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National Clinical Programme for Older People

Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment

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* For the purposes of this document NCPOP refers to the National Clinical Programme for Older People.

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Glossary of Terms

ADL	Activities of Daily Living
ADR	Adverse Drug Reaction
AMU	Acute Medical Unit
CGA	Comprehensive Geriatric Assessment
CNSp:	Clinical Nurse Specialist
CPD	Continuous Professional Development
CSO	Central Statistics Office
CSP	Clinical Strategy and Programmes
DH	Day hospital
DOH	Department of Health
ED	Emergency Department
GHD	Geriatric Day Hospital
HCP	Home Care Packages
HEI's	Higher Education Institutes
HSE	Health Service Executive
H&SCP	Health and Social Care Professional
IADL's	Instrumental Activities of Daily Living
interRAI	international Resident Assessment Instrument, source of the Single Assessment Tool (SAT)
KPI	Key Performance Indicators
RANP	Registered Advanced Nurse Practitioner
MDT	Multidisciplinary Team
NCPOP	National Clinical Programme for Older People
NCNM	National Council for Nurses and Midwives
NHSS	Nursing Home Support Scheme
ONMSD	Office of the Nursing, Midwifery Services Directorate
OPD	Outpatient Department
OT	Occupational Therapist
PHN	Public Health Nurse
RCTs	Randomised Controlled Trials
SAT	Single Assessment Tool
SGS	Specialist Geriatric Services
SGT	Specialist Geriatric Team
SGW	Specialist Geriatric Wards

Executive Summary

Ireland is experiencing substantial growth in the older population. The number of people aged over 65 years increased by 14% between 2006 and 2011. An increase of 17% is predicted between 2011 and 2016 and a further 17% is expected by 2021 (Central Statistics Office, 2013). These increases will impact on the way services are delivered with an increasing number of frail older people requiring Comprehensive Geriatric Assessment (CGA).

Published in 2012, the '*Specialist Geriatric Services Model of Care, Part 1: Acute Service Provision'* highlights the need to change health care practices in response to the needs of the older population.

This model of care recommends that older people should have access, if required, to the following services in secondary care:

- Dedicated in-patient Specialist Geriatric Wards (SGW);
- Specialist Geriatric Teams (SGT);
- A CGA for all those identified as frail, at risk, older people to fully assess their individual needs and the range of services they require;
- Access to in-patient rehabilitation facilities;
- Ambulatory day hospital services; and
- Improved links with community based services (residential care and home supports).

Comprehensive geriatric assessment is a "*multi-dimensional, interdisciplinary diagnostic process to determine the medical, psychological and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up" (Rubenstein, L.Z., et al., 1991)*. It emphasises improving the quality of life and functional status of the older adult and at the same time, improves prognosis and outcome for this frail group of older people. For the purpose of this document the term CGA includes comprehensive geriatric assessment and the recommended interventions arising from it. This document does not address the interventions but it is implicit that a co-ordinated multi-disciplinary plan is implemented following CGA.

The aim of this guidance document is to act as a practical resource to assist with the comprehensive assessment of older people in order to improve outcomes for frail, older patients. The guide is primarily intended for use by medical, nursing and health and social care professionals working across many settings, but should also prove useful for education

providers. The information in this guide is grounded on evidence based practice and multidisciplinary expert opinion.

The main focus of the guidance document is on the assessment of older people across the integrated services - in the specialist geriatric ward acute hospital, emergency departments, outpatient clinics and day hospitals. It is recognised, however, that all older people should have equal access to specialist geriatric expertise regardless of the setting.

Recommendations

To achieve optimal health and social care outcomes for older people there is a requirement for an educated and skilled multidisciplinary workforce to meet their individualised care needs across all care settings. The contribution to outcomes for older people is more effective when there is strong team leadership, good team working, a supportive organisational culture and investment in staff development specific to the requirements of this population group.

The following summarises the main recommendations:

- Older people should be referred for CGA on the basis of 'frailty syndromes' or other indicators of likely need for services. All appropriately identified older people should have access to comprehensive geriatric assessment regardless of the setting.
- CGA optimises outcomes for frail, older patients at risk of problems associated with co-morbid conditions, poly pharmacy, falls, change in cognition etc.

All medical and healthcare professionals who care for older people, regardless of their speciality, should access continuous professional development to support ongoing education and training specific to this population group.

1.0 Introduction

Ireland is experiencing substantial growth in the older population. The number of people aged over 65 years increased by 14% between 2006 and 2011. An increase of 17% is predicted between 2011 and 2016 and a further 17% is expected by 2021 (CSO 2013). The population in the oldest age group is increasing at an even faster pace, with implications for service planning and delivery. The National Clinical Programme for Older People (NCPOP) *Specialist Geriatric Services Model of Care, Part 1: Acute Services Provision* was launched by Minister Kathleen Lynch in December 2012. The model describes the structures for management of the acute inpatient, acute rehabilitation, day hospital, outreach and ambulatory services provided by Specialist Geriatric Services and Teams.

Based on a review of the literature the model advocates a Specialist Geriatric Service involving an integrated and cohesive approach to the care of the older person. The objective is to achieve optimal standards of care and outcomes for older people and their carers. With this in mind reorganisation in the way that services for older people are provided is taking place including:

- Dedicated in-patient Specialist Geriatric Wards with Specialist Multi-disciplinary Geriatric Teams
- Dedicated In-patient Specialist Geriatric Rehabilitation - the NCPOP recommends that all hospitals admitting acutely ill older adults have dedicated onsite and or off site rehabilitation wards
- Dedicated Offsite Rehabilitation - the NCPOP recommends that all hospitals admitting acutely ill older adults have access to dedicated offsite rehabilitation wards
- Community Outreach to nursing homes should support primary care services in nursing homes and extended care settings through specialist consultation (Model of Care, Part 2 will address community and primary care service provision)
- Ambulatory Day Hospital - the NCPOP recommends that the Day Hospital becomes the navigation hub for the coordination of the assessments of the frail older adult that requires a step up in care from primary care team/ PHN management in the community
- Support and advice should be available through community-based services for the frail older person through specialist consultation.

The NCPOP's overriding objective is to facilitate an older person to lead an independent life, with dignity, in the community. The appropriate services must therefore be available to each person when and where required. To this end the NCPOP has prioritised the use of evidence-based multidisciplinary care and continuing education to ensure all staff members caring for older people have the appropriate skills and competencies to deliver quality assured services.

As recommended in the NCPOP '*Specialist Geriatric Services Model of Care, Part 1: Acute Service Provision (2012)*', the Social Care Division of the HSE is implementing the Single Assessment Tool (SAT) across acute and community settings nationally (NCPOP, 2012). The SAT uses the interRAI™ assessment system, an internationally validated, comprehensive geriatric assessment enabler and is based on a multidimensional standardised set of geriatric assessment items or domains. All older people applying for service provision under the Nursing Home Support Scheme (NHSS) or the Home Care Package (HCP) schemes will require a comprehensive SAT (interRAI) assessment.

This comprehensiveness is key to planning and delivering high quality of care for individuals. Data captured in these assessment tools can be used by front-line (direct care) staff as well as managers, researchers and policy makers - hence these tools have both clinical and administrative utility.

2.0 Guidance Statement

"*NCPOP Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment*" will be used to guide health service providers and others on roles and responsibilities, competencies and identification of education and training requirements for the specialist geriatric team in CGA to support the provision of care to older people.

3.0 Guidance Purpose

The overall purpose of this document is to act as a practical resource to assist with the CGA of older people by providing a comprehensive framework of the necessary competencies and the identification of roles and responsibilities for multidisciplinary staff working as part of the Specialist Geriatric Service.

4.0 Scope

This guidance applies to the following disciplines working with Older People across many settings:

- Medicine
- Nursing
- Occupational Therapists
- Physiotherapists
- Dietitians
- Speech and Language Therapists
- General Practitioners
- Senior Social Workers
- Pharmacists
- Relevant educational bodies
- Additional health and social care practitioners, such as podiatrists, audiologists etc.

5.0 Frailty

Approximately 10% of people aged over 65 years have frailty; rising to between a quarter and a half of those aged over 85 years (Collard et al 2012, Song et al 2010). On-going advances in the study of frailty have resulted in enhanced methods for clinical measurement of frailty and improved opportunities to develop associated care planning have emerged. The study of frailty, its clinical measurement, and underpinning physiology, has allowed enhanced understanding of a patient's vulnerability to poor health outcomes in a way that chronological age does not (Moorhouse, Rockwood 2012).

Frailty is defined by Morley *et al* 2013 as "*A medical syndrome with multiple causes and contributors that is characterised by diminished strength, endurance and reduced physiologic function that increases an individual's vulnerability for developing increased dependency and/or death."*

Frailty can be viewed from two perspectives (Clegg *et al,* 2013, Moorhouse and Rockwood, 2012). One views frailty as a syndrome, with a frailty phenotype proposed by Fried in 2001. A person is defined as being frail if they experience three or more of the five symptoms; slowness, weight loss, impaired strength, exhaustion and low physical activity/energy

expenditure. Debate continues around factors such as sensitivity, specificity and the number of items that should be considered using this approach. The other perspective views frailty as a state of vulnerability that is quantifiable and that behaves in a predictable way (Moorhouse and Rockwood, 2012). This supports Mitnisky and Rockwood's (2007) definition of frailty as the cumulative effect of individual deficits—"*the more individuals have wrong with them, the more likely they are to be frail'.*

Whereas Clegg et al (2013) highlight the on-going development of more efficient methods of identifying frailty and its severity, Morley et al (2008) stresses that our ageing population demands action in this area and that we cannot wait before implementing screening and management of frailty into clinical practice. They outline a number of simple validated screening tools available to the physician for identifying those in need of more in-depth assessment.

Evidence indicates that frail, older people with chronic and complex health problems and limited functional reserve are at increased risk of adverse outcomes as a result of hospitalisation, particularly if they are not under the direct care of a specialist geriatric service.

The Cochrane Review conducted by Ellis and colleagues (Comprehensive Geriatric Assessment for Older Adults Admitted to Hospital, (2011)) identifies the importance of comprehensive geriatric assessment resulting in better outcomes for hospital patients. The review shows that providing such patients with a specialist geriatric team, on a specialist geriatric ward and cohorted expert nursing care will result in patients being more likely to go home, more likely to go home more quickly and less likely to go into long term care. The greatest benefit (although not reaching statistical significance for all comparisons) was in targeting certain groups of older people such as those with geriatric syndromes and functional or cognitive impairment.

Identifying Frailty

In practice, there are two approaches to identify frailty: identifying frailty through the presence of 'frailty syndromes' and using screening tools. The following are generally agreed frailty syndromes:

- Falls (e.g. collapse, legs gave way, 'found lying on floor')
- Immobility (e.g. sudden change in mobility, 'gone off legs' 'stuck in toilet').

- Delirium (e.g. acute confusion, 'muddled', sudden worsening of confusion in someone with previous dementia or known memory loss).
- Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence).
- Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

The presence of any of these syndromes in any location (that is, whether in an acute hospital, day hospital, community or residential care) should trigger consideration of the need for CGA.

Screening for frailty

Screening for frailty is more controversial and is not yet of proven benefit. The British Geriatric Society report "Fit for Frailty, Consensus Best Practice Guidance for the Care of Older People Living with Frailty in Community and Outpatient Settings" (2014) recommends that "*older people should be assessed for the possible presence of frailty during all encounters with health and social care professionals*". Specific assessments such as the slow gait speed, the PRISMA questionnaire and the Timed-up-and-go Test are recommended as reasonable. However, the report acknowledges that while these specific tests have very good sensitivity, they only have moderate specificity for identifying frailty. This means that if these were routinely carried out on all older people there are many fitter older people who will have a positive test result (false positives). Assessment of such false positives will take up valuable and scarce professional time without ultimate benefit. The document acknowledges that the gold standard for the management of frailty in older people is the process of care within the model of Comprehensive Geriatric Assessment (pg 10).

Recommendation

The NCPOP recommends that identification of older people to refer for CGA should primarily be on the basis of frailty syndromes or other indicators of likely need for services. Those identified on this basis should have a timely CGA performed and documented in their permanent health record. Pathways for treating such people should be agreed in conjunction with the Specialist Geriatric Services.

6.0 Comprehensive Geriatric Assessment

Comprehensive geriatric assessment (CGA) is a "*multi-dimensional, interdisciplinary diagnostic process to determine the medical, psychological and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up" (Rubenstein, L.Z., et al., 1991).* It is increasingly clear that CGA, to be effective, involves the directed provision of treatment and services, and not just assessment alone – the Cochrane review of CGA in the acute care setting concluded that it was maximally effective when delivered in the context of a geriatric medicine ward with the associated specialist services.

This chapter of the guidance document provides an overview of comprehensive geriatric assessment; describes the benefits of CGA; identifies appropriate patients for CGA; details the components of CGA; describes the members of the CGA MDT team; gives a brief overview of interdisciplinary vs. multidisciplinary team working; and discusses the most appropriate settings for undertaking CGA.

6.1 Overview

Population ageing is accelerating rapidly worldwide, presenting unique challenges to provide sustainable health and social services. Physical, psychological and socioeconomic factors interact to influence the health and functional status of older people. Strategies are required to consistently assess health and social care needs in order to provide services in a timely manner and in the most appropriate setting, while utilising available resources as efficiently as possible. CGA is an approach developed for this purpose and has become an increasingly important cornerstone of modern geriatric care.

In 'Health in Ireland: Key Trends 2013' the Department of Health illustrated the faster rate of increase in the numbers aged ≥ 65 in Ireland compared to the overall rate in the EU. Between 2006 and 2011 Irish people aged 65 and over increased by 14%, including a 21% increase in those ≥ 85(CSO 2006). The projection for the over 65s from 2011 to 2016 is for an increase of 17.3%, representing an additional 92,200 people and 16.9% from 2016 to 2021, a further increase of 105,500 people. The 4% per annum increase in the number of those ≥ 85 is ongoing and projected to continue at least to 2021 (Table 1).

Table 1 Population aged 65 and over 2011, 2016 and 2021 (thousands).

Source: CSO Census 2011

Age group	Population*			5 year % change 2011-2016	Annual change % 2011-2016	5 year % change 2016-2021	Annual change % 2016-2021
	2011	2016	2021				
65 - 69	172.1	205.5	224.7	19.4	3.9	9.3	1.9
70 - 74	130.1	157.6	190.9	21.1	4.2	21.1	4.2
75 - 79	101.4	112.2	139.1	10.7	2.1	24.0	4.8
80 - 84	69.8	78.6	89.8	12.6	2.5	14.2	2.8
85 +	58.2	69.9	84.8	20.1	4.0	21.3	4.3
Total	531.6	623.8	729.3	17.3	3.5	16.9	3.4

* Actual population at Census 2011 and projections for 2016 and 2021 (lowest of 3 projections for those ≥ 65 years)

The results from Wave 2 of the Irish Longitudinal Study on Ageing (TILDA) highlight the very high prevalence of chronic disease, multimorbidity and use of medication in older Irish adults. The TILDA cohort aged from 50 upwards reported substantial use of health services in the previous year: 90% visited the GP, 45% attended OPD, 16% the ED and 15% were admitted to hospital. The most frequently used community services were the optician (12%), dental services (11%), PHN (7%) and physiotherapy (5%). Use of health services increased with age:

- In those ≥ 70 one in 5 visited the ED in the previous year
- Almost one in five aged 70-79 had a hospital admission and one quarter of those ≥ 80
- One in 20 of those 70-79 received home help services which increased to 21% of those ≥ 80.

The ongoing increase in the number of 'oldest old', i.e. those aged ≥ 80 years, is particularly relevant to CGA as a foundation for timely access to appropriate services. CGA emphasises improving quality of life and functional status of the older adult and at the same time, improves prognosis and outcome for this frail group of older patients. CGA is the detailed evaluation and/or measurement of an older person's health status to identify their health care needs, develop and inform the implementation of an individualised care plan. It involves the organisation and arrangement of multidisciplinary teams using standardised instruments to evaluate aspects of patient functioning, impairments and social supports, while at same time, optimising a person's quality of life. There is a considerable body of evidence supporting the effectiveness of complex interventions for frail older adults, particularly in those who are admitted to hospital. CGA, when applied to those admitted to hospital, is

associated with better outcomes for the frail older person such as a reduction in disability, health improvement, less institutionalisation and a greater chance of living independently at home.

6.2 Benefits of Comprehensive Geriatric Assessment

CGA has the objective of improving diagnostic accuracy, optimising medical treatment and health outcomes, improving function and quality of life, extending community living, reducing use of unnecessary formal services and instituting or improving long-term care management. (Wieland, Hirth 2003) The benefits of CGA are clearly established in hospital patients, where in comparison to less structured MDT assessment CGA:

- leads to improved diagnostic accuracy and effectiveness of intervention
- informs the development and implementation of individualised care plans
- facilitates discharge planning and reduces use of unnecessary formal services
- helps avoid potential complications of hospitalisation
- leads to other improved patient outcomes, including:
    - reduced medication use
    - improved functional status or reduction in functional decline
    - improved quality of life and mental health
    - improved client/carer satisfaction and a reduction in carer responsibility
    - reduced use of hospital services
    - reduced need for residential care
    - decreased annual health care costs
    - prolonged tenure in the home/community survival (A guide for assessing older people in hospital, Australian Health Ministers' Advisory Council 2004)

The merits and effectiveness of CGA have been analysed in a number of Randomised Control Trials (RCTs) including a Cochrane Review completed in 2011. This review included 22 trials involving more than 10,315 patients aged 65 and older in high income countries.

The review compared the effectiveness of CGA for frail older adults with usual caretaking into account the following outcomes:

- living at home
- admission to residential care
- death or deterioration
- cognitive function.

Flodgren and Ellis 2012 in an evidence summary of a Cochrane EPOC systematic review describe the benefits of CGA versus usual care. See Table 2.

Table 2

Summary of a Cochrane EPOC systematic review describe the benefits of CGA versus usual care

Outcomes	No. of studies	No. of Participants	Evidence	CGA versus usual care odds ratio
Living at home	14 studies up to 6 months 18 studies up to 12 months	5117 and 7062 participants respectively	High quality evidence that CGA can improve care of frail older patients admitted to hospital as an emergency as compared to usual care	1.25 at a median of 6 months 1.16 (1.05 to 1.28) at a median of 12 months follow up
Admission to Residential Care	14 studies up to 6 months 19 studies up to 12 months	4925 and 7137 participants respectively	High quality evidence that CGA can decrease the number of patients admitted to residential care	0.76 (95% CI 0.66 to 0.89) at a median of 6 months
Death or deterioration	5 studies	2622 participants	High quality evidence for a significant reduction in death or deterioration of frail elderly patients receiving CGA at up to 12 months after hospital admission	0.76 (0.64 to 0.9) at a median of 12 months
Cognitive status	5 studies	3317 participants	Moderate quality evidence for a significant improvement in cognitive function for patients in receipt of CGA at a median of 12 months	not described in the review

It must be emphasised that this evidence applies only to those older people admitted to hospital. The evidence to date for use of CGA in other settings is less compelling. As Professor David Oliver, President of the British Geriatric Society and former National Clinical Director for Older People at the Department of Health in Britain has noted *"Comprehensive Geriatric Assessment delivered by a hospital-based team delivers better long-term outcomes*

for patients. By contrast, the evidence that interventions to prevent hospital admission and reduce bed occupancy are cheaper, more effective or cost-effective than current models is at best highly contestable."

6.3 Who should have Comprehensive Geriatric Assessment?

From the inception of geriatric medicine, it was recognised that frail and disabled older adults were those at highest risk of adverse outcomes and were most likely to benefit from dedicated geriatric care. The best evidence for CGA is based on identifying appropriate older adults, and excluding those who are either too well or too sick to derive benefit. No criteria have been validated to readily identify patients who are likely to benefit from CGA; however, certain criteria can be used as a guide. Indications for referral include:

- Advanced age
- Medical co-morbidities (cancer, chronic obstructive pulmonary disease, dementia, osteoporosis)
- Psychosocial disorders (depression)
- Specific geriatric conditions (falls, fractures and cognitive impairment)
- Previous or predicted high health care usage (increasing emergency department attendance or admission)
- Consideration of change in living situation (older people in sheltered accommodation or long term care)

CGA is most effective if there is appropriate identification of older people who benefit from it. In most cases those who would benefit from CGA tend to be frail or disabled, with multiple interacting co-morbid conditions. The scope of the CGA is dependent on the care setting and resources available.

6.4 Components of Comprehensive Geriatric Assessment

Models of CGA have evolved in different healthcare settings and to meet differing needs. Common to these interventions are several key features that have been attributed to their effectiveness. The key components include:

- Coordinated multidisciplinary assessment, including multidisciplinary team meetings
- Geriatric medicine expertise
- Identification of medical, physical, social and psychological problems

- The formation and implementation of a plan of care including appropriate rehabilitation

CGA includes medical (physiological and physical), psychological, social and environmental components as well as functional components at the level of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Table's 3-6 deal with specific critical assessment issues under the key components of CGA, not all components may be required for a particular assessment.

Tables 3-6 summarises the key components of CGA under the following four main health dimensions: Physiological/ Physical Assessment, Functional Assessment, Psychological Assessment and Social Assessment. Columns 1 and 2 deal with specific critical assessment issues requiring additional detail. Column 3 provides examples of validated and reliable assessment tools/outcome measures currently in clinical use which can be used to support the assessment process and outcome evaluation (this is neither an exhaustive nor exclusive list). The SAT, when implemented, will also provide measurement in many relevant domains.

Table 3 Components of Comprehensive Geriatric Assessment –Physiological /Physical Assessment

Component – Physiological/Physical Assessment			
Element	**Assess for**		**Examples of Assessment Tools and Outcome Measures**
Problem list (active and inactive)	Musculoskeletal disorders/bone health/sarcopenia		Oxford Grading Scale; UL Dynamometry
	Falls and syncope		Multifactorial Assessment, SAT (interRAI assessment system)
	Pain		Abbey Pain Scale; Numeric Pain Rating Scale, SAT (interRAI)
	Recent/recurrent infections.		SAT (interRAI assessment system)
	Elimination patterns/continence status		SAT (interRAI assessment system)
	Skin problems		SAT (interRAI assessment system)
	Impaired vision/hearing		SAT (interRAI assessment system)
	Previous fractures		SAT (interRAI assessment system)
	Previous/recent hospitalisation		SAT (interRAI assessment system)
	Alcohol		SAT (interRAI assessment system)
	End of life/Palliative care needs assessment (encompassing physical, emotional, psychosocial and spiritual domains		Palliative Care Needs Assessment Guidance (HSE, 2014) (SAT identifies some aspects)
	Stroke		Glasgow Outcome Scale; The Modified Rankin Score (MRS) National Institute of Health Stroke Severity Scale (NIHSS); Postural Assessment Scale for Stroke Patients (PASS); Motor Assessment Scale for Stroke Postural Assessment Scale for Stroke Patients (PASS); Motor Assessment Scale for Stroke; Orpington Prognostic Scale. SAT (interRAI assessment system)
Dysphagia assessment	Bedside Clinical Assessment and Mealtime Observation	Clinical assessment of Feeding Eating, Drinking and Swallowing Disorders (Dysphagia)	IASLT Standards of Practice for Speech and Language Therapists on the Management of Feeding, Eating, Drinking and Swallowing Disorders (Dysphagia) 2012, SAT (interRAI assessment system)
	Videofluoroscopic Evaluation of Swallow (VFES) Fibre-optic Endoscopic Evaluation of Swallowing (FEES)	Further view the structure and function of swallowing mechanism for the purpose of rehabilitation and management of dysphagia.	
Co Morbid Conditions and disease severity	Respiratory Disorders		SAT (interRAI assessment system)
	Cardiac disorders		SAT (interRAI assessment system)
	Neurological disorders		Wide range of disease specific assessment tools available; Modified

(prior and current)-timelines		Ashworth Scale; Nottingham Sensory Assessment SAT (interRAI assessment system)
	Endocrine Metabolic disorders	SAT (interRAI assessment system)
	Renal profile	
	Gastrointestinal system	SAT (interRAI assessment system)
Medication review	Polypharmacy	STOPP-START (Screening Tool of Older People's potentially inappropriate Prescriptions/Screening Tool to Alert Doctors to Right indicated Treatments), SAT (interRAI assessment system)
	Adherence	
	Screening	
	Interactions / Adverse Drug Reactions	
Nutritional status	Nutritional Status Biochemistry	MNA = Mini Nutrition Assessment Tool, SAT (interRAI assessment system) 'MUST' = 'Malnutrition Universal Screening Tool' • SGA = Subjective Global Assessment • MAG = Malnutrition Advisory Group of BAPEN • SNAQrc = Short Nutritional Assessment Questionnaire • SNAQ65+ = Short Nutritional Assessment Questionnaire residential care Questionnaire 65+ • NRI = Nutritional Risk Index residential care.
	Malnutrition risk	
	Weight changes	

Table 4 Components of Comprehensive Geriatric Assessment – Functional Assessment

Component - Functional Assessment		
Element	**Assess for**	**Examples of Assessment Tools and Outcome Measures**
Basic Activities of Daily Living	Transfers	Barthel Index/Functional Independence Measure (FIM), Functional Assessment Measure, MRS, SAT (interRAI Assessment System)
	Dressing	SAT (interRAI Assessment System)
	Eating	SAT (InterRAI Assessment System)
	Toilet use	SAT (InterRAI Assessment System)
	Bathing	SAT (InterRAI Assessment System)
	Personal Hygiene	SAT (InterRAI Assessment System)
	Mobility in bed	SAT (InterRAI Assessment System)
	Locomotion inside and outside home	SAT (InterRAI Assessment System)
Frailty		SHARE-F1 (Survey of Health, Ageing and Retirement in Europe); SAT (interRAI Assessment System)
Instrumental Activities of Daily Living	Meal Preparation	Lawton IADL scale, SAT (interRAI Assessment System)
	Housework	SAT (InterRAI Assessment System)
	Managing medications	SAT (InterRAI Assessment System)
	Managing finances	SAT (InterRAI Assessment System)
	Phone use	SAT (InterRAI Assessment System)
	Shopping	SAT (InterRAI Assessment System)
	Transportation	SAT (InterRAI Assessment System)
Activity/Exercise Status	Mobility-ambulation/transfer	Elderly Mobility Scale, SAT (InterRAI Assessment System)
	Activity levels	SAT (InterRAI Assessment System)
	Endurance	6 Minute Walk Test; Borg/RPE Scale
Gait and Balance	Falls & history	Activities Specific Balance Confidence Scale (ABC Scale); Falls Efficacy Scale Multifactorial Falls Risk Assessment, SAT (InterRAI Assessment System)
	Assistive devices	SAT (InterRAI Assessment System)
	Gait/ Balance Analysis	Timed Up and Go; Timed 10-Meter Walk Test; Tinetti Performance Oriented Mobility Assessment; Berg Balance Scale; Mini BES Test, SAT (InterRAI Assessment System)

Communication Assessment		
Aphasia	Multi-modal language disorders affecting a person's ability to understand and produce spoken and written language.*	• Comprehensive Assessment Test (CAT) • Western Aphasia battery (WAB) • Supporting Partners of People with Aphasia in Relationships and Conversation (SPPARC), SAT (InterRAI Assessment System)
Dysarthria	Speech disorders that are due to disturbances in muscular control of the speech mechanism*	• Frenchay Dysarthria Assessment • Assessment of Intelligibility of Dysarthric Speech • SAT (InterRAI Assessment System)
Dyspraxia of speech	Speech disorders that represent a disruption to the selection, programming and online control of the movements for speech.	• Apraxia Battery for Adults, Second Edition 2000 (ABA-2) • SAT (InterRAI Assessment System)
Voice Disorders (Dysphonia)	Assessment for abnormality of pitch, volume, resonance and/or quality, and/or a voice that is inappropriate for the age, gender or culture of the speaker.*	• Lee Silverman Voice Treatment (LSVT-Loud) • Voice Impairment Profile • SAT (InterRAI Assessment System)
Cognitive-Linguistic Disorders	Communication assessment is required in order to aid differential diagnosis, establish a baseline for monitoring change and to advise carers and MDT.	• Arizona Battery for Communication Disorders of Dementia (ABCD) • SAT (InterRAI Assessment System)

Table 5 Components of Comprehensive Geriatric Assessment – Psychological Assessment

Component – Psychological Assessment		
Element	**Assess for**	**Examples of Assessment Tools and Outcome Measures**
Cognition	Deficits in cognitive domains including short term memory, language, executive functioning, orientation and attention	Mini mental state examination/ abbreviated mental test score/ Montreal cognitive assessment scale Addenbrooke's cognitive examination/ Rivermead behaviour Memory Test, SAT (InterRAI Assessment System)
	Collateral history of temporal course and fluctuations	Informant Questionnaire of Cognitive Decline in the Elderly
Mood/depression testing	Mood symptoms and disorders including anxiety or depressions-taking timelines into account and identifying baseline Requirement for therapeutic support to deal with loss, separation, grief and bereavement.	Geriatric Depression Scale SAT (InterRAI Assessment System)
Capacity	Understanding of risks and benefits of a proposed course of action	
Advanced Care Planning	EPOA/advance directives Assess ability of older person/family/carer to put legal affairs in order. Support with end of life care and advanced care planning. "Think Ahead" - recording of advance care directives	"Let Me Decide", "A Kinder Future"
Health behaviours	Addiction behaviours; substance misuse; dual/multi addictive behaviours; self-neglect; ability to manage care plan and problem solving.	MMSE; Change model including Motivational Interviewing (Miller, W. R. & Rollnick, S. (2009). SAT (InterRAI Assessment System)

Table 6 Components of Comprehensive Geriatric Assessment – Social Assessment

Component – Social Assessment		
Element	**Assess for**	**Examples of Assessment Tools and Outcome Measures**
Support needs and Resources	Clinic social work support for service users and their family and care-giver(s). Enhancing family and carer arrangements for future care planning. Assess and mobilise community services/resources & supports. Addressing issues relating to individual rights, ethnicity, equality and diversity. Assess the impact of social isolation and promote the potential for sustainable social engagement. Living arrangements; Inter-generational relationships, care-giver supports, need for advocacy and mediation to assist with making difficult decisions. Therapeutic support for bereavement, (anticipatory) grief, attachment issues, loss and separation. Adopt a functional approach to assist in the assessment of learning, mental, emotional and physical capacity and overall health. Negotiation, coaching, problem solving and conflict management skills to manage complex care planning. Advocacy with, and for older people, in complex cases.	SAT (InterRAI Assessment System)
Care Resource Eligibility/Financial assessment	Carer stress and strain Transport; social protection rights and entitlements. Living arrangements, relationship with caregiver, frequency of contact, reliability, social engagement.	SAT (InterRAI Assessment System)
Personal Safety	Risk of elder abuse, neglect and extreme self-neglect Domestic Violence When required, child protection issues responding to retrospective disclosures by adult service users.	SAT (InterRAI Assessment System)
Transportation	Accessing and arranging access to appropriate transport	SAT (InterRAI Assessment System)
Living conditions	Adequacy of housing Condition of housing.	SAT (InterRAI Assessment System)

6.5 Who should deliver Comprehensive Geriatric Assessment

Members of the CGA multidisciplinary core team should include experienced individuals drawn from medical, nursing and associated health professions. They should be responsible for the coordinated assessment, discussion and recommendation or implementation of treatment plans. Core team members are identified in Model of Care Part 1 and some or all may be involved in undertaking a CGA. Many components of CGA can be jointly undertaken by a number of disciplines on the team. Tables [2-6] outline the key components and many of the assessments and interventions undertaken overlap between disciplines.

Expertise from other disciplines may be required for specific aspects of assessment. Other team members may include members from podiatry, psychology, psychiatry of old age and other disciplines or areas of specialty. The members of the multidisciplinary team may include:

- Medical – e.g. Geriatrician, Psychiatrist of Later Life, Palliative Care Specialist, GP
- Nursing
- Medical social worker
- Physiotherapy
- Occupational therapy
- Speech and Language therapy
- Dietetics
- Pharmacists
- Psychology
- Podiatry

In most teams, a senior geriatrician would have the responsibility for team leadership. Experienced team members can vary in their roles including physical and functional assessments, providing advice and coordination of teams and services.

6.5.1 Multidisciplinary versus Interdisciplinary Team Working

Health care teams can operate in a number of different models. The most common are multidisciplinary or interdisciplinary team working. Interdisciplinary teamwork can be contrasted with multidisciplinary teamwork. Multidisciplinary team members work sequentially where the patients' medical record is the chief means of communication. Interdisciplinary teams work collaboratively to discuss patient status and the evolving plan of care.

Working as a team allows for:

- Working for common goals
- Pooling of expertise
- A forum for problem solving
- Opportunities for personal growth and development
- Shared responsibility and personal support, particularly for professional self-care.

Shared decision-making and flexible leadership characterises interdisciplinary teamwork. The team has an identity that is separate from the identities of individual team members. Team function is based on small group processes. The skills of multiple disciplines working together in coordinated patient/family focused care teams are needed to elicit different aspects of the patient's and family's illness experience and each member of the team will bring different management skills and perspectives. Teamwork permits sharing of physically and emotionally draining situations *(Adapted from von Gunten CF, Ferris FD, Portenoy RK, Glajchen M, eds. 2001).*

Table 7 Multidisciplinary Versus Interdisciplinary Team Working

	Multidisciplinary	**Interdisciplinary**
Guiding Philosophy	Team members recognise the importance of contributions from other disciplines	Team members are willing and able to develop, share and be responsible for providing services that are part of a total service/care plan
Family Participation	Family meets with individual team members	Family meets with team or team representatives
Assessment	Separate assessment by team members	Separate assessment by team members, may use common tools, some joint assessments
Goal Setting	Team members develop separate plans for their discipline	Team members share their separate plans together, some integrated programmes
Treatment	Team members implement the part of the service plan related to their discipline	Team members implement their section of the plan and incorporate other sections where possible
Lines of Communication	Informal lines of communication between the team members and the family and between members of the team themselves	Periodic case –specific team meetings and meetings with the family

6.5.2 Multidisciplinary Team Education

The skills and knowledge of many health professionals are needed to conduct a CGA of the physical, mental, emotional, functional, and social status of a frail older person. Education based on national guidelines, evidence-based and current best practice provides opportunity to learn about common issues in gerontology and the care of older people. Multidisciplinary education provides theoretic and practice-based learning to prepare for working as a member of a Specialist Geriatric Team. It is the intention of the NCPOP Programme to undertake additional analysis/scoping of education requirements for specialist geriatric teams that can be incorporated into this guidance document. Suggested topics for MDT education might, amongst others, include a good knowledge and understanding of the following areas:

- Ageing process
- Frailty
- Diagnosis and management of acute illness
- Diagnosis and management of chronic illness
- 3 D's Delirium, Depression, Dementia
- Old Age Psychiatry
- Stroke
- Nutrition/Hydration/ Nutritional management
- Sarcopenia
- Malnutrition
- Drug therapy/ Medication management
- Instability and falls
- Orthogeriatrics and bone health
- Movement disorders
- Discharge Planning
- Rehabilitation
- Prevention, detection and management of Elder Abuse and self-neglect
- Sociology of Ageing.
- Continence care
- Palliative Care/End of life / bereavement
- Functioning as a team
- Interfacing with community
- Long term care
- Health Promotion

- Ethics & health care
- Human Rights and Older Persons- ageism, equality and social inclusion.
- Social work practice with older persons, family/carers- including relationship-based practice.
- Life span development and inter-generational perspectives.
- Health related matters in later life including addiction and the impact on the individual and their family/carers.
- Grief work (especially if complicated bereavement) regarding losses and separation in later life
- Social policy, law and older people; Decision Making (Capacity) Act; Enduring Power of Attorney, Power of Attorney that could have a role in care planning, consent, etc.
- Conflict management and group facilitation skills to manage case meetings, case conferences, family meetings, discharge planning meetings, in particular for complex cases.
- Single Assessment Tool Information System (SATIS) education and training- inclusive of interRAI Clinician training; training on 'Read- only' access; and Administrative access to SATIS.

6.6 Appropriate Settings for Comprehensive Geriatric Assessment

The presence of frailty syndromes in any location (that is, whether in an acute hospital, day hospital, community or residential care) should trigger consideration of the need for CGA. However, the best evidence of benefit is only available for those older people admitted to hospital.

6.6.1 Hospital Admissions and Inpatient Consultation

There is evidence that for the older person with complex care needs CGA increases the person's likelihood of being alive and in their own home 12 months later (Ellis et al, 2011).
There are two broad models of inpatient CGA. The first is delivered in a discrete ward with a coordinated specialist geriatric multidisciplinary team. In the second model, various disciplines assess frail, at risk older people in a general ward setting. The team assesses the older person and makes recommendations regarding the management of the issues. Evidence shows that the first model improves the patient's likelihood of being alive and in their own homes after the emergency admission to hospital, with dedicated wards being

associated with potential cost reduction compared with general medical care (Ellis et al, 2011).

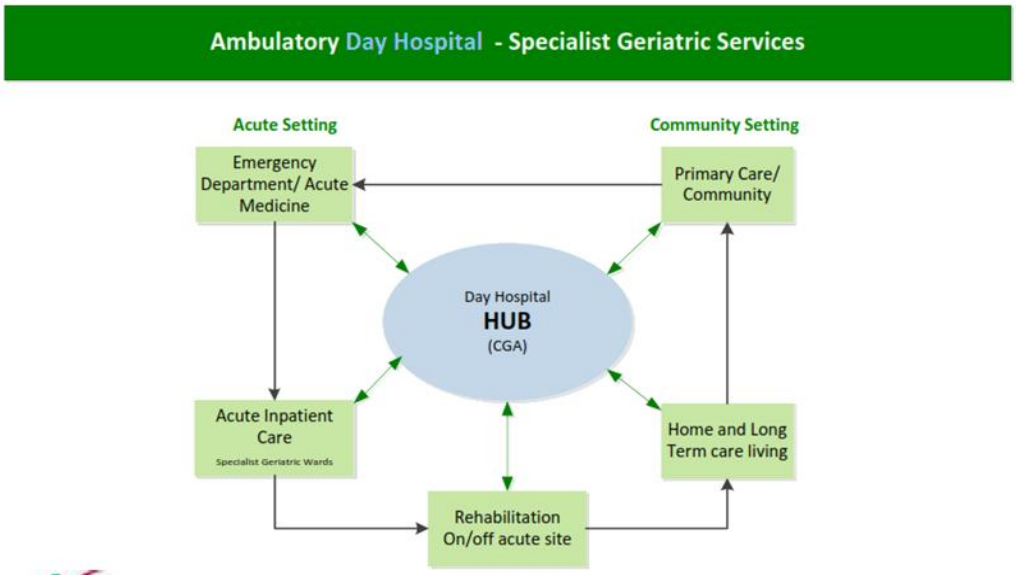
6.6.2 Comprehensive Geriatric Assessment in Acute Medical Units

Delivering CGA in the context of an Acute Medical Unit (AMU) is challenging for several reasons including time, bed pressures and lack of appropriate expertise. Medical review, early rehabilitation and patient-centred care appear to confer improvements in mortality and early discharge of patients to home. At risk older people who would most likely benefit from CGA may be identified in the AMU and a plan put in place to carry out CGA in the most appropriate setting. Given the frequency with which older people are assessed and treated in AMUs, it seems reasonable to require AMU physicians to have expertise in gerontology or to work closely with a geriatric service.

6.6.3 Comprehensive Geriatric Assessment in the Ambulatory Geriatric Day Hospital

The Ambulatory Geriatric Day Hospital is particularly suited to CGA of the older person with physical and cognitive co-morbidities which may require multiple visits to complete the assessment. CGA in this setting is a clinical management strategy which will give a framework for the delivery of interventions to address relevant and appropriate issues for the individual patient (fig 1, CGA Recognition of Frailty in an individual). The initial assessment and care planning for a full CGA can take at least 1.5- 2 hours of professional time, plus the necessary time for care plan negotiation and documentation (and time for review) (FFF, BGS, 2014). Thus such assessments are not suited to a busy outpatient department where time constraints impose important limits on what can be achieved by CGA. Where rehabilitation is offered / appropriate it can be arranged on a planned basis through MDT input in the Geriatric Day Hospital. Increasingly the CGA model deployed through the Geriatric Day Hospital has lent itself to the rapid assessment of patients with complex medical and psychosocial needs in the ambulatory care model as described in the NCPOP (NCPOP, 2012).

Figure 1 Ambulatory Geriatric Day Hospital – Specialist Geriatric Services



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6.6.4 Comprehensive Geriatric Assessment in the Emergency Department

The number of older people attending Emergency Departments (ED) has increased in Ireland in recent years and is likely to continue to increase, in line with the increase in the population. Those admitted to hospital as emergencies are at especially high risk for adverse events, including long stays, high readmission rates, and high rates of long term care use. Conroy *et al* 2013 showed the use of CGA in the ED was associated with a clinically and statistically significant reduction in admissions and readmissions at 90 days in patients aged 85 years or older following discharge from the ED. However, the authors acknowledge that the methodological limitations of the study design 'makes inferring a causal effect difficult'. A recent systemic review of CGA in the ED suggested that screening of high-risk patients is more efficient than age-based screening, and noted that CGA performed in the ED, followed by appropriate interventions, improved outcomes in some studies. In conclusion, the evidence for the benefit of CGA in the ED is less compelling than in other settings.

6.7 Comprehensive Geriatric Assessment in the Older Person's Home

Internationally, CGAs and associated home care assessment programmes have been shown to be consistently beneficial on older person's health outcomes. Several meta-analyses have found home assessments to be consistently effective in reducing functional decline as well as overall mortality (Stuck, *et al,* 2002; Elkan, *et al,* 2001; Huss *et al,* 2008). The literature identifies that community-dwelling older patients with functional disability, increased fall risk, depression, cognitive decline or those at high risk for high healthcare utilisation are appropriate candidates for CGA (Ward, *et al,* 2015). SAT (interRAI- Home Care Assessments) when implemented in the community will address this group of individuals, that is, older people with complex needs who are applying for NHSS or HCPs. There is little doubt that a systematic evaluation of frail older persons as part of an integrated community/ acute based model of CGA may identify a variety of treatable health problems and lead to better health outcomes.

Currently there is a dearth of comparative research outlining the advantages of domiciliary assessment over other settings. Nonetheless, clinical experience dictates that a greater wealth of information is often obtained in the home. For example, home assessments allow direct observation and identification of need of the older person's capability and function in his / her own environment, of how meals and food are prepared, of the person's carer network, and medication management, thus enabling prompt and appropriate referral to acute based services as needed.

Lantry, (1996) in an Australian study comparing outcomes of domiciliary home assessment and clinic visits in general practice setting found that home assessments were more likely to yield problems with social support which were rarely mentioned in the medical record. Assessment at home may also influence the decision to move to long-term care, with those assessed at home four times more likely to remain at home with increased community supports than those assessed in hospital. In addition in this study there was little association between health status and recommendation for placement in supported residential/hostel care, suggesting that this effect was not explained simply by a sicker inpatient population. The home visit has traditionally been seen as the domain of the general practitioner but it should also be seen as a vital part of the specialist geriatrician's practice. In order for older people to receive geriatrician input in their homes, structural elements of the healthcare system will need to be addressed. All geriatricians should have some degree of training in home visits.

A broader range of information is sought in the home visit with particular regard to the person's social and physical function. This could range from an initial home visit by a trained SAT clinician, or other member of the multidisciplinary CGA team such as a clinical nurse specialist, physiotherapist, dietitian, speech and language therapist, or occupational therapist, with input where necessary from the consultant geriatrician, to coordinate a whole range of services to enable a person to remain at home. Assessments occurring in the community will not all involve a geriatrician, particularly as in many cases there may be few diagnostic dilemmas which require their direct input.

However the geriatrician due to their experience and training may have a key role to play in complex cases and they should therefore be available as a resource to other members of the multidisciplinary team operating in that setting. Alternatively the team members may include GPs, PHNs and other community or primary care based professionals.

The method of clinical examination is also different in home assessment and requires a separate set of skills. Some aspects of clinical examination, for example detailed physical examination may be difficult to perform. However functional assessments such as observation of gait, arising from a chair and other simple daily activities are easier and better performed at home where the environmental hazards can be directly observed. Standardised clinical examinations of gait are good predictors of falls in community, institutional settings and populations including the very old. Cognitive testing is also reliably and easily carried out at home.

The SAT (interRAI- Home Care) comprehensive geriatric assessment when implemented in the community for HCPs and NHSS assessments will provide a holistic CGA of older person's needs using a standardised language of clinical assessment. This will enable older person's health outcomes to be monitored and compared across community settings. It will further benefit older person's health outcomes by identifying opportunities for quality improvement or service improvement initiatives, through the use of aggregated data derived from embedded Quality Indicators (Q.I.s) items within the interRAI Home Care assessment. There a wealth of internationally based studies available that demonstrate the benefits of the use of aggregated data from embedded Q.I.s within the interRAI Home Care assessment and their use in Quality Improvement programmes with regard to practice, service and policy initiatives (Mofina, and Guthrie, 2014; Carpenter and Hirdes, 2013; Doran, *et al,* 2013).

6.8 Comprehensive Geriatric Assessment in Residential and Nursing Home Care

Studies conducted in long term care settings internationally consistently describe cohorts of residents with significant levels of cognitive impairment and multiple morbidities. A recent Care Homes Outcomes Study in the UK also demonstrated a high prevalence of malnutrition, or risk of malnutrition. It described residents' medical problems as being dominated by chronic illnesses and end-of-life considerations. It identified significant issues with polypharmacy and under-diagnosis of dementia which suggested that current care models were not meeting residents' needs. In presenting these findings it demonstrated a need for input from clinical nurse specialists , mental health services, palliative care services, occupational therapists, physiotherapists, dietitians, general practitioners and geriatricians (Gordon, 2012; BGS, Quest for Quality, 2011). A similarly complex picture of resident need emerges in national data in the long-term care setting with high levels of dependency, medication use and comorbidity emerging in the recent literature.

However a recent comprehensive review of the literature on the role of CGA in the extended care setting highlighted some of the challenges with its evaluation in this setting. The authors concluded that Randomised Controlled Trials (RCTs) which were identified as evaluating CGA-type interventions either focused on relatively narrow, predominantly psychogeriatric, interventions, or suffered significant methodological flaws that served to undermine their conclusions. Several component parts of CGA had, however, been effectively evaluated at RCT and shown to work – these were advanced care planning; pharmacy interventions to reduce prescribing; staff education around prescribing, dementia and end-of-life care; calcium and vitamin D in preventing fractures; alendronate in preventing osteoporosis; influenza vaccination; oseltamivir or zanamivir for influenza prophylaxis; functional incidental training and bladder training for incontinence. For a number of other components, the literature was inconclusive, in part due to the methodological shortcomings of a significant proportion of the RCTs reviewed. Further work is therefore required to establish what the optimal delivery of CGA in this setting might be (Gordon et al 2013).

Similar to domiciliary assessment in the patient's home described above, CGA in the nursing home has many potential benefits to offer both the resident and MDT. For patients with advanced frailty or dementia, assessment in their own environment gives a clearer, concise picture in terms of true functional ability. The CGA process also allows for facilitated communication and mentoring of other team members involved in the day to day care of the

resident. Issues around end of life care can be discussed with residents and families in a more time-appropriate and context-appropriate fashion.

7.0 Roles of each Discipline in Comprehensive Geriatric Assessment

Section 6.5 outlines the core team members involved in undertaking a CGA. This section identifies the roles and responsibilities of each of those disciplines in support of the older person undergoing CGA. It therefore attempts to clarify the components within CGA that each discipline is responsible for whilst recognising the following:

- The roles and responsibilities of different team members will often depend on resources available, locations and local practice/processes
- Isolating sections of responsibility from CGA is not recommended practice and each setting will have varying inputs to CGA
- Not all aspects of the assessment will be necessary for all older people
- There may be overlap in the assessments of the various disciplines
- Team members roles will vary according to the level of relevant experience
- Additional tests/ aspects of assessment may be required for some older people.

Key principles of best practice pertinent to all disciplines caring for older people should encompass the:

- Right to receive the 'highest attainable standard of health care' (UN Declaration of Human Rights)
- Right to be treated by healthcare staff with due competence in gerontological care
- Right to be treated with dignity and respect
- Respect and recognition for the older person's wishes
- Right to self-determination
- Right to participation
- Right to empowerment
- Right to confidentiality
- Least restrictive practice where there is a risk.(adapted from Protecting our Future, Report of the Working Group on Elder Abuse September 2002)

7.1 Consultant Geriatrician and Medical Team

The core roles of the medical team are outlined as follows:

Physiological/Physical Assessment:

- **Problem list (active and inactive) / Co morbid Conditions and disease severity**

Establishing the medical issues is the core assessment of CGA. If medical issues are not assessed and treated, the older person can't fully benefit from the input of the MDT and rehabilitation is hindered. The medical team in conjunction with the MDT generates a problem list which can guide the care plan and identify potential issues.

- **Medication Review**

Older people often have several co-morbidities requiring medications and are at increased risk from medication side effects due to physiological and pathological changes in organ systems with ageing. Polypharmacy increases the risk of adverse drug reactions and reduces medication compliance. The medical team, in conjunction with clinical pharmacists and other MDT members, plays a key role in reviewing medications as part of CGA. CGA has been shown to reduce medication number and daily doses by facilitating discontinuation of unnecessary or inappropriate medications use. CGA can help to prioritise the diseases that require on-going treatment, combining evidence-based clinical practice guidelines, optimisation of the person's ability to take medications (access, supervision or reminders, adapted prescribing for swallowing difficulties, etc.) and consideration of their overall prognosis and wishes for treatment.

Functional Assessment

- **Falls and Bone Health Assessment**

One third of community dwelling older people fall each year and falls are a common cause for admission in older people, or may complicate an admission, particularly post stroke and during delirium. Although nursing staff often take the lead in screening for risk of falls in hospitalised older people many members of the MDT contribute to the assessment and identification of specific falls risk factors that may be amenable to modification. Medical staff should assess syncopal falls, looking for cardiac rhythm or valvular abnormalities, orthostatic hypotension, carotid sinus hypersensitivity or vasovagal syncope. In non-syncopal falls, medical staff need to assess the person for undiagnosed neurological disease, visual disturbance, cognitive or executive dysfunction, medication side-effects injuries resulting from a fall (e.g. a missed fracture hindering rehabilitation, a subdural haematoma causing gait and cognitive decline post fall) and osteoporosis, which would increase the likelihood of

a future fall-related fracture. Physiotherapists often take the lead in gait and balance assessment, using validated assessment tools such as the Berg balance scale, while occupational therapists provide a holistic assessment of physical, cognitive, environmental and social factors that contribute to the falls. Most falls require multifactorial interventions, typically including medication review, patient education, home modifications, and an exercise programme that incorporates high intensity muscle strengthening and balance components.

- **Frailty assessment and integration of all other disciplines inputs**

The geriatrician and medical team often serve an integrative function, putting together the findings from other disciplines, and interpreting multiple modes of medical investigation, including radiological and laboratory investigations and standardised screening bloods. These are interpreted in order to find a unifying diagnosis or diagnoses and hence guide a comprehensive, interdisciplinary management and treatment plan. The older persons social history and current circumstances must be considered and include aspects such as social habits (smoking - past and present, alcohol) who is living in the house as well as personal and domestic Activities of Daily Living (ADL's).

Psychological Assessment

- **Cognition**

CGA should involve the assessment of cognition, which includes the use of validated and standardised cognitive assessment tools. However, formal cognitive testing is only one part of the overall assessment, and the context of the cognitive impairment and a careful and comprehensive collateral history are vital. It is particularly challenging to differentiate between delirium and dementia without adequate collateral history of the time course of cognitive decline. The pattern of cognitive decline due to dementia can indicate diagnosis (i.e. slowly progressive or step-wise or fluctuating). Blood testing for medical causes of cognitive impairment and imaging are often required.

- **Mood/depression testing**

As well as cognitive assessment and diagnosis, the assessment of mental status includes screening for depression, followed by more formal assessment. psychiatry of later life and psychology services play an important role in specific situations.

- **Assessment of Capacity**

The indications for and the method of assessment of capacity (the ability to make a decision about a particular matter at a particular time) are key knowledge requirements for all members of the MDT. It is important to remember that a person is always presumed to have capacity (regardless of age, appearance or disability) unless there are some clear indications to the contrary, and knowing when to perform a capacity assessment is as important as knowing how to do it. Capacity is specific to a particular decision (i.e. a person may not have capacity to make a will, but still could make a decision to accept a medical treatment) and the threshold for capacity relates with the magnitude of the risk associated with the decision. When passed into law the Assisted Capacity Bill 2013 will facilitate a person with reduced capacity to participate in decision making as fully as possible (http://www.oireachtas.ie/documents/bills28/bills/2013/8313/b8313d.pdf).

❖ **Advance Care Planning**

Advance care directives can help the MDT to understand the person's wishes for treatment if the person can no longer communicate their wishes (there is currently no supporting legislature but this is under review); while an enduring power of attorney allows a proxy decision maker to make certain decisions (usually not treatment decisions) for a person without capacity. As part of the CGA, planning for the future or "advance care planning" may be an additional component. Advance care planning is a voluntary process of discussion about future care between an individual and their care providers. If the individual wishes, their family and friends may be included. The discussion should be documented, regularly reviewed and communicated to key persons involved in their care. This discussion regarding advance care might include:

- The individual's concerns and wishes
- Their important values or personal goals for care
- Their understanding about their illness and prognosis
- Their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.

7.2 Nursing

The nurse plans and provides care using professional knowledge, skill and expertise in person-centred holistic care. Nursing care is based on a holistic framework guided by an appropriate model of nursing to assess, identify needs, plan, implement and evaluate

change in patient status. McCormack *et al* 2006 state that “comprehensive person-centred nursing care is knowledgeable, skilled, vigilant, pro-active and positively motivated about caring for the older person”. The nurse involves the older person and their family as appropriate in in accordance with the wishes of the older person, as active partners in identify needs, perspectives and expectations based on the person’s own values and beliefs. Nursing at all grades and levels of specialisation contribute to CGA in a variety of settings.

- **Physical Assessment**

The nurse assesses presenting symptoms, admitting diagnosis and medical history. Assessment is ongoing in order to inform a more focused assessment and plan of care. Physical assessment should encompass:

- Overall general appearance and demeanor
- Oral hygiene and dentition
- Skin integrity
- Mobility
- Foot assessment
- Pressure sore risk
- Wound assessment
- Nutritional status

The nurse is proactive in problem identification and addressing comfort measures:

- Pain assessment is carried out using an appropriate scale which captures location, frequency, intensity, aggravating and alleviating factors.
- The nurse reviews medication and concordance with treatment plan and consults with doctor or pharmacist where issues arise.
- Continuity of care facilitates ongoing monitoring and physiological markers of health status form part of a CGA.

- **Functional Assessment**

For all aspects of assessment nurses use a holistic approach with a focus on continuity of care over a 24 hour period facilitates an in-depth functional assessment. A range of tools are employed in order to assess function and identify potential risks such as:

- Level of independence and ability to attend to own Activities of Daily Living (ADL)
- Falls history
- Pressure ulceration present or risk
- Aspiration risk
- Communication-approaches and queues
- Vision, hearing and sensory deficits
- Bladder and bowel function is assessed and may include urine investigations or bladder scanning.
- Palliative care need following a diagnosis of life-limiting disease

- **Psychological**

The nurses' intuitive skills and ongoing observation of physical cues facilitate problem identification such as anxiety, withdrawal, apathy and depression signaling the need for more detailed assessment and appropriate referral. Mood and depression should be assessed and evaluated using ongoing observational skills and the use of a validated screening tool. The nurse sensitively assesses patient/family coping strategies, responsibility of care and potential self-neglect or elder abuse. The nurse assesses cognition using validated tools, noting impact on function and quality of life. In the presence of confusion and responsive behaviours, the nurse conducts a detailed assessment noting potential causes and alleviating and aggravating factors.

- **Social and Environment**

The nurse assessment captures home circumstances, family support, accommodation, living arrangements, social supports and other services (home help, day care, meals on wheels). Discussion with the patient and family enables the nurse to assess the older person's goals of care, engagement in local community, their hobbies and interests and flags social isolation and the need for intervention. Liaison with the Public Health Nurse (PHN) and primary care team completes the comprehensive assessment and determines the adequacy

of social supports. The nurse discusses spiritual wellbeing with the person as part of an holistic assessment.

7.3 Occupational Therapy

The Occupational Therapy role in CGA is concerned with the functional status of the older person in addition to cognitive function (memory, attention deficits, executive functioning, information processing) of the older person. Functional status refers to the ability to perform activities both necessary and desirable in daily life.

Functional Assessment

Functional Assessment includes a number of components including the following:

- **Activities of daily living**

An older adult's functional status can be assessed at three levels: basic, instrumental or intermediate (IADLs) and advanced activities of daily living. Occupational Therapists should look at both objective measures and subjective experience from client's perspectives on the above topics. The frail older person is at risk of functional decline, falls, dementia, delirium, depression, incontinence, sleep disorders, malnutrition, dehydration and pressure sores.

- **Impairments and Functional Limitations**

This includes the assessment of functional mobility impairment, muscle weakness, limited activity tolerance and endurance, impaired balance and memory loss. Occupational therapy will specifically assess safety and independence - physical (strength, hand function, range of movement, coordination, balance, endurance, abnormal tone), sensory (tactile, vision, hearing, vestibular, pain), behavioural, cognition and/or perception. This includes the assessment of the older person's ability and safety in functional mobility (sit to stand; bed mobility skills; transfers; ambulation and wheelchair mobility) during ADL and IADL tasks. Assessment will also include the patient's ability to shop, access kitchen, prepare nutritious meals and get adequate hydration as well as supporting the overall multi-disciplinary clinical assessment on fitness to drive.

- **Health and Safety checks**

Occupational Therapists access the requirement for adaptive equipment and home adaptations and the ability to drive safely.

- **Complete a comprehensive, performance-based home assessment**

The Occupational Therapist plays a major role in assessing home safety and functional safety and recommending environmental modifications and adaptations. The Occupational Therapist also assesses family and care giver involvement and requirements. The provision of the right and timely assistive technology is in the centre of enabling and maintaining independence and quality of life. The use of telecare in the home can facilitate independent living and the Occupational Therapist must be familiar with the increasing amount of technology that is available to users. Telecare can only be used where there are sufficient carers or care support available to respond quickly when an alarm is raised. (Atwal *et al* 2013). Current and future living environment and its appropriateness to function and prognosis should be considered. Family/caregiver involvement in the above should be determined including their ability to provide this level of care and their desire to continue, particularly in the case of older people caring for each other. This then helps Occupational Therapist to evaluate the level of care needed with any of the above areas.

- **Cognitive assessment of function**

The Occupational Therapist assesses an older person's ability to remember to check safety in home – lock up at night, turn off electrical equipment, stove, manage the fire etc.; ability to remember to take medications and follow medication regimes and the ability to follow directions and use cueing to aid memory. The Occupational Therapist assesses a person's capacity to understand risks to facilitate decision making.

- **Assessment of occupational needs within acute care setting**

Many people in hospital settings risk occupational deprivation if they are not engaged in meaningful occupation and are not connected with their usual social networks while they remain in hospital. They can quickly loose skills, abilities and confidence and become 'de-conditioned'. The Occupational Therapist has an important role in assessing patients at risk and ensuring that therapeutic interventions are implemented to negate against these factors.

- **Social Assessment**

The current and future living environment and its appropriateness to function and prognosis should be considered. Family / caregiver involvement should be determined including their ability to provide this level of care and their desire to continue, particularly in the case of older people caring for each other. This helps Occupational Therapist to evaluate the level of

care needed with any of the above areas. Social networks should be assessed as health is influenced by social connection, which can be diminished in the older population. The Occupational Therapist assesses an individual's community of care – friends, family and neighbour involvement. Occupational Therapist assessment includes sensory components especially vision, hearing, attention deficits, musculoskeletal endurance and coordination relating to the ability to drive or use transport.

- **Nutrition**

The Occupational Therapist should assess the patient's ability to prepare food and feed him or herself including opening containers, observing safety during food preparation etc and to determine needs including assistive devices or training in adapted methods where needed.

7.4 Speech and Language Therapy

The Speech and Language Therapist (SLT) assesses the older person's communication and/or swallowing difficulties, evaluating the impact of any noted difficulties on the psychosocial and physical well-being of the client and significant communication partners. A plan is then developed to maximise quality of life and ability to function as independently as possible, and minimise levels of risk. The SLT liaises with the older person's family members/carers and other MDT members to support and enable optimum levels of function.

- **Physiological/ Physical Assessment: Dysphagia**

The term "dysphagia" refers to the total process of feeding, eating drinking and swallowing. A clinical bedside assessment of swallowing is conducted initially, and thereafter as required, and may also include an assessment of the person at mealtime as appropriate. A Videofluoroscopic Evaluation of Swallowing (VFES) and/ or Fibre-optic Endoscopic Evaluation of Swallowing (FEES) may also be carried out:

- To further visualise the structure and function, and to gain a dynamic view of the upper aero digestive tract.
- To assess presence and cause of aspiration and residue.
- To facilitate techniques which alleviate aspiration and residue and improve swallow efficiency
- To compare baseline and post treatment function.
- To identify and direct specific therapeutic strategies and regimes.
- To further assist in diagnosis unless there are clear clinical contraindications.

A management plan may include a range of compensatory or therapeutic interventions such as diet or fluid modifications or targeted exercise regime.

- **Functional Assessment: Communication**

The older person's communication skills can be affected in many ways by a variety of medical conditions such as stroke, parkinson's disease and dementia and can have a significant negative impact on the wellbeing of the older person and their carer.

Communication assessment crosses many domains: voice, fluency, intelligibility, receptive and expressive language skills, social use of language and non-verbal communication skills including facial expression and gesture. The speech and language therapist also takes into account the impact of the communication difficulty on the older person and family members/others:

- Aphasia: This is a multi-modal language disorder and may affect a person's ability to understand and produce spoken and written language, leaving other cognitive abilities intact.
- Dysarthria: This is the collective term given to a group of related speech disorders that are due to disturbances in muscular control of the speech mechanism.
- Dyspraxia of speech: Speech disorder that represent a disruption to the selection, programming and online control of the movements for speech.
- The speech and language therapist uses a variety of formal and informal assessments to aid diagnosis and overall management plan. Please refer to Tables 3-6.

The speech and language therapist works closely with other team members to help enable the older person communicate as effectively as possible in different social contexts.

7.5 Physiotherapy

When completing a CGA, physiotherapists perform a comprehensive and specific assessment that leads to an evaluation, diagnostic classification, treatment, plan, design and/ or referral to another practitioner. Physiotherapy assessments will be performed using reliable and validated outcome measures and where appropriate and necessary family/carers will be involved to complete these assessments. The outline below is in line with the recommendations made by the International Physical Therapist Working with Older People Standards of Clinical Practice (IPTOP, 2013).

❖ **Physiological / Physical Assessment**

This consists of a comprehensive subjective and objective assessment of current physical symptoms and limitations, including the assessment of:

- ❖ Anthropometric characteristics (e.g. body composition, body dimensions, oedema)
- ❖ Integumentary integrity (e.g. activities, position, postures, devices, and equipment that produce or relieve trauma to skin; burn; signs of infection; and wound and scar characteristics)
- ❖ Cardio respiratory conditions. This may include, but is not limited to:
    - Observation, palpation, auscultation and assessment of vital signs
    - Assessment of circulation (arterial, venous, lymphatic) including signs, symptoms and physiological responses to positions
    - Assessment of pulmonary signs of respiration/gas exchange and ventilatory function
    - Questions in relation to cough, sputum, wheeze, chest pain and breathlessness
    - Assessment of aerobic capacity/endurance during functional activities and during standardised tests; cardiovascular signs and symptoms during exercise or activity; pulmonary signs and symptoms of distress during exercise or activity

- ❖ Neuro-musculoskeletal conditions. This may include, but is not limited to:
    - Assessment of pain including type, location, severity (irritability, intermittent/constant, quality, pattern, duration, time, cause); soreness and nociception
    - Evaluation of cranial and peripheral nerve integrity including motor and sensory distribution of nerves; response to neural provocation; response to stimuli; and electrophysiological testing
    - Assessment of sensory and proprioceptive integrity including combined/cortical sensations and deep sensations
    - Evaluation of reflex integrity including deep and superficial reflexes; postural reflexes and reactions; primitive reflexes and reactions; and resistance to passive stretch
    - Assessment of joint integrity and mobility including pain, tenderness, effusion, erythema and deformity

- Evaluation of functional range of movement; joint passive and active movements; muscle length; and soft tissue extensibility and flexibility
- Assessment of muscle performance including muscle strength, power, endurance and tension
- Evaluation of motor function (motor control and motor learning) including dexterity, coordination, and agility; hand function; control of movement patterns; and voluntary postures
- Assessment of posture including static and dynamic postural alignment and position

❖ **Functional Assessment**

The functional assessment of the older person may include, but is not limited to:

❖ Assessment of baseline and current ability to transfer, mobilise and climb stairs safely, including the use of assistive devices or equipment and the level of physical assistance or supervision required

❖ Evaluation of gait, locomotion, and balance including:

- gait pattern and speed
- steady state and proactive balance in sitting and standing; steady state, proactive and reactive balance during gait; balance during functional activities;
- gait and locomotion during functional activities with and without devices or equipment;
- gross contribution of the different sensory systems to gait and balance and the impact of the cognition on stability and balance.

❖ Assessment of current physical activity levels, restrictions to participation in recommended physical activities, attitude towards exercise

❖ Multifactorial falls risk assessment. This should encompass a detailed falls history (including frequency, mechanism, where / when / how, footwear, use of aid when falling, ability to get up from the floor, ability to get help, length of incapacity following fall and any injuries sustained) and assessment of fear of falling

- Evaluation of self-care and home management including activities of daily living [ADL] and instrumental activities of daily living [IADL]; ability to gain access to home environment; and safety during self-care and home management.

- Assessment of orthotic, protective, supportive devices and prosthetic requirements. This may include assessment of components, alignment, fit; use during functional activities; remediation of impairments, functional limitations, disabilities, activity limitations, and participation restrictions;

- **Communication and Psychological Assessment**

As part of the comprehensive assessment, physiotherapists will observe the older person's levels of arousal; attention; communication; consciousness; orientation; and recall.

- **Social Assessment**

As part of the social assessment the physiotherapist will record details of living situation that may impact the person's ability to transfer and mobilise safely at home. This may also include the assessment of ability to assume or resume community and leisure activities; ability to gain access to community and leisure environments; and safety in community and leisure activities and environment.

7.6 Clinical Pharmacists

Clinical pharmacists have a duty of care that they enact through the optimisation of medicines use and the development and promotion of evidence-based practice. The pharmacist's responsibility for optimising medicines use is often referred to as Pharmaceutical Care and the description most pertinent to the care of the older person is when "a pharmacist liaises with a patient and/or other healthcare professional to optimise pharmacotherapy, by designing, implementing and monitoring therapeutic goals that will produce specific therapeutic outcome for patients" (Spinewine et al, 2012). This usually involves the identification, resolution and prevention of drug related problems (DRPs)

- **Physiological/ Physical Assessment: Medication Review:**

Medicines reconciliation and review: The systematic and structured assessment of a patient's medication history and current status is an essential first step to preparing a care plan. Pharmacists possess a knowledge and expertise which positions them ideally to deliver comprehensive medication reconciliation reviews, both at admission to and discharge

from hospital and across other settings. Evidence from TILDA shows that both medicine use and supplement use increases with age in the elderly putting them at risk of adverse interactions (Peklar, et al, 2013; 2014) and that alcohol use also contributes to this risk (Cousins, et al, 2014).It is estimated that up to 50% of patients have at least one un-intentional discrepancy at admission and these discrepancies can often perpetuate throughout the patients stay and beyond (Fitzsimons et al, 2011; Galvin et al, 2013; Grimes et al, 2011). It is crucial that medication reconciliation reviews are carried out effectively to ensure that the most accurate and up-to-date medication list is attained, preventing these errors occurring. A pharmacist has a number of additional roles in CGA:

- **Optimisation of prescribing:**

Pharmacists can work either independently or as part of a multidisciplinary team to balance the competing and conflicting clinical needs of older people for medicines, to support the use of safe and appropriate medicines and formulations, to manage drug-related problems, to prevent potential ADRs thereby maximising the benefits of medicines use and minimising the risk of drug-related morbidity, mortality and the associated healthcare costs (Spinewine et al, 2012; O'Connor et al, 2012).Collaborative pharmaceutical care involving medicines reconciliation and review, delivered by clinical pharmacists and physicians, at admission, during inpatient care and at discharge has been shown to be protective against potentially severe medication errors in acute medical patients and improved the quality of prescribing in older patients (Grimes et al, 2014).

- **Promoting adherence:**

Pharmacists possess an in-depth knowledge of medicines, i.e. how and when to take them appropriately. It is estimated that over 50% of older people over 65 years are non-compliant with at least one of their prescription medications and this has been shown to lead to poor clinical outcomes. Pharmacists identify adherence issues and take the appropriate measures to address such problems.

- **Education:**

One of the primary roles of a pharmacist is to educate the older person and or carers i.e. communication of information about; how and when a medication should be taken, why they are on a particular medication, the potential side-effects and adverse effects associated each particular medication. Improving older people or carer's knowledge and understanding

of their medications enables them to take greater ownership of their own care and improves compliance. Pharmacists provide patients and other healthcare professionals with educational training material to optimise medication use in older people (Reilly et al, 2012). The National Medicines Information Centre and the National Palliative Care Medicines Information Service are national services, run by pharmacists to provide advice and support for prescribers in every health service setting in Ireland.

- **Developing Guidelines and Supporting Medicines Use:**

Pharmacists analyse drug utilisation within institutions and work with colleagues to develop Medicines Guides that establish the framework for medicines use in specific patient groups, including the older patient. Pharmacists play a pivotal role in the design and development of clinical guidelines, e.g. National Cancer Control Programme, to promote the optimal use of medicines in older people.

7.7 Nutrition and Dietetics

The Dietitian provides a comprehensive assessment of the older person's nutritional intake and requirements and evaluates the impact of medical, cognitive, physical and emotional conditions on the individual's nutritional status. Data collected in the nutrition assessment are used to identify a nutrition diagnosis.

- **Physical/ Physiological assessment**

The Dietitian will base the CGA around scientific interpretation of numerous physiological parameters using a range of standard & alternative anthropometric measurements: weight/ height/ BMI/ hand grip strength/ ulna length/ knee height/ calf circumference and mid upper arm circumference.

Further assessment includes:

- the calculation of energy, macro (protein carbohydrate, fat) and micro nutrient i.e. FE/B12/Folate/Vitamin D intakes from oral diet, Oral Nutritional Supplements, Enteral tube feeding and Parenteral nutrition
- estimation of Basal Metabolic Rate (BMR) and Energy requirements using evidence based calculations i.e. Henry Oxford equation/PAL values
- assessment of Energy Expenditure associated with the rehabilitation process, clinical illness etc

- interpretation and monitoring laboratory /biochemistry results
- nutrition focused physical findings i.e. physical appearance, muscle and fast wasting, swallow function, appetite

Medical/clinical conditions more often associated with the older person i.e. cardiovascular, stroke, gastrointestinal, endocrinological, dementia, cognitive impairment, renal impairment, respiratory illness and bone disorders will have nutritional implications and require dietetic assessment. Dietetic assessment will also include assessment of nutrient & fluid losses via gastro-intestinal disturbances, mal-absorptive conditions, wounds and pressure ulcers. Identification of individuals at high risk of malnutrition is crucial as a component of the CGA. Use of Nutrition Screening Tool's i.e. Mini Nutritional Assessment (MNA), Malnutrition Universal Screening Tool (MUST) should form standard CGA practice.

Further dietetic assessment core to the CGA includes:

- Assessment of dietary & fluid patterns likes and dislikes: Dietary Intake Records / 24 hour Diet recall/ Food frequency records
- Assessment of hydration status and risk of dehydration
- Identification of Re-Feeding Syndrome risk
- Assessment for Sarcopenia
- Assessment of those identified at falls risk: calcium and Vitamin D intakes, risk of under/over –weight, muscle mass, malnutrition risk
- Assessment of drug-nutrient interactions: appetite suppressants, medications inhibiting nutrient absorption or exasperating gastrointestinal disturbance.

- **Functional Assessment**

The physical ability of the older person to chew, swallow and co-ordinate the function of eating and drinking will impact on the nutritional status of the individual. In liaison with speech and language therapy, the dietetic assessment will focus on evidence of dysphagia and assessment of the nutritional adequacy of texture modified diets and fluids. Inadequate dentition and poor oral hygiene can impede on the ability to chew food and leads to avoidance of significant food components. Hand-mouth co-ordination, ability to use utensils and independent eating and drinking can be affected by arthritic and neurological conditions, particularly stroke and Parkinson's disease, due to tremor and upper limb limitations.

Further dietetic assessment core to the CGA include:

- Dementia/ cognitive impairment assessments: mealtime observations to assess behaviours that challenge associated with mealtimes and meal intake; wandering/pacing and its impact on nutritional intake and energy expenditure
- In liaison with physiotherapy and occupational therapy, assessment of muscle tone and posture for sitting & lying positions, access to table/ tray, tube feeding positions
- Assessment of rehabilitation progress and requirement to continuously assess nutritional requirements to meet the demands of the rehabilitation process and prevent associated complications i.e. pressure ulcers, dehydration
- Observation of independent dining: level of assistance required with eating and drinking and time taken to consume foods and drinks
- Liaison with catering services in determining the nutritional adequacy or availability of an individual's therapeutic diet
- Refer to ADL's for meal preparation, cooking & shopping.

- **Psychological Assessment**

A history of restrained eating patterns and eating disorders will have implications on the nutritional status of an older person, particularly bone health, micro nutrient status and muscle mass. It will also alter their perception of food, in particular if dietary behaviours now need to be changed to high calorie & protein intakes. The older person's knowledge and beliefs in relation to food and nutrition can affect their eating patterns and eating behaviour as well as their readiness to make changes to diet/lifestyle. Evidence of cognitive impairment, low mood, depression, loneliness and bereavement can impact on nutritional and hydration status. Emotional and cognitive changes and altered taste preferences which occur in patients with dementia can affect eating behaviour.

- **Social Assessment**

Discussion and questioning from the older person and/ or from the family and carer should ascertain the situation on home support systems i.e. family support, carers, home help, meals on wheels or community meals, details of cooking, shopping, and food storage facilities should also be assessed. History of alcohol abuse can have impact on nutrient depletion of the older person and therefore potential benefit of further dietary interventions.

7.8 Social Work

The senior social worker will manage, plan and implement the provision of the social work service as part of the specialist geriatrician multi-disciplinary team. The role is an integral part of the multi-disciplinary team in completing the CGA. The social worker provides expert advice and liaises with other hospital staff, specialists / disciplines as required, to optimise discharge planning with linkages to the community care sector and outpatient-based patient services.

Social work assessment includes ascertaining the physical and psychological capacity, to empower the older person to maximise their potential to maintain and improve their quality of life, ascertain the level of social functioning of the older person and determine the support services requirements to meet their needs on discharge. Social work plays a crucial role in the assessment of increasingly complex cases and risk situations that older people can present with. The role of social work in CGA is on-going as it facilitates MDT care planning in case conferences, psycho-social and family meetings.

8.0 Core Competencies for the Specialist Geriatric Team/Service

Specific individualised discipline competencies are determined by their professional bodies. Many professional groups have identified the skill sets and specific competencies in relation to care of the older person. The overarching values and knowledge identified by each discipline are similar throughout. It would be difficult to refer to each within this document. For the purpose of this guidance document it was agreed by the group to reflect each disciplines' core competencies in care of the older person using An Bord Altranais five domains of generic competency (An Bord Altranais 2005) and adapted from various professional bodies' competency frameworks.

Each domain consists of performance criteria and their relevant indicators. The generic core competencies required by members of the multidisciplinary team undertaking a CGA were identified and agreed as follows:

- Domain 1 Professional/ethical practice
- Domain 2 Approaches to care and integration of knowledge
- Domain 3 Interpersonal relationships
- Domain 4 Organisation and management of care
- Domain 5 Personal and professional development
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Domain 1 Professional and Ethical Practice

Performance Criteria	Indicators
(A) Practices in accordance with legislation, regulation and policy affecting professional practice and health care	• Exercises a professional duty of care to older persons and acts in their best interest at all times • Recognises the impact that frailty has on an older person and their family • Maintains a professional therapeutic relationship with older persons in line with professional and organisational codes of conduct. • Recognises ethical issues associated with care of the older person and practices with integrity and in accordance with relevant legal, professional and regulatory requirements.
(B) Practices within the limits of own competence and takes measures to develop this	• Demonstrates knowledge of and keeps up to date with evidence based practice, standards and guidelines specific to CGA. • Recognises own scope of practice, knowledge and competencies in undertaking components of CGA. • Fulfils professional responsibility within own scope of practice and local policy, and takes necessary action where professional development/expansion of knowledge is required.

Domain 2 Holistic Approaches to Care and Integrated Knowledge

Performance Criteria	Indicators
(A) Conducts a systematic holistic gerontological assessment of the patient based on evidence based-practice, and takes into account carers needs where appropriate	• Understands the purpose and components of an multidisciplinary CGA and the roles individual disciplines play in conducting and interpreting the CGA. • Demonstrates evidence based practice and an ability to undertake CGA in a variety of healthcare settings • Understands the concept of frailty in old age and integrates and applies knowledge of the biological, physical, cognitive, psychological, and social changes commonly associated with ageing • Displays knowledge of factors influencing health status in older people and the influences ageing, disease, acute and chronic co morbid conditions and associated treatments have on the different organs and body systems • Selects and administers validated, reliable and age-appropriate assessment and screening tools in response to presenting symptoms • Demonstrates knowledge of and sensitivity to later life and age related issues including diversity, equality, culture, discrimination and ageism within the older population • Understands and adopts principles of informed consent and upholds older persons rights in relation to any assessments and treatments being undertaken • Collaborates skilfully with the service user (or person(s) acting on his/her behalf) and facilitates their involvement in all aspects of assessment and subsequent planning, implementation and evaluation of care, including in complex situations • Interprets outcome of CGA and initiates feedback to the older person and team members. • Develops treatment plans in collaboration with the older person, (where possible), their family and members of the multidisciplinary team.
(B)Plans care in consultation with the	• Respects the patients' wishes, perspective, concerns and expectations. Manages the patients and family's expectations and balances these with

older person, their family and carer-givers taking into consideration the therapeutic regimes and interventions by multi-disciplinary members of the specialist geriatric team	appropriate care options in the context of available resources • Recognises the implications for selected intervention strategies in the context of health planning, quality of life assessment, managing risks, and appropriate use of available health-related and social-related resources • Understands and balances the principles of best practice with values such as equality, empowerment and participation, fulfilment and independence, and adopts a rights-based perspective including the right to self-determination and the least restrictive approach when addressing or evaluating risks and determining pathways of care • Consults and advocates for/with, on behalf of the patient, in planning care pathways. Where necessary, negotiates and mediates with service providers, family members and carer-givers regarding the needs of the older person • Demonstrates sound knowledge of the services for older people and their carers and has the ability to negotiate healthcare systems in order to develop a responsive patient orientated plan of care • Manages safe and effective transitions of care and appropriate onward referral where this is indicated in the CGA. Promotes continuity of care and effective communication at all times • Has the ability to manage a complex caseload and provide ongoing support to the older person, their families and colleagues within professional scope of practice • Works in partnership with older people, their families and care-givers, and implements a person-centred and therapeutic approach. This may involve emotional and psychological support when dealing with issues such as new diagnoses, long term illness, admission to hospital, transitions, bereavement and carer stress • Ensures that key stakeholders are fully informed of the management of individualised strategies and associated known risks and that patient receive and understand relevant and current information.
(C) Implements planned care and prescribed interventions to achieve the identified outcomes	• Recognises and monitors complex cases and situations, including actual or potential mistreatment or elder abuse, neglect and self-neglect and responds appropriately • Responds effectively to consumer feedback including complaints and concerns, in a timely manner. Manages any presenting conflicts whilst prioritising each individual patient's needs and wishes • Continually monitors the older persons progress against agreed goals and consistently takes effective and appropriate action based on sound clinical judgement and evidence based practice • Modifies treatments and interventions in response to the older persons changing needs/wishes and condition and/or as prescribed by the MDT • Demonstrates knowledge of and participates in processes employed in measuring health status and outcome. Evaluates outcomes of intervention in collaboration with all parties.

Domain 3 Interpersonal Relationships

Performance Criteria	Indicators

(A) Establishes and maintains caring therapeutic inter-personal relationships with the older person, their family, carers and healthcare team	• Displays professionalism, thoroughness, empathy, and respect for older people. • Treats individuals in a fair, equitable and inclusive manner, in all therapeutic and professional relationships • Works in a manner that maintains patient/patient confidentiality and that upholds the patient's trust • Promotes and facilitates patients in communicating their needs and wishes and in making informed decisions. Provides information to enhance people's ability to problem solve and to make decisions on their own behalf • Recognises barriers to effective communication and adapts strategies to overcome sensory, intellectual, physical and cognitive limitations where present. • Uses case meetings, conferences, family meetings to develop interpersonal relationships and views them as opportunities to develop optimal treatment strategies with and for older persons. • To work together to maintain and enhance the older person's quality of life
(B) Collaborates with all members of the health care team	• Takes an active role in MDT discussions and decision-making processes. Communicates and provides feedback with clarity (oral and written) and in a manner that ensures confidentiality, privacy and sensitivity • Actively seeks to develop collaborative interdisciplinary relationships to deliver optimal care to older persons • Displays ability to liaise and communicate effectively with colleagues across the full spectrum of healthcare settings • Recognises own scope and limits of authority and when it is appropriate and necessary to make decisions in collaboration with others • Understands governance structures within the team and wider healthcare system. Remains accountable for one's own practice whilst contributing to and participating in team work and key decisions • Respects agreed lines of accountability and responsibility within the healthcare team and maintains clarity in relation to associated interdependencies in order to provide a seamless service to older persons.

Domain 4 Organisation and Management of Care

Performance Criteria	Indicators
(A) Refers to other professionals activities commensurate with their expertise and professional practice	• Recognises when it is appropriate to refer decisions to other members of the healthcare team, a higher level of authority or seek expertise outside the healthcare team, for example where legal advice may be required in order to progress an individual's care plan • Coordinates person centred interventions with patients and other members of the team and with other agencies to ensure optimal service is provided for the older persons • Plans and implements discharge and follow-up with all parties, including in complex situations. Ensures onward referral is communicated effectively.
(B) Facilitates the coordination of care	• Agrees and sets goals and intervention strategies with the older person and communicates these goals, their purpose and expected outcomes effectively with relevant members of the healthcare team and associated agencies. • Writes and maintains accurate, clear, contemporaneous records in accordance with legal and professional requirements and agreed local protocols/procedures.

	• Recognises the specific local context of practice and responds to the impact of inequality, poverty, exclusion and diversity. Analyses and adapts the environment to increase function, social participation and quality of life. • Actively participates in risk management and quality improvement processes within the service and demonstrates ability to initiate and act on recommendations for improving services/practices. • Understands the requirement for continuous quality improvement of services and practice and participates in the design and implementation of evidence-based protocols and processes of care to reduce adverse events in areas common to older adults, such as infections, falls, and polypharmacy.

Domain 5 Professional and Personal Development

Performance Criteria	Indicators
Acts to enhance the personal/professional development of self and others.	• Maintains a commitment to continuous professional development and evidence-based practice by keeping up to date with current research in accordance with service and professional body requirements. • Displays commitment to one's own continued professional development and learning and facilitates the learning and development of others, in order to improve care for those older people and their families/carers. • Develops and maintains specialist clinical knowledge and assessment skills within the context of the CGA. • Participates in supervision and practice teaching commensurate with own role. • Acts as an educational resource for colleagues, students and other health professionals in collaboration with relevant service managers and HEI's where appropriate. • Disseminates knowledge in skills required to care for older persons to other health care workers and caregivers through peer education, staff development, and preceptor experiences. • Uses evidence to evaluate whether learning outcomes are achieved and to modify programmes where necessary. • Acts as an advanced clinical resource in own organisation and respond to queries from internal and external resources. • Enables others through a willingness to share knowledge and skills in gerontology.

9.0 Conclusion

The biggest challenge to the delivery of services for older people is the fact that this population is projected to increase from 2009 to 2016 by 25%. The future of gerontology involves changing demographics and longer lifespan and, therefore, will lead to an increase in demand for geriatric services. It is recognised that frail and disabled older adults are those at highest risk for adverse outcomes and are also most likely to benefit from CGA.

CGA offers a multi-domain and multidisciplinary assessment of a frail older person, centred on function with the focus being on maintaining and improving quality of life. Effective CGA does rely on the appropriate identification of frailty through the presence of "frailty syndromes". In most cases, they are older individuals who are frail and disabled or have complex or multiple interacting co-morbid conditions.

CGA allows broad and integrated plans for immediate and future management, rehabilitation, care and monitoring to be made and communicated across the multi-disciplinary team and across the care settings. Optimising and maintaining function of older adults whilst promoting wellness and independence, should be the key outcomes of successful geriatric assessment and intervention.

The NCPOP recommends that identification of frail older people should primarily be on the basis of frailty syndromes. Those identified as being frail on this basis and others who are likely to have unmet service needs should have a timely CGA and the findings documented in their permanent health record. Pathways for treating such people should be agreed in conjunction with the Specialist Geriatric Service. The evidence for the benefits of CGA is clearest for those who are inpatients in the acute hospital setting and home care settings, although provision of CGA may also be helpful in other settings including ambulatory day hospitals.

CGA should become standard practice for the older adult and clinical expertise is needed to implement these approaches. Healthcare professionals need to apply a lifespan approach to assessing the complex needs of older people in a variety of care setting. This guidance document sets out the core competencies as to the knowledge, attitudes and skills that are required by the specialist geriatric team in the delivery of care to older people.

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Appendices

Appendix 1: Additional Resources

This section provides some additional resources (including Relevant Legislation/Policies/Health Service Requirements) which may assist practitioners undertaking CGA.

- National Clinical Programme for Older People: Specialist Geriatric Services Model of Care Part 1: Acute Service Provision July 2012
- Irish National Audit of Dementia in Acute Hospitals 2014
- National Quality Standards for Residential Care Settings for Older People in Ireland, Health Information and Quality Authority
- Health Act, 2007
- Trust in Care, 2005, HSE
- Protecting our Future, 2002, HSE
- Equal Status Act, 2000 and 2004
- Equality Act, 2004
- Disability Act, 2005
- Nursing Home Support Scheme Act, 2009
- Health and Social Care Professionals, Act 2005, (CORU)
- Mental Health Act, 2001
- Wards of Court; Enduring Power of Attorney, Power of Attorney and Assisted Decision-Making (Capacity) Bill, 2013 Human Rights Commission Act, 2000 & 2001
- European Convention on Human Rights Act, 2003
- Domestic Violence Act 1996; Domestic Violence (Amendment) Act, 2002; and Family Law (Miscellaneous Provisions) Act 1997
- Pharmacy Act, 2007
- Health (Pricing and Supply of Medical Goods) Act, 2013
- Regulation of Retail Pharmacy Businesses Regulations 2008

Appendix 2: Membership of the NCPOP Comprehensive Geriatric Assessment Subgroup

Name	Representing	Role
Ms Carmel Hoey	NCPOP Working Group / Service Planner	Project Lead
Ms Judy Vahey	Directors of Nursing Older Peoples Services	Chair
Dr Suzanne Timmons	Consultant Geriatrician	Member
Ms Doreen Lynch	Centres of Nurse & Midwifery Education	Member
Ms Dervela Gray	NCPOP Programme Manager	Member- from Oct 2013
Ms Vanessa Colgan	Former NCPOP Programme Manager	Member- to July 2013
Ms Alice Gormley	NCPOP Working Group and Occupational Therapy	Member
Ms Brenda Reginatto	NCPOP Working Group and Physiotherapy	Member
Ms Bridget Catterson	Directors Public Health Nursing	Member until April 2013
Professor Kathy Murphy	NUIG /HEI's Academia	Member
Ms Niamh McMahon	NCPOP Working Group/Pharmacy	Member from September 2013
Ms. Kate Browne	Community Pharmacist	Specialist input
Ms Mary J. Foley	RANP Rehabilitation of the Older Person	Member
Mr Neil Dunne	Nurse Lead NCPOP / RANP Community Older People	Member
Dr Joe Browne	Specialist Registrar in Geriatrics, St. James Hospital Dublin	Specialist input
Dr Rachael Doyle	Consultant Geriatrician	Member
Dr Siobhan Kennelly	Consultant Geriatrician	Specialist input
Ms Grainne Flanagan	Dietetics	Member until August 2014

Ms. Hilda Griffin	Dietetics	Member from August 2014
Ms Mary Walsh	Speech and Language Therapists	Member
Mr John Brennan	NCPOP Working Group/Social Work	Specialist input
Dr. David Robinson	Consultant Geriatrician	Specialist input
Dr. Diarmuid O'Shea	NCPOP Clinical Lead / Consultant Geriatrician	Specialist input
Dr. Emer Shelley	NCPOP Working Group/Specialist in Public Health Medicine	Specialist input
Ms Bernadette Casey	Social Work	Member
Mr Joseph Morris	CNSp Gerontology	Member- to March 2013
Ms Margaret Buckley	Nursing and Midwifery Development Officer	Member- to May 2013