Comprehensive Assessment of the Frail Older Patient

Executive Summary
Comprehensive geriatric assessment (CGA) is a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances. The purpose is to plan and carry out a holistic plan for treatment, rehabilitation, support and long term follow up. CGA is part of an integrated approach to assessment based on the following principles:

- The older person is central to the process
- Their capacity to participate voluntarily must be assessed, and if lacking, then there needs be a system to address their needs in an ethical fashion.
- Links between social and health care should be good enough for older people who need comprehensive assessment to receive it in a timely and efficient manner, and proportionate to their degree of need.
- Assessments should be standardised and carried out to a reliable standard

Circumstances which warrant a comprehensive assessment include, among others -

- Acute illness associated with significant change in functional ability
- Transfers of care for rehabilitation/re-enablement or continuing care
- A frail patient prior to surgery or experiencing two or more "geriatric syndromes" of falls, delirium, incontinence or immobility.

Introduction
It is a great success of society that we now have so many older people living into what we traditionally regarded as advanced old age – 80 years and beyond. The increases in life expectancy from the age of retirement continue to increase, for men and women – in the region of about four years over the two decades from 1990. But not all these additional years are spent in good health. Although the incidence of some disabling conditions is falling, eg stroke, it is not true for fragility fractures or arthritis. Overall, based on self report by older people in representative epidemiological surveys, about half the extra time is associated with some disability, This disability - such as limited mobility or needing help in day-to-day tasks like washing or dressing can be linked to a range of limitations such as breathlessness, weakness, fatigue, forgetfulness or pain, and is often associated with identified medical conditions.

Many individual diseases produce similar outcomes in terms of functional disability and reduced quality of life for older people. Furthermore many common conditions share risk factors for their causation. For these reasons it is perhaps not surprising that the severity of individual diseases only contribute some (usually less than half) of the variation in functional ability of older people. In addition, taking a longitudinal perspective, many older people lose functional ability without there being a clear-cut single diagnosis to explain it. The explanation for this "extra" disability includes a wide range of age-related changes affecting cell metabolism, organ function, mental health, homeostasis and integration. When individuals lose critical amounts of reserve at any or all of these levels, then they become particularly vulnerable to adverse health states such as functional dependency, hospital admission or even death. The tipping point may be a new event, even a mild acute illness or a fall. This state of vulnerability is called frailty. The severity of these age-related changes varies considerably between individuals and are often partially reversible.

For these reasons the assessment of older people and understanding their health needs requires much more than the traditional diagnostic efforts, and justifies an optimistic approach to being able to do something useful.

Comprehensive Assessment for Frail Older People
This is defined as a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances. The purpose is to develop and carry out a coordinated and integrated plan for treatment, rehabilitation, support and long term follow up. This is "comprehensive geriatric assessment". This should be seen in the context of an integrated approach to the assessment of older people, according to the type and extent of their needs.

The single assessment process/common assessment framework
It is important to see comprehensive assessment in the context of an integrated approach to assessment which is now policy in health and social care services of all the countries in the United Kingdom. The Single Assessment Process (SAP) was developed by the Department of Health to achieve this in England as part of the National Service Framework in 2001. Similar approaches have been used elsewhere. Details vary but all have policies to place the older person at the centre of the process, with their family or carers if needed. The SAP sets out four levels of assessment.

1. **Contact assessment** – this is the basic information about an individual and what they are seeking help with and is used routinely in all interactions for an older person who might seek help from a doctor, apply for Meals-on-Wheels Service, or request a hearing aid, for example.
2. **Overview assessment** – this is a broad but simple assessment across all the domains of comprehensive assessment but of a much lighter touch. The purpose is to identify whether there is or is not a problem. This is commonly incorporated into an assessment when anything more than the most basic health or social care provision is to be provided. This overview assessment identifies individual areas where more detailed and specialist assessments are necessary.
3. **Specialist (in depth) assessment**. This then is the in depth assessment which usually requires a diagnostic process and treatment planning by a clinician trained to deal with that particular aspect, e.g. a physiotherapist or audiology technician or geriatrician.
4. **Comprehensive assessment**. This can be understood as an in depth assessment across all domains, and can be adapted to the specific purpose and usually requires a trained multidisciplinary team.

Recently the Department of Health has decided to spread the principles of this approach to all adults in a new Common Assessment Framework.

Components of Comprehensive Geriatric Assessment
The domains were specified in the DH guidance on the SAP, but the details differ in various specialised tools designed for particular purposes. The table indicates the likely content.

Domains	**Items to be assessed**
Medical	Co-morbid conditions and disease severity
	Medication Review
	Nutritional status
	Problem list
Mental Health	Cognition

	Mood and anxiety
	Fears
Functional capacity	Basic activities of daily living
	Gait and balance
	Activity/exercise status
	Instrumental activities of daily living
Social circumstances	Informal support available from family or friends
	Social network such a visitors or daytime activities
	Eligibility for being offered care resources
Environment	Home comfort, facilities and safety
	Use or potential use of telehealth technology etc
	Transport facilities
	Accessibility to local resources

How is this done?
There are some key principles.

1. The older person, with any others whom they choose to be involved, is central to the process.
2. There must be an explicit procedure to assess the capacity of an older person to participate voluntarily and systems to address their needs in an ethical fashion if they lack capacity (see source 4).
3. Links between social and health care should be good enough for older people who need comprehensive assessment to receive it in a timely and efficient manner, without multiple delays, referral hurdles or endless repetition

4. Assessments should be standardised and carried out to a reliable standard

The assessments are usually done with standardised tools. These are usually designed to identify the presence/or severity of a problem or need. For example, for nutritional status this might be weight or recent weight change. For gait and balance it might be speed of walking 6 metres or ability to stand unaided for a minute. For cognition it would be a tool validated for older people such as the Mini Mental State Examination. For most tools in common use, there is reasonably good evidence about how consistent the assessment is when done by different individuals, how reproducible it is over time and how good it is in detecting change affecting an individual.

In addition, the assessment as a whole should be able to indicate the likely impact of any impairment or condition on health and wellbeing, now but also in the future, i.e. the prognosis and likelihood of future change. The medical diagnostic aspect plays a particularly important role in this forward prediction. Some of the measures are very good at identifying the presence or absence of a problem. Others are better at identifying the severity of a problem and may be sensitive to change and therefore become good measures for effective treatments and rehabilitation. A good source of information on such assessments is given in Sources 1.

When is it done?
Assessment should be adapted to the context, remembering the purpose at hand. It should be proportional to need, adequate but not heavy handed. Any individual whose overview assessment indicates the presence of several problems needing in depth assessment would probably benefit from the comprehensive approach. This might occur when a social care manager has been asked to consider providing home care but discover that the older person is confused, has been falling and is isolated, or when a district nurse is asked to do a continence assessment by a GP but then discovers there are a range of other health problems as well. These examples show why there needs to be clear referral pathways in community health and social care to access specialist teams. These teams could be based in multi-agency resource centres, community day hospitals, intermediate care services or on general hospital sites.

There are also circumstances where policy or good practice dictates that there **must** be a comprehensive assessment. Examples include:

- An older person admitted acutely to hospital and who is likely to develop specialist medical care needs, based on a case finding approach in a general ward.
- Planning for transfer of care for rehabilitation/re-enablement
- Continuing Care assessment (using the national Decision Support tool in England)
- An older person having multiple falls.
- A frail patient prior to surgery
- A person receiving intermediate care or other community based rehabilitation

Who should do this?
It is possible to train many health and social care workers do a more simple assessment across all domains if detailed measurement is not required. This can take the form of a screening approach to find out whether there is or is not a problem within a particular domain (an overview assessment). Most individual clinicians do not however have the skills to carry out a detailed assessment across all the above domains. That is why we usually need a coordinated multidisciplinary team effort to provide an adequate comprehensive geriatric assessment. Evidence for where a comprehensive assessment has been useful suggests that the team should consist of:

- A competent specialist physician in medical care of older people.
- A co-ordinating specialist nurse with experience.
- A senior social worker or a specialist nurse who is also a care manager with direct access to care services.
- Dedicated appropriate therapists.

- And of course the older person and their family, carers or friends

What are the benefits of comprehensive assessment?
It is generally frail older people who benefit most. A great majority of older people particularly those who are younger do not require this depth of detailed assessment when they seek help for specific medical conditions or practical problems. On the other hand, those people with a range of severe and disabling illnesses will require detailed assessment in order to maximise their recovery, function or quality of life, and the comprehensive assessment will be adapted to meet their particular needs. Between these two extremes there are a larger number of frail people – in whom a standardised comprehensive assessment linked to a coordinated and integrated plan for treatment and follow up can make a significant difference.

There is good evidence for improved functional outcomes as a result of this approach in a variety of conditions. These include stroke, hip fracture, people having elective surgery, heart failure, older medical inpatients with complications such as delirium, and community dwelling individuals at the time they first develop problems personal care. There are other circumstances where a coordinated and comprehensive assessment can identify the potential for avoiding significant changes in life such as admission to a care home. Evidence for rehabilitation linked to CGA is available in the list of references below and in another best practice guide in this set

Sources

1. Book or web guide to assessment tools

2. Department of Health guide to the Single Assessment Process

3. Department of Health pilot of the Common Assessment Framework for Adults

4. BGS Compendium on Capacity

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