GERIATRIC ASSESSMENT – AN APPROACH

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WHAT IS IT?

Diseases in older people are often multiple, impact on function and cause disabilities, may present subtly or atypically and give rise to secondary complications like iatrogenesis, deconditioning etc. Often, the problems are complex and multidimensional both in effect and etiology and cannot be 'solved' by the traditional medical or disease model. Hence the need for assessing the elderly focusing on the major health domains comprising medical, functional, psychological and social.

The NIH Consensus Development Programme (1987) defines comprehensive geriatric assessment as "a multidisciplinary evaluation in which the multiple problems of older persons are uncovered, clarified and explained, if possible, and in which the resources and strengths of the person are catalogued, need for services assessed and a care plan developed to focus intervention on the person's problems". Briefly, it is a tool to help with identifying problems in the elderly patient as well as the resources to manage them. Like all tools, it should be used well for an end.

DOES IT WORK?

It has been shown to :

1. improve diagnostic accuracy
2. achieve better functional outcomes
3. reduce readmissions to acute hospitals and use of hospital services
4. delay admissions to nursing homes
5. improve affect/cognition
6. improve medical care costs
7. enhance appropriate utilization of health care services

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The 2 key elements for successful geriatric assessment are :

a. the selection of appropriate patients (i.e. targeting)
   1. > 75 yrs,
   2. living at home alone
   3. having a 'geriatric syndrome' e.g. fall, immobility
   4. recent functional decline or low scores in ADLs, mental or mood

Geriatric assessments are lengthy to do and consume resources. To be cost-effective, you want to apply it to groups of elderly who are most at risk and therefore need it most and would likely to benefit most. The above categories help identify that group commonly associated with frailty.

b. the intervention (i.e. linking between assessment and adequate followup services). There is nothing magical about the assessment. The multidimensional and detailed assessment by itself merely identifies the problems and needs of the elderly and if not coupled with interventions and followup would be ineffective.

HOW TO DO IT?

a. Ask who is the target group e.g. older people in sheltered homes, attend day care or rehabilitation services, recent hospitalization, falls, functional decline or 'failure to cope' etc.

b. Patience on everybody's part, starting with yourself. You are likely to encounter difficulties with what I call the 7 Ds – dialect, deafness, difficult personality types, dysphasia,

delirium(acute illness), depression and dementia that will test not merely your patience but also your skills. But patience is virtue especially with elderly and practice makes perfect

c. Skill in communication and history taking – both spoken and observed. You probably would be able to guess the diagnoses (usually a number) and the severity and impact it has on his life before you start examining him. The history is given to you by the patient, his family, the memos/referrals that he brings or the drugs that he's got. Enhance communication : His – by encouraging him to use his glasses or hearing aids; Yours – by speaking slowly, repeating (if necessary) and remembering to switch off your radio. This is also the part to foster rapport and build confidence and trust

d. Obtain information from many sources – memos, family, observation, direct questions, examination. Check and cross-check (especially for patients with cognitive difficulties or depressed moods). Begin your information collection by observing who he comes with, how he walks into your clinic, dresses and greets you etc.

e. You may not be able to get everything at one or at the first encounter – e.g. time, patient factors. It is the norm and so do not be discouraged. Next time it will be better (both for you and the patient)

f. You can do a 'first level' screen by questionnaire e.g. the patient reads the questions and answers by himself/herself or by the carer. Alternatively, the nurse can direct the questions to the patient or carer. The screen would 'save time' and allow you to address all the 'positive results'. You can then followup by detailed questions based on problem orientated approach

g. Start by asking him/carer what he thinks is the problem. Usually it is one or more of the following 'geriatric syndromes' i.e immobility, falls, incontinent, cognitive impairment or a general 'failure to cope or thrive' (or 'acopia'). Get to know all his 'known' diseases first – list them down.

Ask about the following main areas:

1. Cognition
2. Affect (mood)
3. Mobility (indoor vs community, use of aids, feet, falls)
4. Difficulty coping and assist in ADLs?
   - Basic ADL (e.g. feeding, bathing, grooming, dressing)
   - instrumental ADLS (taking medications, housekeeping, marketing, public transport, marketing, handling bills & phonecalls etc.)
   - social/leisure (cinema, church, volunteering, golf, mahjong, beer rounds in coffee shops)
5. Bowel/bladder – Difficulty with 'getting it out or keeping it in'
6. Senses – eyes, ears
7. Mouth – Teeth (including nutrition, weight, appetite), speech & communication
8. Drugs – Both prescribed and over-the-counter, ask him/carer to show 'everything'
9. Social
   - Home environment (access, bathroom & toilet)
   - Family and support (who is the primary carer? How does he get food and money?

Who to call in crises?)
- How is the carer (Coping? Stressed? Are there signs of failure?)
- What is the patient and carer's daily routine? What are the 'specials'? e.g. grandchildren visits, outings ?
- What community health/social services are they currently using? Who does the medical followup?
- Who is the person behind the disease? His interests, views, what did he retire from and to?

Physical – Routine medical as usual but concentrate on 10 items:

1. 'TEEF' (teeth, eyes, ears, feet)
2. Communication
3. Mental assessment – cognitive & mood
4. Weight/nutrition
5. Cardiorespiratory especially postural BP
6. Neurological
7. Musculoskeletal
8. Gait
9. Environment
10. Drugs

Write down all the active problems and prioritise issues. Problems/issues need not necessarily be medical – e.g. failure of carer support (social issue) if unaddressed very soon could lead to 'medical' problems like dehydration, a fall or decubitus ulcer. Priorities may be different but should always consider patient-carers' perspective or concerns.

Tackle the medical issue. Often, certain problems require further evaluation like gait problems and falls. There are also specially designed scales or scores to probe and 'measure' the various domains of health dysfunction e.g. the Elderly Cognitive Assessment Questionaire (ECAQ) for cognition, the Geriatric depression scale, the Katz, Lawton and Barthel for physical function, Tinetti Gait and Balance Scale for balance etc. This is where the role of the multidisciplinary team (including geriatric specialists, if necessary) is required for assessments. Meet to discuss goals, review progress, raise new issues etc.

Any change in function – Do another reassessment and decide what to do next. Review medication and function (e.g. appetite, sleep, no pain/giddiness) every time. Check if you are achieving goals i.e. improving function, preventing disability and improving his (and carer's) QOL.

It takes some practice to do a geriatric assessment. You will become more confident and efficient with use. You would need a network of support services to refer your patients to after you have detected their 'problems' and if you continue with followup, you will achieve satisfaction in seeing that it 'works' for your patients.