**Twenty (One) Tips for junior doctors working with older people**

(by DrSean Ninan, DME SpR in Merseyside, via Twitter)

1. Be good to older people. Many of your patients will be frail and vulnerable. Much of society may view them as a burden. You should not. These are mothers, fathers, husbands and wives. They have been on this planet two or three times as long as you have and many of them will have rich tales to tell. It is your job to look after them as well as you can, with empathy and kindness.
2. Be part of the team. Physiotherapists, occupational therapists, other allied health professionals and experienced nurses will know things that you don’t know – both day to day information, and nuggets of clinical wisdom. Introduce yourself to them, ask about progress, and feed back relevant information. You are now working in a multidisciplinary team.
3. Older people are really complicated. Acute coronary syndrome (to give just one example) will rarely be treated in a standardised fashion on an elderly ward. Some patients may be suitable for all the drugs on an ‘ACS protocol’. Others may not be suitable for more than one (or even none). Far more will be in between. Look at what your seniors are doing, and ask them why. Remember there is very little black and white in geriatric medicine and different doctors may do different things. Think about their reasoning and decide what kind of doctor you will be.
4. Because they are complicated, it may be helpful to write summary lists of problems (active, and inactive). It is also useful to consider nutrition, mobility, continence, and mood – document these periodically so that you record the progress of the patient in the notes. If you do this, you are well on your way to performing a comprehensive geriatric assessment! (<http://www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/195-gpgcgassessment>)
5. Review the medications – polypharmacy and adverse side effects are common in the elderly. This document from NHS Scotland is very helpful. <http://www.central.knowledge.scot.nhs.uk/upload/Polypharmacy%20full%20guidance%20v2.pdf>
6. Take time to talk to relatives. In fact, offer to do so. Even if it’s just a quick “Hello, my name is…( <http://drkategranger.wordpress.com/2013/09/04/hellomynameis/>) I’ve been looking after your mum/dad/grandparent.” You could quickly summarise their progress (with the patients consent). You can also use it as an opportunity for some collateral history. I appreciate that you are very busy and can’t have in depth conversations with all relatives. But imagine you are a relative of a patient, with little idea of what is going on. You can provide much reassurance. And unless you need to spend a long time speaking to relatives, I think it’s perfectly acceptable to convey what you need to and say “Sorry, but I must get on..” It’s important that you show a willingness to engage with relatives. You will soon find that many relatives are grateful, and you find your job more rewarding.
7. Speaking of collateral history – always get one! If you are ever clerking an elderly patient with cognitive impairment who cannot provide a full history, pick up the telephone and speak to a relative/care home worker/ neighbour. If a patient arrives on your ward and no-one has taken a collateral history, please do so.
8. If the relatives are unable to visit the ward, or only able to visit when you’re not there e.g. weekends or evenings, then (with the patient’s consent), give them a telephone call and offer to inform them of progress. Otherwise families may feel as if they are in the dark, or that nothing is happening.
9. Understand what frailty means. <http://rcpjournal.org/content/11/1/72.full>. In particular, the understanding that relatively minor stressors can result in significant decline in overall health is important to the assessment of the frail older patient.
10. Be excellent at diagnosing and managing delirium. <http://www.rcplondon.ac.uk/sites/default/files/concise-delirium-2006.pdf>. Treat infection (if it’s there), but don’t just treat infection. Reorientation and early mobilisation are important. Carefully review the medications. Treat pain, dehydration and electrolyte abnormalities. Look for constipation (which is often present) and urinary retention, but use urinary catheters for as short a time as possible. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2842841/table/t2-1820465/>
11. Pain can easily go unrecognised among older people. Is your patient agitated and distressed? Consider prescribing analgesia. Co-prescribe laxatives with opioid analgesia.
12. Monitor the patients bowels. Constipation can contribute to delirium, poor appetite, immobility and urinary retention.
13. Monitor the patient’s bladder. Consider the possibility of urinary retention (another cause for agitation and distress) and learn how to use your ward bladder scanner.
14. Don’t perform urine dipsticks in the elderly. <http://www.sign.ac.uk/pdf/sign88_algorithm_older.pdf>. The positive predictive value is disappointing and asymptomatic bacteriuria is common in the elderly. Give antibiotics for UTI if patients have acute urinary symptoms, or have bacteriuria and evidence of systemic inflammation (fever/raised inflammatory markers) without another more likely source of infection.
15. UTI is commonly overdiagnosed in older people, partly because of excess weight given to features such as the character of urine and urine dipstick results. Don’t assume a UTI every time your patient becomes unwell but instead, perform a thorough clinical evaluation.
16. Be excellent at managing falls. A ‘mechanical fall’ is a rare event. Most elderly people admitted to hospital will have acute illness and/or recurrent falls that may be multifactorial in nature. Treat acute illness e.g. infection, renal failure. But also do a thorough review to identify risk factors for falls, and treat appropriately. The falls may be ‘multifactorial ‘– but what are the factors? And how will you address them?  <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2010.03234.x/pdf>
17. When you are doing tasks at the bedside e.g. venepuncture, cannulation, take the opportunity to find out a little bit more about your patients. Ask them where they live, what their hobbies are, how long the have been married for etc. You will have a much richer picture of your patient as a person, and most of your patients will appreciate you for talking to them.
18. If your patient is hard of hearing, get their hearing aids, refer them for hearing aids or use an electronic amplifier. Some wards have one, but if they don’t you can buy one as an app for your smartphone which you can then connect to headphones.
19. You will often get asked: “Do they have capacity?” Capacity is decision and time specific. A patient may have capacity to choose what they want for lunch but not to consent for endoscopy. Read <http://www.mental-capacity.com/abouttheact/assessingcapacity/index.html> for more details of capacity assessment.
20. If a patient “sounds chesty” frequently and has recurrent pneumonia, consider the possibility of recurrent aspiration. A SALT review and modified diet may reduce their risk of further aspiration.

21. Never diagnose a patient as “acopic.” Patients who are labelled with this offensive term usually have several co-morbidities, often have evidence of an acute illness, and always deserve a thorough assessment. <http://www.ncbi.nlm.nih.gov/pubmed/24098878>