



# Attitudes, Beliefs, and Challenges: ABC's of Geriatrics

Guy Peifer, EMT-P



You are dispatched to a residence for an 87 year-old female that fell.

Thoughts?











AGING IS  
STYLISH  
ALL THE BEST  
PEOPLE  
ARE DOING IT!







# Geriatrics

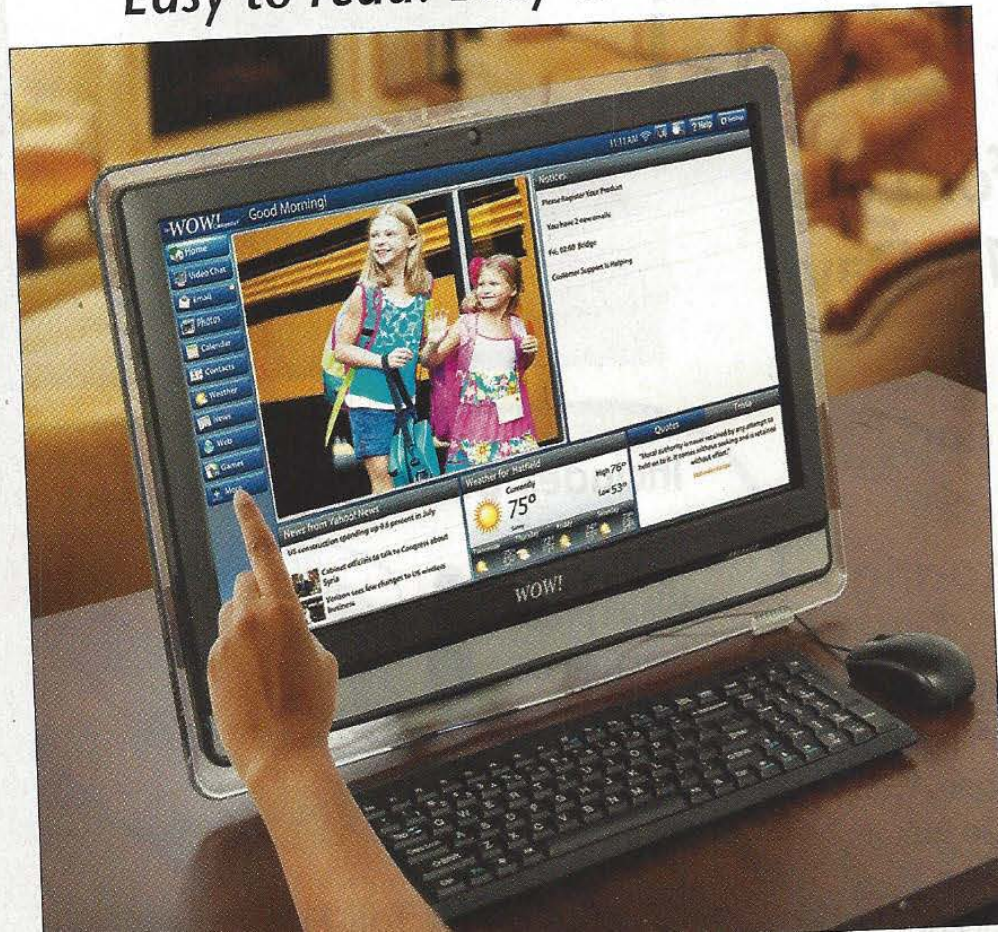
- 65 years and older
- 38% of patients EMS encounters
- 70 million by year 2030
- “Geriatric patients are the second most nerve-wracking group after pediatrics”



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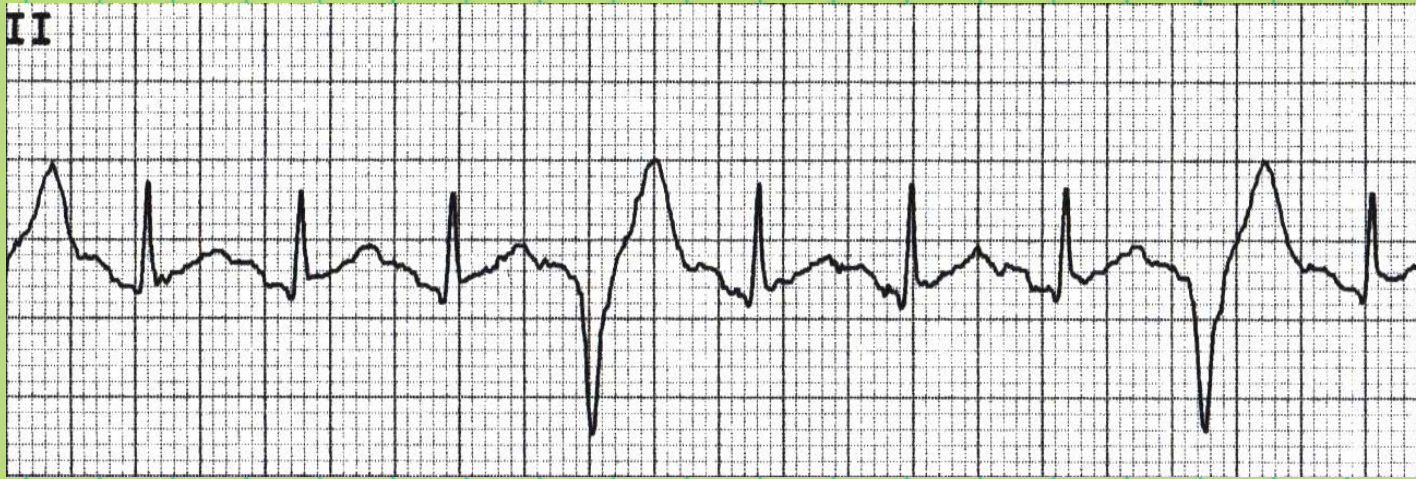
Your patient is an 89 year old woman who lives alone, and is complaining of dyspnea. Her daughter states the patient hasn't been feeling well, has had nothing to eat or drink for 2 days, and has been confined to bed. Today, she became short of breath, which has been worsening for the last 3 hours.



She has a history of myocardial infarction and congestive heart failure, and has been prescribed several medications including digoxin, lisinopril, isosorbide, and furosemide. On exam, she is lethargic and in mild respiratory distress, with a blood pressure of 70/40 and a pulse of 104 and irregular. Lung sounds reveal rales 1/4 of the way up, and there is 1+ pedal edema.



ECG shows sinus tachycardia with frequent premature ventricular beats. You place an IV line and oxygen, and transport her to the emergency room.



# Medications

- Digoxin: Inhibits sodium-potassium pump. Treats CHF and Atrial Fibrillation
- Lisinopril: Angiotensin-converting enzyme (ACE) inhibitor. Treats hypertension.





# Medications

- Isosorbide: Nitrate vasodilator. Treats angina pectoris.
- Furosemide: Inhibits sodium absorption. Treats CHF & HTN.



# Discussion

- Myocardial ischemia
- Volume depletion
- Decreased cardiac output
- Decreased renal blood flow



# Not Just Old Adults



Because of the aging process, there can be many subtle differences in how illness and injury present in geriatrics when compared to their younger counterparts.



# Change Occurs With Age

- The aging process is inevitable.
- Change occurs as early as 30 years of age.
- Increased longevity of people with chronic illnesses.
- EMT must be able to differentiate chronic changes from aging and acute changes due to illness or injury.



PHARMACY



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78 year old man with chronic obstructive pulmonary disease (COPD). He has a history of several COPD exacerbations, atrial fibrillation after a surgery 2 years ago, mild renal insufficiency, hypertension, benign prostatic hyperplasia, "sinus troubles" and depression. His recent complaints include insomnia and dizziness especially when standing up.



He recently saw two physicians who prescribed diazepam and meclizine. He has worsening confusion and anorexia. His bag of medications includes: albuterol inhaler 2 puffs 4 times daily, hydrochlorothiazide 50mg per day, potassium chloride 24mEq per day, digoxin 0.25mg per day, methyldopa 250mg 4 times daily, amitriptyline 75mg daily at bedtime, terbutaline 5mg po 3 times daily, .....



meclizine 25mg 3 times daily, diazepam 5mg daily at bedtime, diphenhydramine 50mg daily at bedtime as needed (he takes this for "sinus congestion" and sleep), and Dimetapp 1cap daily at bedtime as needed for "sinus troubles".







# Discussion

Polypharmacy is the use of four or more medications by a patient, generally adults aged over 65 years.

Polypharmacy is most common in the elderly, affecting about 40% of older adults living in their own homes.



Source: <https://en.wikipedia.org/wiki/Polypharmacy>

# Polypharmacy

- Increased adverse drug reactions and drug interactions
- Often associated with a decreased quality of life, decreased mobility and cognition



# Scene Size-Up

- Be attentive to BSI precautions
- Note the environmental conditions they live in.
- The ease in determining the MOI versus NOI is not as clear. The event may have actually occurred days earlier.



# Primary Assessment

## Mental status

- Important to differentiate acute from chronic alteration.

**Ask**  
**family members**  
**“Is this a**  
**change?”**



# Primary Assessment

## Airway Compromise

Decreased airway clearance, decreased cough and laryngeal reflexes, decline in mucociliary clearance.

Loss of elastic recoil in lungs. Increased ventilation/perfusion mismatch.

Decreased numbers of alveoli.

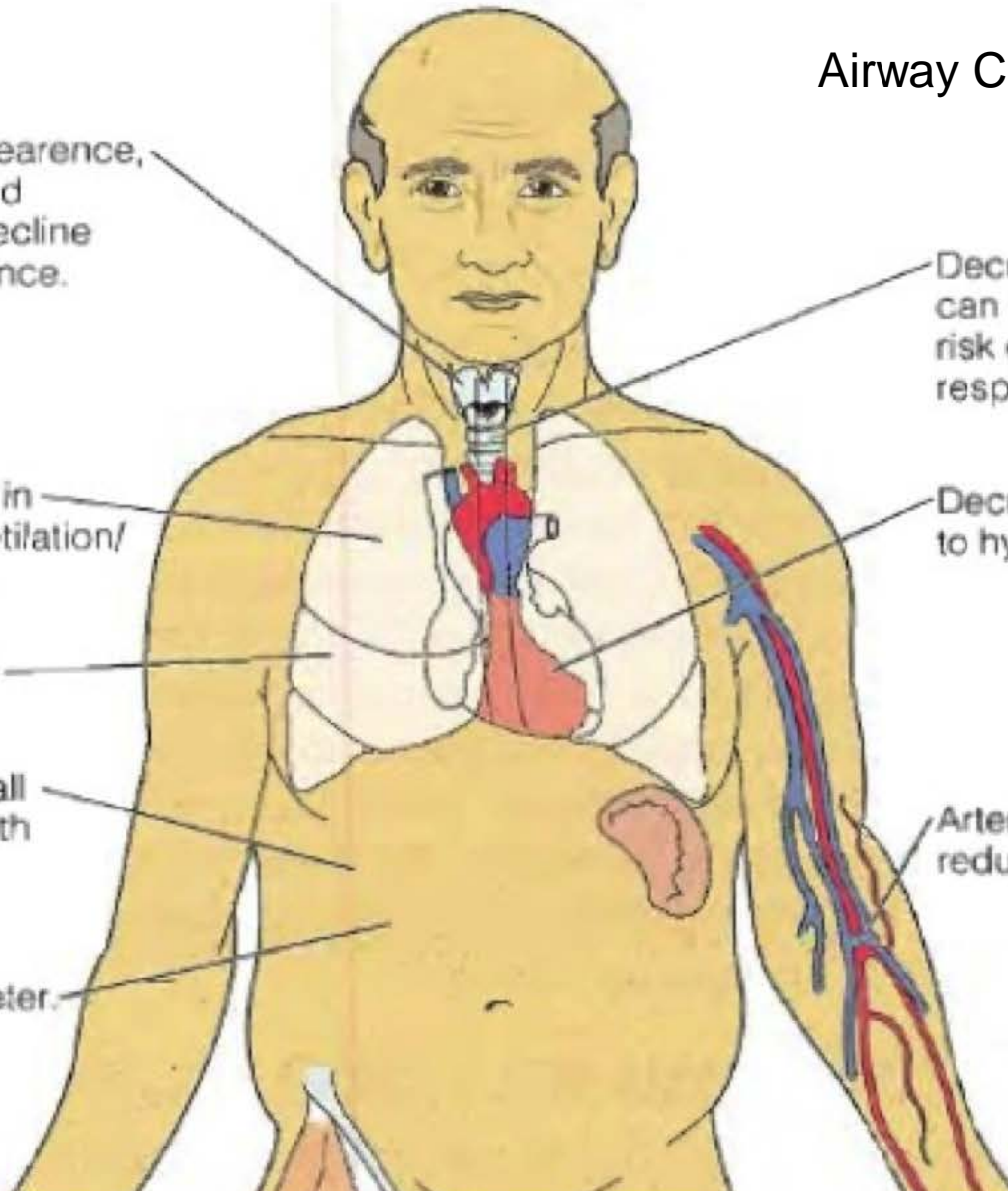
Stiffening of chest wall with declining strength in chest muscles.

Increased A-P diameter.

Decreased ciliary action can contribute to higher risk of aspiration and respiratory infection.

Decreased response to hypercapnia.

Arterial hypoxemia with reduced PO<sub>2</sub> levels.



# Primary Assessment

## Breathing

- Respiratory muscle failure occurs rapidly in light of pulmonary emergencies.
- Carefully assess respiratory rate *and* tidal volume.



# Primary Assessment

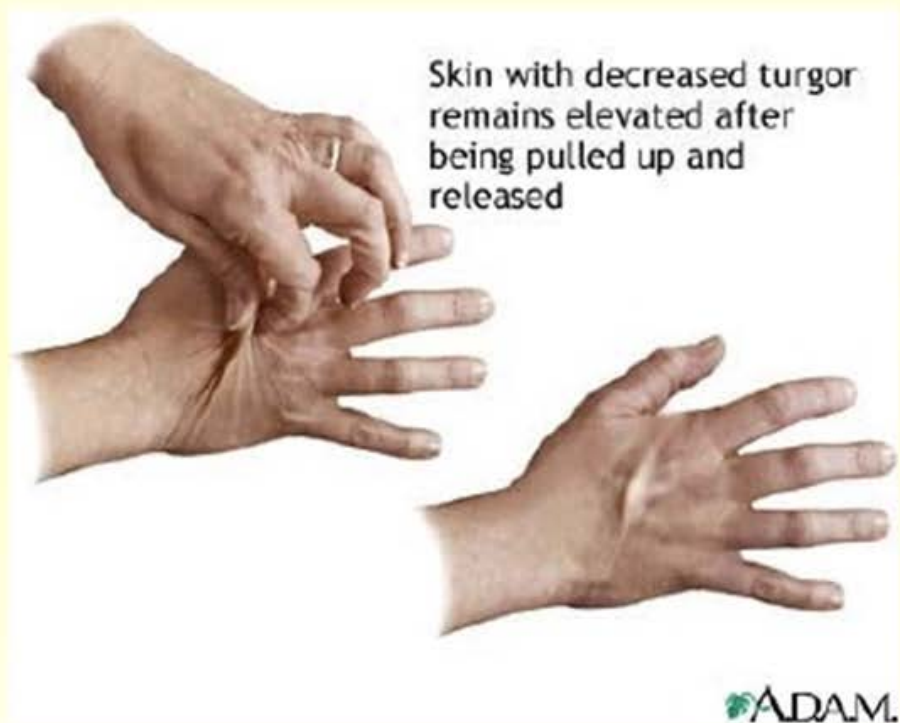
## Circulation

- Assess central and peripheral pulses
- Indirect measures of circulatory adequacy may include mental status and skin characteristics.





# Checking Skin Turgor?



Not on back of hand or forearm  
for an elder client



Forehead, collarbone, or sternum  
(elder client)

# ABCDEFGFG Method

- A – appearance, airway
- B – breathing
- C – circulation
- D – decision, defib, disability, diagnostics
- E – expose, examine
- F – focused history
- G – Go, ongoing assessment





Your unit is dispatched to a 75 year old woman who was found confused and attempting to make her front door key fit an apartment door downstairs from her own.



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It takes several attempts to gain her attention to answer any questions. Her answers are rambling and disorganized, and her speech is at times incoherent. She is drowsy and falls asleep at times during the interview. When awake, she appears to be talking about things that are in the room with her, and is unable to describe where she is, who she is, or where she lives.



A physical exam does not reveal specific abnormalities relating to other body systems, and there is no sign of injury or falling. There are no deficits noted on neurological examination. She is unable to cooperate with a Mini-Mental State exam.

**AEIOU TIPS**



AEIOU-TIPS  
An Altered Mental Status Tune

- A - alcohol
- E - epilepsy
- I - insulin
- O – overdose, oxygen
- U – uremia, underdose
- T - trauma
- I - infection
- P – psychiatric, poisoning
- S – stroke, shock





# Assessment Complications

- Underreporting of symptoms
  - stoicism - "it's nothing, really"
  - attributing symptoms to aging per se - "it's to be expected...I'm just getting old"
  - Fear
  - potential loss of independence and control
  - potential expense or physical discomfort
  - cognitive impairment



# Assessment Complications

- Communication problems
  - older patients often slower to respond
  - hearing problems
  - dysarthria or aphasia
  - 3<sup>rd</sup> party caller



# Assessment Complication

- Multiple complaints
  - the new complaint may be obscured by a "background" of other complaints
  - Interactions between multiple problems and medications





- An 84 year old woman, has fallen. She states it is her 5<sup>th</sup> fall in the past 4 months. She has a medical history of mild Parkinson's disease and mild congestive heart failure. She states that the falls always occur when she walks from one room to another in her house. She denies any syncope or lightheadedness, and states she fell because she lost her balance.





Her medications include carbidopa/levodopa and benztropine for the Parkinson's disease, digoxin and furosemide for the congestive heart failure, ibuprofen for joint pain, and diazepam for insomnia.

On examination, she is alert and well-hydrated. Her blood pressure is 140/90 supine and 128/90 after 3 minutes of standing. Her pulse is 80 and regular supine and standing.



Neuro exam reveals a mild resting tremor of the left forearm, and although she appears fully intact during conversation, a MMSE score is 23/30. She is unable to arise from a chair without pushing off with her hands. She is somewhat unsteady with walking, with decreased step height and length and increased unsteadiness during turns.





# Discussion

- 1 out of 3 geriatrics fall each year
- leading cause of both fatal and nonfatal injuries
- 2.5 million ER visits
- \$34 billion



# Falls....Why?

- Muscle weakness
- Poor balance
- Postural hypotension
- Slower reflexes
- Foot problems
- Medications
- Sensory defecits



# Why the bad attitude?

**“People are deemed useless beyond a certain age and are increasingly ignored as they have an increasing need for kind and compassionate assistance.”**



# Question

Are there any providers who have experienced condescending attitudes or blatant rudeness from EMTs, paramedics, nurses, or doctors during the process of caring for a geriatric patient?



- "hmmmmph, these ain 't that bad, I wouldn't waste the amb time to send her out“

