

A — Older adult

8 statements · Recommended tool: CP-OLDER Older Adult Check · Validated scales: 4AT / CAM, Mini-Cog

A1 Frailty

Group: Older adult | Type: Actual problem

Definition: General weakness, low energy, and slow recovery that raise the chance of falls and illness.

Possible causes: Aging; poor nutrition; inactivity; chronic disease; low reserves

Signs and symptoms: Weakness; slowness; tiredness; weight loss; falls

Scenario. An older woman has a slow walk, exhaustion, and unintended weight loss.

S: "I'm weak and tired all the time."

O: Slow walk; lost 5 kg; weak grip; one fall in 6 months.

Tools: CP-OLDER, CP-SAFE, CP-FLUID · 4AT / CAM, Mini-Cog, Morse Fall Scale, MUST, fluid chart, glucose
****CarePath diagnosis:**** Frailty related to aging, as evidenced by weakness and slowness. ****Interventions and rationale**** | Intervention | Rationale | ---|---| | Assess strength and nutrition. | Measuring grip, walking speed and weight and reviewing food intake shows how frail she is and which causes can be treated, so the plan fits her needs. | | Start an exercise program. | Regular, gentle exercise rebuilds muscle strength and balance, which improves walking speed and lowers the chance of falling. | | Prevent falls. | Weak muscles and slow walking raise fall risk, and a fall can cause fractures and loss of independence, so safe surroundings and aids matter. | | Review medicines. | Some medicines cause dizziness, drowsiness or poor appetite, so a review can find and reduce those that add to weakness or falls. | | Involve the team. | Dietitians, physiotherapists and doctors each address a different cause of frailty, so a team approach gives more complete care. | ****Expected outcomes**** - Gains strength. - No falls. - Walking speed improves in 4-8 weeks. - Nutrition improves. ****Linking the data to the diagnosis****
The patient says, 'I'm weak and tired all the time.' The nurse finds a slow walk, a weak grip, a 5 kg weight loss and one fall in 6 months. Together these show ongoing low reserves, so this is an actual problem and not a risk of falls alone, and it is also more than a single fall or one tired spell. Frailty is the best fit because weakness, slowness and weight loss occur together. The plan aims to build strength, prevent further falls, improve walking speed over 4 to 8 weeks and improve nutrition.

CarePath diagnosis: Frailty related to aging, as evidenced by weakness and slowness.

Intervention	Rationale
Assess strength and nutrition.	Measuring grip, walking speed and weight and reviewing food intake shows how frail she is and which causes can be treated, so the plan fits her needs.
Start an exercise program.	Regular, gentle exercise rebuilds muscle strength and balance, which improves walking speed and lowers the chance of falling.
Prevent falls.	Weak muscles and slow walking raise fall risk, and a fall can cause fractures and loss of independence, so safe surroundings and aids matter.
Review medicines.	Some medicines cause dizziness, drowsiness or poor appetite, so a review can find and reduce those that add to weakness or falls.
Involve the team.	Dietitians, physiotherapists and doctors each address a different cause of frailty, so a team approach gives more complete care.

Expected outcomes: Gains strength. · No falls. · Walking speed improves in 4-8 weeks. · Nutrition improves.

Linking the data: The patient says, 'I'm weak and tired all the time.' The nurse finds a slow walk, a weak grip, a 5 kg weight loss and one fall in 6 months. Together these show ongoing low reserves, so this is an actual problem and not a risk of falls alone, and it is also more than a single fall or one tired spell. Frailty is the best fit because weakness, slowness and weight loss occur together. The plan aims to build strength, prevent further falls, improve walking speed over 4 to 8 weeks and improve nutrition.

A2 Memory loss

Group: Older adult | Type: Actual problem

Definition: Noticeable forgetfulness that affects daily life.

Possible causes: Dementia; stroke; medicines; depression; vitamin B12 deficiency

Signs and symptoms: Forgets names; repeats; misplaces items; gets lost

Scenario. An older man forgets to turn off the stove.

S: "Did I turn off the stove?"

O: Forgets names and tasks; leaves the stove on; repeats questions.

Tools: CP-OLDER · 4AT / CAM, Mini-Cog ****CarePath diagnosis:**** Memory loss related to suspected dementia (not yet confirmed), as evidenced by forgetting names and tasks, leaving the stove on, and repeating questions. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assess. | A structured assessment shows how much memory is affected and what could be treated, such as medicines, depression or low vitamin B12, so care matches the cause. | | Use reminders. | Notes, labels and alarms support a failing memory so daily tasks are done and missed steps are less likely. | | Keep routines. | Familiar, predictable routines reduce confusion and stress and rely on habit memory, which often lasts longer than recent memory. | | Make the home safe. | Safety steps such as stove shut-off devices and removing hazards reduce the chance of fire or injury when he forgets. | | Support the family. | Family members are the main support, and teaching them what to expect and how to help prevents exhaustion and unsafe situations. | | Refer. | A specialist referral allows diagnosis, treatment of reversible causes and access to long-term services so the cause can be treated and the family linked to long-term help. | ****Expected outcomes**** - Safe routines. - Supervision or reminders in place. - Family trained. - Assessment completed. ****Linking the data to the diagnosis**** The patient asks, 'Did I turn off the stove?' The nurse notes that he forgets names and tasks, repeats questions and has left the stove on. Forgetfulness already affects daily life and safety, so this is an actual problem and not a risk, and it rests on these observed memory failures. The plan aims for safe routines, reminders or supervision in place, trained family and a completed assessment, so the stove danger is controlled while the cause is found.

CarePath diagnosis: Memory loss related to suspected dementia (not yet confirmed), as evidenced by forgetting names and tasks, leaving the stove on, and repeating questions.

Intervention	Rationale
Assess.	A structured assessment shows how much memory is affected and what could be treated, such as medicines, depression or low vitamin B12, so care matches the cause.
Use reminders.	Notes, labels and alarms support a failing memory so daily tasks are done and missed steps are less likely.
Keep routines.	Familiar, predictable routines reduce confusion and stress and rely on habit memory, which often lasts longer than recent memory.
Make the home safe.	Safety steps such as stove shut-off devices and removing hazards reduce the chance of fire or injury when he forgets.
Support the family.	Family members are the main support, and teaching them what to expect and how to help prevents exhaustion and unsafe situations.
Refer.	A specialist referral allows diagnosis, treatment of reversible causes and access to long-term services so the cause can be treated and the family linked to long-term help.

Expected outcomes: Safe routines. · Supervision or reminders in place. · Family trained. · Assessment completed.

Linking the data: The patient asks, 'Did I turn off the stove?' The nurse notes that he forgets names and tasks, repeats questions and has left the stove on. Forgetfulness already affects daily life and safety, so this is an actual problem and not a risk, and it rests on these observed memory failures. The plan aims for safe routines, reminders or supervision in place, trained family and a completed assessment, so the stove danger is controlled while the cause is found.

A3 Too many medicines

Group: Older adult | Type: Risk problem

Definition: Many medicines at once raise the chance of interactions and side effects.

Risk factors: Many conditions; multiple doctors; no medicine review

Warning signs: Side effects; confusion; falls; interactions

Scenario. An older woman takes twelve medicines prescribed by four different doctors.

S: "I take lots of pills and I do not know why."

O: 12 medicines; 4 prescribers; no recent medicine review; keeps old tablets at home; no side effects reported yet.

Tools: CP-OLDER · 4AT / CAM, Mini-Cog ****CarePath diagnosis:**** Too many medicines related to many medicines and several prescribers (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Review the list. | Going through every medicine shows what is taken, why, and whether each is still needed, which is the first step in finding interactions or unnecessary drugs. | | Involve a pharmacist. | Pharmacists are experts in interactions and side effects and can advise prescribers on safer combinations and doses. | | Ask the prescriber or pharmacist to remove duplicate medicines. | Only the prescriber can stop or change medicines; the nurse makes sure the review happens and records the changes. | | Teach. | When she knows what each medicine is for and how to take it, she is more likely to take them correctly and report side effects early. | ****Expected outcomes**** - Medicine list reviewed. - Unnecessary medicines stopped only by the prescriber after review. - No adverse effects. - Patient names main medicines. ****Linking the data to the diagnosis**** The patient says, 'I take lots of pills and I do not know why.' She takes 12 medicines from 4 prescribers, has had no recent medicine review and keeps old tablets at home. No side effects have been reported yet, so harm has not occurred. For this reason a risk statement fits, and it rests on the number of medicines and prescribers. The plan aims to review the list, stop unnecessary drugs through the prescribers, avoid adverse effects and help her name her main medicines.

CarePath diagnosis: Too many medicines related to many medicines and several prescribers (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Review the list.	Going through every medicine shows what is taken, why, and whether each is still needed, which is the first step in finding interactions or unnecessary drugs.
Involve a pharmacist.	Pharmacists are experts in interactions and side effects and can advise prescribers on safer combinations and doses.
Ask the prescriber or pharmacist to remove duplicate medicines.	Only the prescriber can stop or change medicines; the nurse makes sure the review happens and records the changes.
Teach.	When she knows what each medicine is for and how to take it, she is more likely to take them correctly and report side effects early.

Expected outcomes: Medicine list reviewed. · Unnecessary medicines stopped only by the prescriber after review. · No adverse effects. · Patient names main medicines.

Linking the data: The patient says, 'I take lots of pills and I do not know why.' She takes 12 medicines from 4 prescribers, has had no recent medicine review and keeps old tablets at home. No side effects have been reported yet, so harm has not occurred. For this reason a risk statement fits, and it rests on the number of medicines and prescribers. The plan aims to review the list, stop unnecessary drugs through the prescribers, avoid adverse effects and help her name her main medicines.

A4 Loneliness at home

Group: Older adult | Type: Risk problem

Definition: Living alone with little contact may lead to loneliness and low mood.

Risk factors: Widowhood; mobility loss; isolation; no contacts

Warning signs: Says he is lonely; no visitors; low mood

Scenario. A widower speaks only to the television.

S: "I only talk to the television."

O: Widowed; lives alone; few visits; speaks mainly to the television.

Tools: CP-OLDER · 4AT / CAM, Mini-Cog ****CarePath diagnosis:**** Loneliness at home related to widowhood and living alone (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Encourage visits. | Regular contact with family and friends gives social connection, which lessens loneliness and protects mood. | | Link to community groups. | Community groups offer shared interests and routine company beyond family, so he builds new relationships. | | Arrange phone calls. | Scheduled calls give predictable contact on days when visits are not possible, especially with reduced mobility. | | Consider a pet. | A pet can give companionship and a reason for daily activity, but only if he wants one and can care for it safely. | | Screen mood. | Mood screening finds low mood or depression early so treatment can start before it worsens. | ****Expected outcomes**** - Contacts at least 3 times a week. - Joins one group. - Mood improves. ****Linking the data to the diagnosis**** The patient is widowed, lives alone, has few visits, and speaks mainly to the television. These are risk factors for loneliness, but no low mood or other harm is recorded yet, so the statement is a risk and not an actual problem. The nurse acts early to prevent isolation from leading to depression. The plan aims for contact at least three times a week, joining one group, and checking his mood regularly so that any change is caught early.

CarePath diagnosis: Loneliness at home related to widowhood and living alone (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Encourage visits.	Regular contact with family and friends gives social connection, which lessens loneliness and protects mood.
Link to community groups.	Community groups offer shared interests and routine company beyond family, so he builds new relationships.
Arrange phone calls.	Scheduled calls give predictable contact on days when visits are not possible, especially with reduced mobility.
Consider a pet.	A pet can give companionship and a reason for daily activity, but only if he wants one and can care for it safely.
Screen mood.	Mood screening finds low mood or depression early so treatment can start before it worsens.

Expected outcomes: Contacts at least 3 times a week. · Joins one group. · Mood improves.

Linking the data: The patient is widowed, lives alone, has few visits, and speaks mainly to the television. These are risk factors for loneliness, but no low mood or other harm is recorded yet, so the statement is a risk and not an actual problem. The nurse acts early to prevent isolation from leading to depression. The plan aims for contact at least three times a week, joining one group, and checking his mood regularly so that any change is caught early.

A5 Neglect or money exploitation risk

Group: Older adult | Type: Risk problem

Definition: The older person may be neglected or taken advantage of by others.

Risk factors: Dependence; dementia; abusers; isolation

Warning signs: Missing money; unpaid bills; poor hygiene; fear

Scenario. An older woman with early dementia lets a relative manage her bank card.

S: "My son handles my money."

O: Early dementia; lives with a relative who manages her bank card; cannot say her balance; clean and well fed; no missing money found yet.

Tools: CP-OLDER · 4AT / CAM, Mini-Cog ****CarePath diagnosis:**** Neglect or money exploitation risk related to dependence and memory problems (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Ask privately. | Speaking alone lets her answer without pressure from the person who may be controlling her, so she can speak freely and safely. | | Document. | Accurate, dated and factual records protect the patient and support any later investigation and clear notes give a reliable record if the concern is investigated later. | | Report per policy. | Reporting through the agreed policy brings in people with legal authority to investigate and protect vulnerable adults. | | Involve a social worker. | A social worker can assess her finances and care, and arrange independent help and protective measures. | | Ensure safety. | Making sure she is safe comes first, so no further harm can occur while concerns are looked into. ****Expected outcomes**** - Patient safe. - Concerns reported per policy. - Independent help arranged. - Finances protected. ****Linking the data to the diagnosis**** The patient says, 'My son handles my money.' She has early dementia, lives with a relative who manages her bank card and cannot say her balance. She is clean and well fed, and no missing money has been found yet, so neglect or exploitation has not been shown. This is why a risk statement fits, and it rests on dependence and memory problems. The plan aims for the patient to be safe, concerns reported per policy, independent help arranged and finances protected.

CarePath diagnosis: Neglect or money exploitation risk related to dependence and memory problems (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Ask privately.	Speaking alone lets her answer without pressure from the person who may be controlling her, so she can speak freely and safely.
Document.	Accurate, dated and factual records protect the patient and support any later investigation and clear notes give a reliable record if the concern is investigated later.
Report per policy.	Reporting through the agreed policy brings in people with legal authority to investigate and protect vulnerable adults.
Involve a social worker.	A social worker can assess her finances and care, and arrange independent help and protective measures.
Ensure safety.	Making sure she is safe comes first, so no further harm can occur while concerns are looked into.

Expected outcomes: Patient safe. · Concerns reported per policy. · Independent help arranged. · Finances protected.

Linking the data: The patient says, 'My son handles my money.' She has early dementia, lives with a relative who manages her bank card and cannot say her balance. She is clean and well fed, and no missing money has been found yet, so neglect or exploitation has not been shown. This is why a risk statement fits, and it rests on dependence and memory problems. The plan aims for the patient to be safe, concerns reported per policy, independent help arranged and finances protected.

A6 Unsafe to live alone

Group: Older adult | Type: Actual problem

Definition: Health or memory problems make independent living risky.

Possible causes: Dementia; falls; poor mobility; no help

Signs and symptoms: Unsafe cooking; wandering; unpaid bills; poor hygiene

Scenario. An older man leaves the gas on.

S: "I can manage on my own."

O: Dementia; left the gas on; wandering; unpaid bills.

Tools: CP-OLDER · 4AT / CAM, Mini-Cog ****CarePath diagnosis:**** Unsafe to live alone related to dementia, as evidenced by leaving the gas on, wandering, and unpaid bills. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assess abilities. | Assessing what he can and cannot do, such as cooking, managing money and moving safely, shows where the real dangers are. | | Make the home safe. | Removing hazards like gas and fitting safety devices lowers the chance of fire, falls and injury. | | Arrange services. | Home care, meals, alarms and visits support him in daily tasks and reduce the need to manage alone. | | Plan for care. | Planning ahead with him and his family prepares for further decline so decisions are not made in a crisis. | ****Expected outcomes**** - Safe living plan agreed. - Supports in place. - No incidents. - Family involved. ****Linking the data to the diagnosis**** The patient has dementia, has left the gas on, has wandered, and has unpaid bills. These events show that unsafe living is already happening, so the statement is actual. The nurse does not assume the cause is only memory loss and also checks falls and mobility. The plan aims to assess his abilities, make the home safe, arrange services, and agree a living plan with the family and no further incidents.

CarePath diagnosis: Unsafe to live alone related to dementia, as evidenced by leaving the gas on, wandering, and unpaid bills.

Intervention	Rationale
Assess abilities.	Assessing what he can and cannot do, such as cooking, managing money and moving safely, shows where the real dangers are.
Make the home safe.	Removing hazards like gas and fitting safety devices lowers the chance of fire, falls and injury.
Arrange services.	Home care, meals, alarms and visits support him in daily tasks and reduce the need to manage alone.
Plan for care.	Planning ahead with him and his family prepares for further decline so decisions are not made in a crisis.

Expected outcomes: Safe living plan agreed. · Supports in place. · No incidents. · Family involved.

Linking the data: The patient has dementia, has left the gas on, has wandered, and has unpaid bills. These events show that unsafe living is already happening, so the statement is actual. The nurse does not assume the cause is only memory loss and also checks falls and mobility. The plan aims to assess his abilities, make the home safe, arrange services, and agree a living plan with the family and no further incidents.

A7 Difficulty adjusting to a care home

Group: Older adult | Type: Actual problem

Definition: Moving to a new setting causes stress, confusion, or sadness.

Possible causes: Loss of home; unfamiliar setting; change; reduced freedom

Signs and symptoms: Withdrawn; sad; refuses help; confusion

Scenario. A woman cries after moving to a care home.

S: "I want to go home."

O: New care home resident; tearful; withdrawn; refuses meals.

Tools: CP-OLDER · 4AT / CAM, Mini-Cog ****CarePath diagnosis:**** Difficulty adjusting to a care home related to loss of home, as evidenced by withdrawn and sad. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Orient her. | Showing her the layout, routine and staff reduces fear of the unknown and helps her feel in control of her new surroundings. | | Allow personal belongings. | Familiar items such as photos and a favorite blanket give comfort and a link to her old home and identity. | | Involve family. | Family visits and involvement keep her relationships strong and help her feel less alone and abandoned. | | Keep routines. | Keeping routines she is used to, such as meal and wake times, gives a sense of normal life and lessens confusion. | | Give emotional support. | Listening and acknowledging her sadness shows respect, lowers distress and builds trust with staff and a trusting relationship helps her accept help and settle in. | ****Expected outcomes**** - Settles within weeks. - Joins activities. - Eats well. - Says she feels more at home. ****Linking the data to the diagnosis**** The patient says, 'I want to go home.' She is a new resident, tearful, withdrawn and refusing meals. She is already showing distress, so this is an actual problem, not a risk, and the evidence is her withdrawn, sad behavior. It fits better than a general low mood statement because it began with the move. The plan aims for her to settle within weeks, join activities, eat well and say she feels more at home.

CarePath diagnosis: Difficulty adjusting to a care home related to loss of home, as evidenced by withdrawn and sad.

Intervention	Rationale
Orient her.	Showing her the layout, routine and staff reduces fear of the unknown and helps her feel in control of her new surroundings.
Allow personal belongings.	Familiar items such as photos and a favorite blanket give comfort and a link to her old home and identity.
Involve family.	Family visits and involvement keep her relationships strong and help her feel less alone and abandoned.
Keep routines.	Keeping routines she is used to, such as meal and wake times, gives a sense of normal life and lessens confusion.
Give emotional support.	Listening and acknowledging her sadness shows respect, lowers distress and builds trust with staff and a trusting relationship helps her accept help and settle in.

Expected outcomes: Settles within weeks. · Joins activities. · Eats well. · Says she feels more at home.

Linking the data: The patient says, 'I want to go home.' She is a new resident, tearful, withdrawn and refusing meals. She is already showing distress, so this is an actual problem, not a risk, and the evidence is her withdrawn, sad behavior. It fits better than a general low mood statement because it began with the move. The plan aims for her to settle within weeks, join activities, eat well and say she feels more at home.

A8 Loss of independence

Group: Older adult | Type: Actual problem

Definition: The person can no longer do tasks they once managed alone and feels reduced control.

Possible causes: Illness; weakness; fear; cognitive decline

Signs and symptoms: Frustration; withdrawal; refuses help; dependence

Scenario. A former driver cannot go out alone after a stroke.

S: "I used to drive myself everywhere."

O: After stroke; cannot go out alone; frustrated; refuses help.

Tools: CP-OLDER · 4AT / CAM, Mini-Cog **CarePath diagnosis:** Loss of independence related to illness, as evidenced by frustration and withdrawal. **Interventions and rationale** | Intervention | Rationale |
|---|---| | Respect choices. | Respecting his choices keeps his dignity and sense of control, which reduces frustration and the urge to refuse help. | | Encourage independence. | Letting him do what he can safely helps rebuild skills and confidence and prevents avoidable dependence. | | Use adaptive aids. | Aids such as walking supports, adapted tools or transport options let him do more for himself and go out more. | | Set goals. | Goals that he helps set give direction and show progress, which supports motivation after a stroke. | **Expected outcomes** - Uses adaptive aids. - Takes part in decisions. - Sets achievable independence goals. **Linking the data to the diagnosis** The patient says, 'I used to drive myself everywhere.' Since his stroke he cannot go out alone, and he is frustrated and refuses help. The loss has already happened, so this is an actual problem, and it rests on illness with frustration and withdrawal. It fits better than a mobility statement because the main issue is his loss of control and independence. The plan aims for him to use adaptive aids, take part in decisions and set achievable independence goals.

CarePath diagnosis: Loss of independence related to illness, as evidenced by frustration and withdrawal.

Intervention	Rationale
Respect choices.	Respecting his choices keeps his dignity and sense of control, which reduces frustration and the urge to refuse help.
Encourage independence.	Letting him do what he can safely helps rebuild skills and confidence and prevents avoidable dependence.
Use adaptive aids.	Aids such as walking supports, adapted tools or transport options let him do more for himself and go out more.
Set goals.	Goals that he helps set give direction and show progress, which supports motivation after a stroke.

Expected outcomes: Uses adaptive aids. · Takes part in decisions. · Sets achievable independence goals.

Linking the data: The patient says, 'I used to drive myself everywhere.' Since his stroke he cannot go out alone, and he is frustrated and refuses help. The loss has already happened, so this is an actual problem, and it rests on illness with frustration and withdrawal. It fits better than a mobility statement because the main issue is his loss of control and independence. The plan aims for him to use adaptive aids, take part in decisions and set achievable independence goals.