear and usual walking aid.

Time: stand, walk 3 metres at usual pace, turn, return and sit.

Stay beside the patient; observe stability, stride, turning and aid use.

Record time and gait findings. Mr. Simon takes 12 seconds.

How does the observed gait change your plan for a resident with recurrent falls?

Fall prevention and injury prevention

FEWER FALLS

Treat acute illness and symptomatic orthostasis.

Review sedatives and medication changes.

Match gait aid, exercise and environment to ability.

LESS HARM

Assess fracture risk and osteoporosis treatment suitability.

Consider hip protection in LTC where appropriate.

Plan rapid help and assessment after a fall.

What could the care team change on the next shift?

A medication decision another clinician can follow

Problem and suspected medication contribution.

Patient preference and alternatives considered.

Specific change, including any taper.

Monitoring, review date and criteria to restart or escalate.

Complete: “I am changing ___ because ___; we will reassess ___.”

Mr. Jones: a change over four days

92, usually independent in basic ADLs; now confused and less mobile.

Cough, reduced intake, constipation and a fall yesterday.

Temperature 38.1°C. Respiratory rate 22/min. Oxygen saturation 92% in air.

CKD, prior stroke, as-needed lorazepam and nightly quetiapine.

What is your disposition, and what must the receiving clinician hear?

Delirium recognition in routine care

WHAT HAS CHANGED?

Hours to days, fluctuation and inattention.

Hypoactive delirium may look quiet or depressed.

Use collateral history and repeated observation.

ASSESSMENT TOOLS

4AT (four-item delirium assessment): score ≥4 suggests delirium.

Confusion Assessment Method (CAM): apply the full diagnostic algorithm.

A negative screen does not end the assessment.

Mr. Jones: several causes can coexist

Pneumonia and impaired oxygenation.

Acute kidney injury (AKI) and poor intake affecting medication tolerance.

Pain after the fall, constipation and possible retention.

Sedating medicines and a disruptive care environment.

What is your initial treatment and reassessment plan?

Ms. Francis: “Please send a urine culture”

92, newly admitted to LTC with moderate dementia.

Her son reports confusion. Staff do not yet know her baseline.

Afebrile and hemodynamically stable. Cloudy, malodorous urine.

Baseline incontinence. No catheter or localizing urinary symptoms identified.

A Culture and antibiotics
B Assess the change and look for causes
C Reassure without assessment

Urinary findings need clinical context

Delirium plus a positive urine result does not establish urinary tract infection (UTI).

Clinical features and catheter status guide culture decisions.

Explain the working diagnosis and what would trigger reassessment.

Treat suspected sepsis promptly while investigating the source.

How will you document the decision not to prescribe today?

Agitation: the indication for medication matters

Address distress, pain, retention and environmental triggers.

Use calm communication, familiar support and de-escalation.

Consider short-term medication only for severe distress or safety risk when these measures are insufficient.

Specify target symptom, monitoring and a stop/review date.

Does a quieter patient necessarily have improving delirium?

Recovery continues after discharge

Record baseline, delirium episode and unresolved contributors.

Review new sedatives and all temporary medicines.

Plan follow-up for cognition, function, nutrition and caregiver needs.

Tell the patient and family whom to contact if symptoms worsen.

Who owns the first review after transfer?

“There is nothing worth getting up for”

Mr. Patel, 79, stopped attending his walking group after bereavement.

Poor sleep, appetite and concentration over two months.

He presents with pain and fatigue, without volunteering sadness.

He says his family would be better off without him.

What must you establish before he leaves the office?

Assessment of late-life depression

Explore mood, anhedonia, somatic symptoms and function.

Assess suicide risk directly and act on immediate danger.

Review grief, medical causes, medications and cognitive change.

Use the Geriatric Depression Scale (GDS) or Cornell Scale for Depression in Dementia.

What would you revisit if cognition improves only partly with treatment?

A treatment plan that fits the patient

TREATMENT CHOICES

Psychological therapy and practical social support.

Antidepressant choice based on prior response, comorbidity and interactions.

Urgent specialty input for severe or complex presentations.

MONITORING

Symptoms, function and suicide risk.

Adverse effects, sodium risk, falls and adherence.

Adequate trial and planned reassessment.

What would influence your first medication choice in this patient?

Mr. Patel: follow-up is part of treatment

Agree on the next contact, often within 1–2 weeks initially.

Arrange earlier review or emergency care when risk requires it.

Track recovery in activities that matter to him.

Revisit safety, side effects, adherence and cognitive symptoms.

Who will contact him if he misses the appointment?

PAUSE

05

Five-minute break

Next: making the care plan work in British Columbia

Mr. Ng: his daughter cannot keep doing this

She is missing work and says she cannot safely manage transfers.

He wishes to remain at home. There is no reliable overnight help.

A referral has been sent, but no service has started.

What is your plan for tonight, and what service request will you make?

BC home and community supports

Need	Potential route	Check locally
Personal care and caregiver respite	Health authority Home & Community Care	Assessment, urgency, costs and capacity
Nursing, mobility and equipment	Occupational therapy (OT) / physiotherapy (PT)	Referral criteria and service availability
Meals, housekeeping and transport	Community agencies / Better at Home	Service scope, access and fees
Medication and caregiver support	Pharmacy / Family Caregivers of BC	Dispensing, administration and caregiver needs

Which part of this plan needs a confirmed handoff?

A referral that communicates urgency

Specific functional change and the patient’s preferred outcome.

Current risks, caregiver limits and services already tried.

Consent, communication needs and best contact.

Requested assessment, interim plan and follow-up responsibility.

What will you do if the service cannot meet the requested timeframe?

Driving: a concerning history, an inconclusive score

Ms. Chen, 81, has become lost twice on familiar routes.

Her family reports a recent near collision. She disputes their account.

A brief office cognitive score does not resolve fitness to drive.

She intends to drive herself home.

What do you advise now, and when does reporting become mandatory?

Driving: the section 230 duty

For a patient aged 16 or older, the duty applies when both conditions hold:

A medical condition makes driving dangerous in the clinician’s opinion.

The patient continues driving after a warning about that danger.

RoadSafetyBC determines licensing. Clinicians assess and report.

Case update: she drives again after your warning. What changes?

The driving report and the care plan

Describe diagnosis, functional effects, severity and course.

Include relevant examination, tests and collateral observations.

Record the advice given and what the patient did afterward.

Plan transport alternatives and clinical follow-up.

What should the report add to a Montreal Cognitive Assessment (MoCA) score of 22/30?

Consent refresher: who decides today?

Presume capability and support communication. Assess this decision now.

If incapable, inspect any advance directive and authorized representative or committee.

If needed, select a qualified temporary substitute decision-maker (TSDM) in legal order.

Document the decision, evidence of capability and source of authority.

“I have power of attorney, so I decide.” How would you respond?

Consent refresher: instruments and safeguards

Instrument / route	Clinical reminder
Advance directive	Check applicability to the proposed care and other documents.
Representation Agreement 7 or 9	Scope and capability tests differ. Read the actual authority.
Enduring power of attorney (POA) / committeeship	Financial POA does not confer health-care authority. Check court-order scope.
TSDM / Adult Guardianship Act	Verify TSDM eligibility. Engage a designated agency for abuse/neglect concerns.

Would a dementia diagnosis alone justify a global incapability letter?

Mr. Thompson: “I want to breathe easy at home”

86, severe chronic obstructive pulmonary disease (COPD), heart failure and frailty.

His daughter supports planning. His son wants every treatment attempted.

Mr. Thompson fears both another hospital stay and “giving up too soon”.

What recommendation would you offer after exploring what matters to him?

Goals of care and treatment orders

THE CONVERSATION

Illness understanding and likely outcomes.

What the person hopes to preserve.

A recommendation linked to those goals.

THE ORDERS

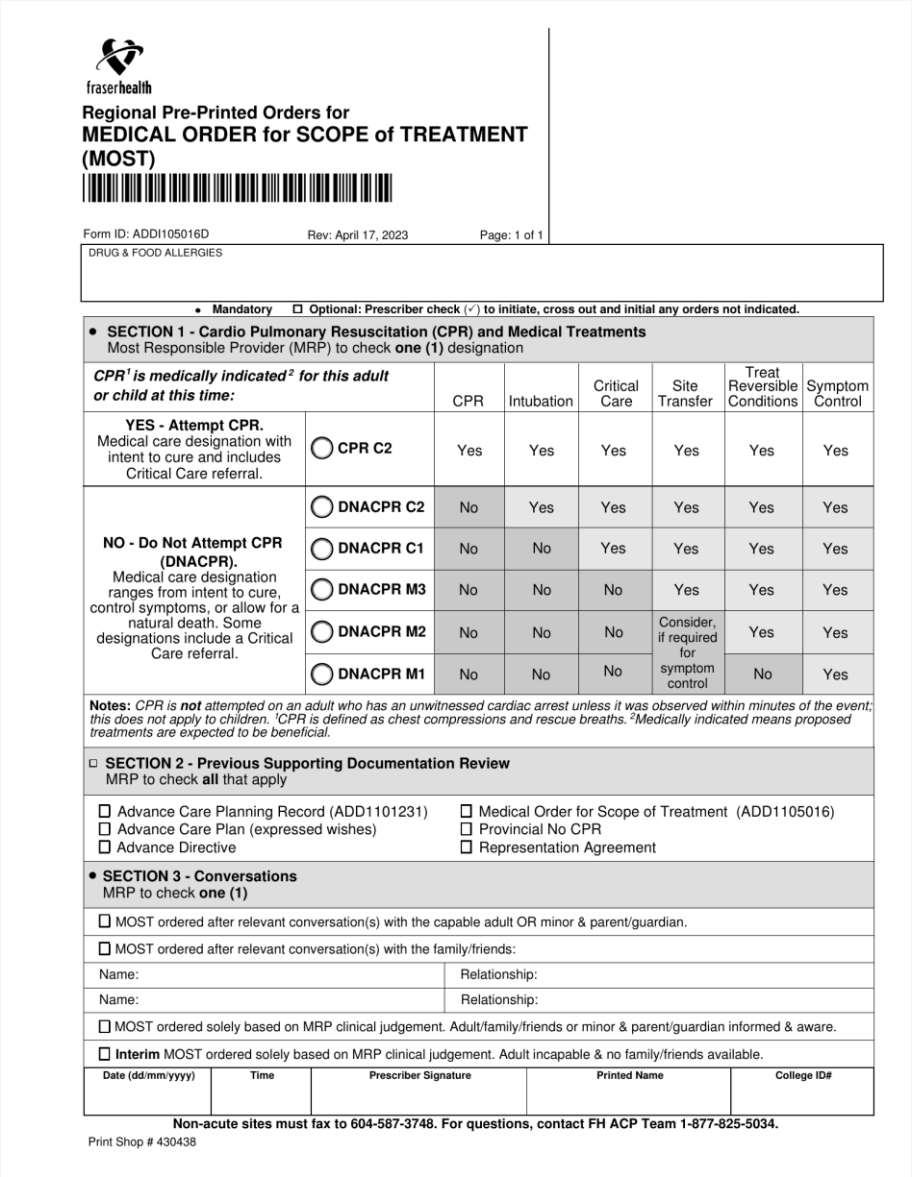
Medical Orders for Scope of Treatment (MOST) records the local treatment plan.

No cardiopulmonary resuscitation (No CPR) addresses arrest.

Specify treatments, transfers and review triggers.

Does No CPR mean “no antibiotics” or “never transfer”?

Medical Orders for Scope of Treatment (MOST)



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Regional Pre-Printed Orders for
MEDICAL ORDER for SCOPE of TREATMENT (MOST)

Form ID: ADDI105016D Rev: April 17, 2023 Page: 1 of 1

DRUG & FOOD ALLERGIES

• Mandatory ☐ Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.

• **SECTION 1 - Cardio Pulmonary Resuscitation (CPR) and Medical Treatments**
Most Responsible Provider (MRP) to check **one (1)** designation

CPR[1] is medically indicated[2] for this adult or child at this time:		CPR	Intubation	Critical Care	Site Transfer	Treat Reversible Conditions	Symptom Control
YES - Attempt CPR. Medical care designation with intent to cure and includes Critical Care referral.	◯ **CPR C2**	Yes	Yes	Yes	Yes	Yes	Yes
NO - Do Not Attempt CPR (DNACPR). Medical care designation ranges from intent to cure, control symptoms, or allow for a natural death. Some designations include a Critical Care referral.	◯ **DNACPR C2**	No	Yes	Yes	Yes	Yes	Yes
	◯ **DNACPR C1**	No	No	Yes	Yes	Yes	Yes
	◯ **DNACPR M3**	No	No	No	Yes	Yes	Yes
	◯ **DNACPR M2**	No	No	No	Consider, if required for symptom control	Yes	Yes
	◯ **DNACPR M1**	No	No	No		No	Yes

Notes: *CPR is **not** attempted on an adult who has an unwitnessed cardiac arrest unless it was observed within minutes of the event; this does not apply to children. [1]CPR is defined as chest compressions and rescue breaths. [2]Medically indicated means proposed treatments are expected to be beneficial.*

☐ **SECTION 2 - Previous Supporting Documentation Review**
MRP to check **all** that apply

☐ Advance Care Planning Record (ADD1101231)
☐ Advance Care Plan (expressed wishes)
☐ Advance Directive
☐ Medical Order for Scope of Treatment (ADD1105016)
☐ Provincial No CPR
☐ Representation Agreement

• **SECTION 3 - Conversations**
MRP to check **one (1)**

☐ MOST ordered after relevant conversation(s) with the capable adult OR minor & parent/guardian.

☐ MOST ordered after relevant conversation(s) with the family/friends:

Name:	Relationship:
Name:	Relationship:

☐ MOST ordered solely based on MRP clinical judgement. Adult/family/friends or minor & parent/guardian informed & aware.

☐ **Interim** MOST ordered solely based on MRP clinical judgement. Adult incapable & no family/friends available.

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name	College ID#

Non-acute sites must fax to 604-587-3748. For questions, contact FH ACP Team 1-877-825-5034.

Print Shop # 430438

Fraser Health form • April 17, 2023 • Teaching example; use the current local form

Prognostication in long-term care

The Robinson–Jarvie tool supports goals-of-care conversations.

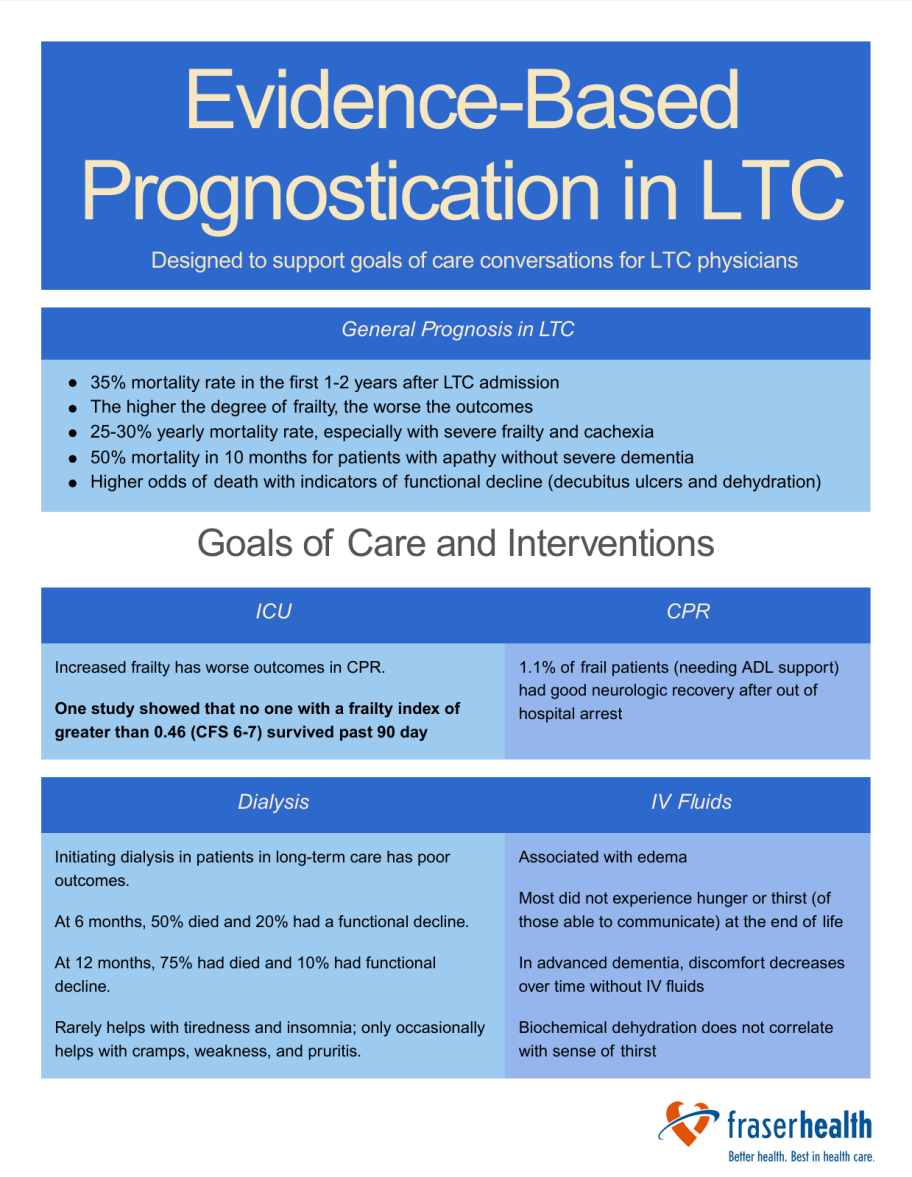
Consider frailty, trajectory, function, intake and acute complications.

Match any estimate to the study population and outcome.

Use uncertainty to plan reassessment and contingencies.

Which observation in this patient would make the discussion urgent?

Prognostication in long-term care: full tool



Evidence-Based Prognostication in LTC

Designed to support goals of care conversations for LTC physicians

General Prognosis in LTC

- 35% mortality rate in the first 1-2 years after LTC admission
- The higher the degree of frailty, the worse the outcomes
- 25-30% yearly mortality rate, especially with severe frailty and cachexia
- 50% mortality in 10 months for patients with apathy without severe dementia
- Higher odds of death with indicators of functional decline (decubitus ulcers and dehydration)

Goals of Care and Interventions

ICU	*CPR*
Increased frailty has worse outcomes in CPR. **One study showed that no one with a frailty index of greater than 0.46 (CFS 6-7) survived past 90 day**	1.1% of frail patients (needing ADL support) had good neurologic recovery after out of hospital arrest

Dialysis	*IV Fluids*
Initiating dialysis in patients in long-term care has poor outcomes. At 6 months, 50% died and 20% had a functional decline. At 12 months, 75% had died and 10% had functional decline. Rarely helps with tiredness and insomnia; only occasionally helps with cramps, weakness, and pruritis.	Associated with edema Most did not experience hunger or thirst (of those able to communicate) at the end of life In advanced dementia, discomfort decreases over time without IV fluids Biochemical dehydration does not correlate with sense of thirst

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Prognostication in long-term care: full tool

In End-Stage Dementia
• 50% 6 month mortality after first episode of pneumonia • 40% 6 month mortality after onset of swallowing problems or decreased oral intake • 45% 6 month mortality after first episode of febrile illness • 4.1 month survival (mean) in severe dementia with loss of ability to walk • 3 month survival (median) in severe dementia with pressure sores • Feeding tubes: similar or higher risk of aspiration, pressure sores, and restraints. Only truly beneficial long-term for patients with oropharyngeal cancer and motor neuron disease. • Minimal evidence for thickened liquids and association with more UTIs and dehydration

Specific Illnesses (for all patients in LTC)

Pneumonia	*UTI*	*Acute Illness*
90% had severe disability or death within 2 months of hospitalization 25% mortality in 6 weeks (40% if hospitalized) **Overall reviews show no survival difference between routes of administration of antibiotics** 60% mortality if all 3 of: higher respiratory rate, baseline needing feeding assistance, baseline altered diets (23% for 1-2 of these)	Asymptomatic bacteriuria (delirium and positive urinalysis) is common and hydration alone without antibiotics had similar outcomes at 30 days (though majority of LTC patients were treated with antibiotics) In severe dementia: • 25% mortality within 135 days • No significant association between overall antibiotic use and mortality • Hospitalization associated with shorter survival	Outcomes of patients transferred to emergency from long-term care are poor: **50% died within 3 months and survivors associated with functional decline** Certain signs indicate worse prognosis: • Higher CTAS score upon arrival to ER, shortness of breath, and changes in LOC more likely to die • Higher respiratory rate (RR>40): poor prognostic sign, especially in respiratory illness • Hypernatremia in febrile illness: poor prognostic sign (35% mortality) • 25% of patients with hip fractures die within 3 months. 50% died or were unable to walk independently after 6 months. Increased risk if age >90, more comorbidities, or severe dementia

Other helpful resources:

1. Clinical Frailty Scale
2. FRAIL-NH criteria

Created by: Dr. Belinda Robinson and Dr. Amber Jarvie, December 2023

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LTC case: another pneumonia

A 90-year-old resident has advanced dementia and needs full personal care.

Over recent months: weight loss, reduced intake and recurrent pneumonia.

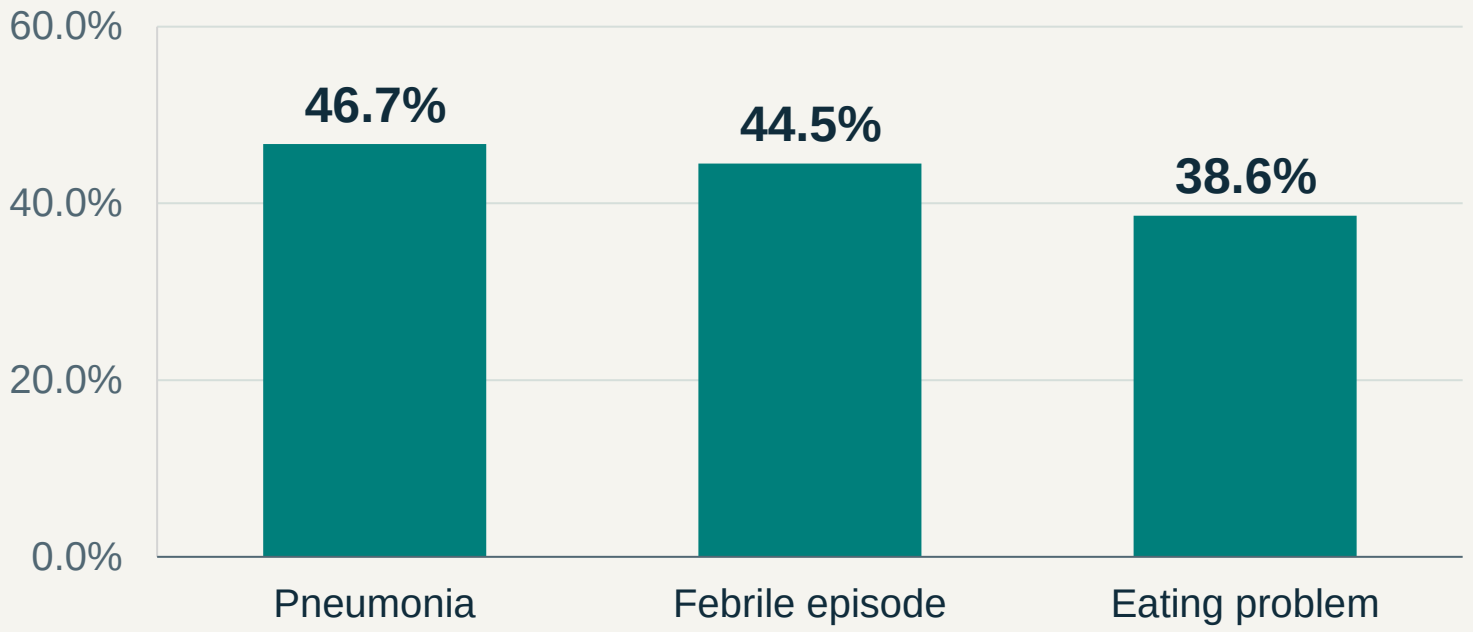
Today: worsening breathlessness and difficulty swallowing medicines.

The family asks, “How much time, and should we send him to hospital?”

What would you assess now, and what would you explain about prognosis?

Advanced dementia: six-month mortality

After a complication in a cohort of residents with advanced dementia



323 residents
22 United States nursing homes
18-month follow-up

Group estimates guide a conversation. Individual outcomes vary.

Mitchell et al., New England Journal of Medicine, 2009. Separate estimates, not additive.

A prognosis conversation with a plan

“I am worried that time may be short. Another illness may be harder to recover from.”

“Some people recover from this episode; others continue to decline. What would matter most if time were limited?”

How would you turn that conversation into orders for tonight?

Medical assistance in dying (MAiD)

Ms. Laurent, 84, has advanced COPD and persistent suffering.

She asks, “Can you tell me about medical assistance in dying?”

Her daughter says she should wait. The physician has a conscientious objection.

What does a respectful first response and next step look like?

MAiD: eligibility is an individual assessment

Age 18 or older, decision-making capacity and qualifying publicly funded health-service eligibility.

A voluntary, informed request without external pressure.

A grievous and irremediable medical condition under the legal criteria.

Natural death need not be reasonably foreseeable.

Frailty or a poor prognosis alone does not establish eligibility.

MAiD safeguards and consent

BOTH PATHWAYS – Track 1 & 2

Two independent assessments and required request formalities.

An opportunity to withdraw.

Capacity and consent requirements remain central.

WHEN DEATH IS NOT REASONABLY FORESEEABLE Track 2

Additional expertise and support discussions.

Generally at least 90 clear days for assessment, with a limited exception.

Express consent immediately before provision.

BC pathway and professional responsibilities

Offer accurate, unbiased information and address ongoing care needs.

Connect the patient with the health authority MAiD coordination service.

Maintain continuity when conscientiously objecting.

Document the discussion, access plan and agreed follow-up.

Which tasks can you undertake within your CFA licence and supervision arrangements?

APPLICATION

Final case: the phone call at 17:00

Ms. Lai is newly drowsy after a fall and has eaten very little.

A nurse asks for antibiotics because a urine dipstick is positive.

Her daughter says, “She is No CPR, so please keep her comfortable.”

Name your immediate action, one authority question and one follow-up responsibility.

APPLICATION

Take-home for your CFA

A change in function deserves a clinical explanation.

Medication decisions need an indication and a monitoring plan.

Patient goals and valid consent guide treatment.

BC responsibilities include reporting, service access and clear handovers.

A care plan is complete when someone owns the next step.

What will you do differently in your first week?