

Geriatric assessment – lessons from personal experience

LUDOMYR MYKYTA AND JUSTIN ENGLISH

Ludomyr Mykyta is a consultant geriatrician and the Clinical Director/Executive Officer of Western DomCare, an Aged and Extended Care Service of The Queen Elizabeth Hospital and Health Service, Woodville, South Australia.

Justin English is the Manager of Research and Evaluation at Western DomCare and is a PhD student at the University of South Australia.

Abstract

The aim of this study was to develop a framework for comprehensive specialist geriatric assessment in rural settings. A protocol that used a number of standardised assessment instruments was developed and applied routinely. Data from two rural centres in South Australia over a two-year period were analysed. Study results offer important insights and have implications for clinical practice and policy development. They particularly reinforce the need for a comprehensive assessment irrespective of the information received from the referrer.

Emerging issues in assessment

Assessment has always been a contentious issue in Australia, even though there is a well-established nationwide Aged Care Assessment Program in place. A large part of the problem is the complexity of the health and aged care system, divided as it is into Commonwealth (Federal) and State jurisdictions, and below that into separate residential care and home care systems with public, private, and NGO agencies and service providers.

In South Australia, social theorists dominate the assessment debate. The clinical point of view is actively discouraged as part of the politically correct pejorative perception of the “medical model”. Health care practitioners, and specifically medical practitioners, are depicted as paternalistic (or is it parentalistic), self-serving and intent on denying the client (never the patient) their right to choice and autonomy. We suspect the political and bureaucratic audience for these perceptions tends to hold a similar viewpoint.

In the context of aged care, one of the key functions of assessment is to determine eligibility for publicly funded services. This eligibility is unequivocally based on the presence of disability. For example, the Home and Community Care Act 1985 (HACC 1985) defines its target population as follows.

“The program shall be directed towards assisting –

(a) persons living in the community who, in the absence of basic maintenance and support services provided or to be provided within the scope of the program, are at risk of premature or inappropriate long term residential care, including –

- (i) frail or at-risk aged persons, being elderly persons with moderate or severe disabilities;
- (ii) younger disabled persons, being persons with moderate or severe disabilities; and
- (iii) such other classes of persons as are agreed upon by the Commonwealth Minister and the State Minister; and

(b) the carers of these persons.”

The inclusion of carers in the target population can create a very important dilemma in choosing between the best interests of the client rather than the carer.

The South Australian Disability Services Act (DSA) 1993 (DSA 1993) defines its target population very similarly, as follows.

“In this Act, unless the contrary intention appears: “disability” in relation to a person means a disability:

- a) that is attributable to intellectual, psychiatric, cognitive, neurological, sensory or physical impairment, or to a combination of any of those impairments; and
- b) that is, or is likely to be, permanent; and
- c) that results in the person having:
 - (i) a reduced capacity for social interaction, communication, learning, mobility, decision-making or self-care; and
 - (ii) a need for continuing support services,

and includes such a disability notwithstanding that it is of an episodic nature.”

The defining concepts in both pieces of legislation are based on the World Health Organisation's framework for conceptualising the health experience and the consequences of illness (WHO 1980). One of the objectives of the introduction of this framework was to take the health experience beyond the bio-medical domain. The terms are defined as follows.

Impairment: in the context of health experience, an impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function.

Disability: in the context of health experience, a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

Handicap: in the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.

There can be no argument that eligibility for entry into residential care is dependent on evidence of disability. Entry guidelines require that there be a threshold of disability before entry can be considered.

Impairments, disabilities, and handicaps do not arise in a vacuum. They are the result of pathology. While the term “frail” is often used to distinguish between those who need medical involvement versus those who do not, frailty is simply an imprecise term for disability. Practitioners of geriatric medicine take a wide view of pathology in this context, and if they can be stereotyped as operating within a conceptual model, it is the bio-psycho-social model as described by Engel (1980).

There are a number of current directions being actively promoted in formal assessment. These directions include the following.

- The pressure to create “single assessment” services that is based on the largely anecdotal assertion that assessments which seek identical information abound, and that there is massive resentment and resistance to multiple and repeat assessments from the client population.
- The separation of assessment from service delivery.
- The demedicalisation of assessment on the premise that the client population needs welfare support not “care”, and certainly not health care, and that any required health information can be obtained from the client's general practitioner, if required.
- The contention that there are two streams of home and community care clients (basic and complex), and that only complex clients need comprehensive professional assessment.

There are two important corollaries to the latter contention. The first is that clients can accurately define and articulate their needs, and are knowledgeable about appropriate service responses. The second is that assessment can be de-medicalised and de-professionalised by the introduction of protocols and screening instruments that can be administered by clerical rather than clinical workers, and without the need for personal contact.

In the light of these pressures, we determined to test some of these assertions against personal experience. The authors have always found the Rubenstein definition of assessment a useful starting point. He conceptualised

assessment as a “... multidimensional, usually inter-disciplinary, diagnostic process used to quantify an elderly individual's medical, psychosocial and functional capabilities and problems with the intention of arriving at a comprehensive plan for therapy and long-term follow-up” (Rubenstein 1987, p1).

We further contend that an assessor or an assessment team has the following responsibilities:

- accurate diagnosis of all significant problems, and precise definition of disability and dependency
- determination of prognosis (recognition of preventive, remedial, and rehabilitation potential)
- determination of intellectual capacity and decision-making competence and diagnosis of mental illness
- identification of the social support network, and carer stress and burden
- identification of the patient's/client's and family's perceptions of needs and possible solutions.
- formulation of a management plan that can be offered to the patient/client, the family, and referrers
- information, communication with patients/clients, family and referrers
- assistance with access to the most appropriate alternative care options
- continuing surveillance, monitoring and review
- awareness of comparative need and ability to set priorities.

Study background

One of the authors (Ludomyr Mykyta) is a consultant geriatrician with long and wide experience in internal medicine, aged care and rehabilitation. He visits five rural regions in South Australia on a regular basis. The visits are co-ordinated by the regional Aged Care Assessment Teams (ACAT). All patients are referred by their general practitioners, though many of these referrals are triggered by concerns of the ACAT, staff of residential facilities, and particularly families. This paper is based on personal experience and data collected of sequential rural assessments in two regions completed in the years 1999 and 2000 (N=170).

Patients were seen in all settings including hospitals, residential facilities, clinics and home visits. For all patients seen for the first time, a comprehensive assessment was undertaken wherever feasible, irrespective of the referral request. This involved an initial interview with the patient in private. Informal carers or advocates were interviewed separately following the patient interview. Often a family interview was done at the conclusion of the assessment.

A protocol was developed to facilitate this process. Its main features were as follows.

- Basic demographic data was gathered followed by a clinical assessment that covered physical, psychiatric, social and functional domains.
- Mental Status Screen. In most instances a modified Pfeiffer SPMSQ was completed to establish a rapid impression of the patient's cognitive status from the outset.
- Past Medical History. The patient's recollection of admissions, operations, and chronic illnesses and their treatment was tested, irrespective of the availability of this information from the referrer or records.
- Main current health concerns. Again, the patient's perception was deliberately sought.
- Systematic Somatic Inquiry. Systematic cover of all the major systems with specific focus on common geriatric issues, such as incontinence and falls. This included a history of medications used, alcohol and smoking.
- Brief psychiatric history. This covered the patient's concerns about memory, affective disorders and anxiety and psychotic symptoms. The patient's interests and activities were noted. Inquiry was made about relationships with family, carers, and others. The Geriatric Depression Scale was used as an aide memoir only. The affective history was sufficient to meet the DSM-IV criteria for the diagnosis of depression.
- Activities of daily living (ADL) history. Patient's perception was sought first on each item and scored.
- Instrumental activities of daily living (IADL) history. Again, the patient's perception was sought and scored.
- The patient's plans for the future were also discussed at this point.

Other key elements of the assessment included a physical examination, environment assessment, and the gathering of a patient's history from their caregivers. The physical examination, undertaken in every instance, involved measuring blood pressure in two position, lying and standing if feasible, sitting and standing if not; and the “get up and go test”, which tests balance and gait. Each patient is asked to remove (then put back on) an item of clothing such as sweater, shirt, or shoes and socks as a very rough functional assessment of praxis.

The environment assessment always involved the patient being asked to produce their medication from where it was usually kept. Any outstanding feature of the residence was noted. Such environmental features included access, hygiene, and the presence or absence of appropriate furniture.

Caregivers were interviewed separately to obtain an informant history. This is in itself contentious, because some people, including representatives from consumer advocacy and support groups, insist that it is a fundamental right for the person being assessed to have an advocate of their choice present at all times. This is contrary to sound practice and we could produce many examples where critical information would not have been forthcoming if patients and carers were interviewed together. This process was semi-structured and the informant was asked to present their overall concerns and reasons for seeking assessment and intervention, their concerns about memory problems, with examples. The Neuropsychiatric Inventory (NPI) items were then dealt with systematically and examples of disturbed behaviour explored. The ADL and IADL questionnaires were repeated and scored from the carer's perspective. The medical history was confirmed. The family's plans for future management of the patient were explored.

At the completion of the interviews a short family conference was held to discuss findings and recommendations. Participation was entirely voluntary and this presented an opportunity to answer final questions and to provide some basic counselling.

Methods

The two communities selected are both important regional centres in South Australia, but are somewhat different in their nature and demography. One is an agricultural and fishing port reasonably close to several smaller towns. Patients were generally seen in a community health centre clinic.

The other centre is a remote urban industrial city, with no surrounding towns. In this community, many patients were seen on home visits.

The presented data underestimate the proportion of patients seen on home visits in Ludomyr Mykyta's rural practice overall. Both centres have resident physicians (internists) and access to a wide range of visiting specialists.

Results

Homogeneity

Analysis was undertaken to examine the homogeneity of the two study groups. In all domains examined, no statistical significant difference was revealed.

Age and sex

The average age overall was 79.51 years with 68% falling between 70.85 and 88.51 years. 36.2% were male and 63.8% female.

Language

Only 10.3% were of non-English speaking background. They tended to be very long term residents in their regions and interpreters were rarely required, though both original language and level of education had to be kept in mind when undertaking formal mental status testing.

Assessment location

In Study Site One, clinic-based assessments comprised 60.4% of all assessments undertaken. In the Second Site, home visits comprised 54.1% of assessments and clinic-based assessments comprised only 1.4%. For the overall group, home visits comprised 27.6% and clinic based assessments 37.4% (Table 1).

Table 1: location of assessment

Hospital	15.5%
Residential facility	19.5%
Clinic	37.4%
Home visit	27.6%

Living arrangements at time of assessment

The living arrangements of patients at the time of assessment were also examined. 81.4% of all patients resided in the general community, 16.0% lived in a residential facility, whilst 1.9% resided in a retirement unit at the time of assessment.

Informal in-home support at time of assessment

The availability of in-home informal care support available to the patient was examined from the assessment data. This data revealed that 56.3% of all patients were living alone; 30.5% received in-home support from their spouse or de facto partner; 6.3% received this support from their children; 2.3% from another relative; and 4.7% identified an “other” source providing this support.

Principal caregiver identified at time of assessment

The patient’s principal caregiver was also identified at the time of assessment. The majority of principal caregivers were children (55.6%) and/or spouses or de facto partners (28.1%). In both centres there were a number of “loners”, who literally had no relatives or friends.

Main reason for referral given by the general practitioner

Three broad options were examined in relation to reason for referral given by the general practitioner:

- 1 Primarily somatic, physical health issue
- 2 Primarily psychiatric, behavioural issue
- 3 Primarily consideration for placement.

From the pattern of referral it rapidly became apparent that general practitioners are more confident in dealing with somatic than mental health problems. Furthermore, mental health services for older people, and psychiatric services generally, are not readily available in rural South Australia. This has resulted in a behavioural dominance in referrals.

Combinations of somatic and behavioural referrals were also analysed (Table 2). These results reveal the importance of psychiatric/behavioural issues. The importance of these issues in both home care and residential care can not be over-stressed.

Table 2: somatic and behavioural referrals

Somatic	
Somatic alone	4.6%
Somatic & placement	1.1%
Somatic & behavioural	10.9%
Behavioural	
Behavioural alone	28.7%
Behavioural placement	32.8%

Patient's perception of reasons for the referral

The patient's perceptions about concerns with their health or their situation were specifically sought in every instance. 56.6% of patients did not perceive any concerns at all with their health or situation at the time of assessment. 11.0% reported the same concerns as the referrer, whilst 32.4% indicated that they had some concerns, but that these were different from the referrer's concerns.

These marked differences in perception cannot be attributed to paternalism on the part of general practitioners, as they generally respond to the concerns of formal or informal caregivers. From these data, it was observed that there was a statistically significant relationship between the "No patient perceived concerns at the time of assessment" response and referral for "behavioural" or "behavioural plus placement reasons" ($X^2 < 0.05$ df 12).

Pfeiffer score

A brief cognitive assessment was done routinely, irrespective of the reason for assessment and the apparent intactness of the patient. This is also contentious issue. Many assessors are unwilling to undertake cognitive assessment because it is perceived as an affront to the patient. Some only undertake an assessment when they feel that it is indicated in some way. Some are philosophically opposed to cognitive assessment because they believe that the cognitively impaired person's perceptions must be given the same value as those of any other individual. Findings are summarised in Table 3.

Table 3: the Pfeiffer Mental Status Score

Normal (0-2 errors)	24.3%
Mild deficit (3-4 errors)	18.6%
Moderate deficit (5-7 errors)	28.3%
Severe deficit (8-10 errors)	28.8%

Testamentary capacity

A judgement was made of the patient's capacity to make care decisions based on cognitive capacity, psychiatric and behavioural factors, and insight. A very high proportion of this, admittedly selected, population (56.5%) lacked testamentary capacity under these terms. Furthermore, there was a statistically significant correlation between lack of "testamentary capacity" and the lack of "health concern" ($X^2 < 0.001$ df 2).

Evidence of planning for future incapacity

Only nine patients were clearly known to have granted Enduring Powers of Attorney to anyone. There were only two Enduring Powers of Guardianship and no Medical Powers of Attorney noted. While these are almost certainly underestimates, few patients and caregivers were aware of the value of these Powers and the distinctions between them.

Drug history

All patients were asked to recall what medication they were taking and to explain what the broad reasons were for taking this medication. Only 18.6% of all patients were able to give a reasonably accurate drug history. There was a statistically significant correlation between a behavioural/psychiatric reason for referral and lack of testamentary capacity and inability to provide a drug history. ($X^2 < 0.001$ df 2). The implications for compliance are profound.

Systematic inquiry

Among other items all patients were specifically interviewed about anorexia and weight loss, urinary dysfunction and incontinence, and unsteadiness and falling. 40.0% of patients reported urinary incontinence, and a further 22.4% reported urinary dysfunction without incontinence. 14.7% reported anorexia and weight loss and 41.2% reported falling.

In many cases these issues were not being medically addressed at the time of assessment, and again the importance of systematic enquiry with this client population was demonstrated. The implications for independence if these issues are not effectively addressed are obvious.

Examination

Patient examination data were analysed. It was found that 7.6% of all patients showed a significant postural drop in their blood pressure. This must be an underestimate as the circumstances often precluded measurement of lying and standing BP. 16.5% of all patients had atrial fibrillation. The majority of these patients also had neurological findings suggestive of cerebro-vascular disease. Atrial fibrillation is a well-recognised risk factor for stroke.

ADL and IADL capability

It was common for people who were moderately and severely cognitively impaired to overestimate their independence and recognise the need for assistance, when compared to informant rating. These items are useful measures of the patient's general awareness and insight.

Recommendations following assessment

For the purposes of presentation the recommendations have been grouped under five headings, as follows.

- 1 Somatic health-related. In 64.7% of cases, recommendations were made about the diagnosis, investigation, treatment and rehabilitation of somatic disorders.
- 2 Behavioural and Psychiatric. In 77.6% of cases, recommendations were made about the diagnosis and management of dementia, and in 38.8% about depression. There was considerable overlap between these two groups. In a further 17.1% of cases, there were issues related to other psychiatric disorders.
- 3 Community Support and Placement. Increased community support was recommended in 27.6% (n=47) of cases, and placement in supported residential facilities in only 19.4% (n=33) of this very vulnerable group.
- 4 Guardianship Board intervention was recommended in 22.9% (n=39) of cases, including virtually the entire group for whom placement was recommended.
- 5 Cancellation of the driver's licence was recommended in 9.4% (n=16) of cases.

Discussion

The capability to undertake a comprehensive multi-dimensional assessment is one of the most important skills that distinguish a geriatrician from a general physician, or other organ system specialist.

Where questions are raised about the patient's capacity to manage at home, a home visit should be undertaken whenever possible. We are, after all, being asked if that person can continue to survive in a specific environment, and we can only do that with full confidence if we are familiar with that environment. Ludomyr Mykyta has seen several cases of the Diogenes Syndrome, which is characterised by extreme self-neglect, domestic squalor, social isolation, hoarding, and refusal of help (Cooney & Hamid 1995, p451-453). Often these patients appear cognitively intact and unimpaired mentally. They would have been very difficult to evaluate without first-hand knowledge of the patient's home circumstances, though in one case, the family brought a very graphic photo album and a video to the clinic.

It is very difficult to persuade clinical staff to undertake routine cognitive assessment. There are people whose social skills are retained quite late in dementia, and even their general practitioners may be surprised to learn that there is a significant cognitive deficit present. This is an important factor in shaping the concerns that are presented at the time of referral.

All referrals in this study were channelled through a general practitioner, but most formal assessment services accept referrals from clients, carers and others. The perceived problem as presented can determine the outcome, which may include the decision not to undertake formal assessment, re-direction to another agency, or channelling to an agency that deals with simple level home care. In a high proportion of cases, the chance to detect remediable problems or preventive opportunities may be lost. Ideally, we should be undertaking skilled assessment as often as possible, irrespective of the nature of the referral.

The highly selected patient population that was referred illustrated general practitioners' greater confidence in dealing with somatic than behavioural and psychiatric issues. In rural and remote areas access to expert opinion in most of the somatic sub-specialities is much easier to obtain than in geriatrics, rehabilitation and mental health.

It is impossible to over-stress the importance of routine systematic inquiry. With many geriatric problems, the simple aphorism "If you don't ask, you will never know" applies. In this series, only 18.6% of patients (including cognitively intact patients) were able to give a reasonably accurate drug history, yet many consultations result in new prescriptions and changes in regimes, with compliance being accepted as a given. Taking a psychiatric history, or at least screening for depression is equally important. Depression is common in at-risk aged people and it may present in ways that make it difficult to spot.

Again, this study highlighted the importance of the informant history. Apart from producing clinical information, it gives us the opportunity to gauge the family dynamics and the carer's stress, knowledge, and capabilities.

Finally, we would like to remind the reader of the concept of triage. The term originated in the First World War and has come to mean "the sorting out and classification of patients or casualties to determine priority of need and proper place of treatment". Because of the obvious importance and far-reaching implications of these decisions, battlefield triage was undertaken by the most skilled and experienced surgeons available. Geriatric assessment is triage, and it too should be performed by those who are most skilled and experienced. Removal of clinical expertise from the front line of assessment or removing assessment from its clinical connections would do a disservice to aged people.

References

- Cooney C & Hamid W 1995, 'Review of Diogenes Syndrome', *Age Ageing*, 1995, vol 24, pp451-453.
- Engel GL 1980, 'The clinical application of the biopsychosocial model', *American Journal of Psychiatry*, May 1980, vol 137, no 5, pp535-44.
- Home and Community Care Act 1985, no.184 of 1985, *Commonwealth Government of Australia*, Printed by the Commonwealth Government of Australia, Canberra, ACT.
- Pfeiffer E 1975, 'A Short Portable Mental Status Questionnaire For The Assessment Of Organic Brain Deficit In Elderly Patients', *Journal American Geriatric Society*, 1975, vol 23, pp433-441.
- Rubenstein LZ 1987, 'Geriatric Assessment: An Overview of Its Impacts', *Clinics In Geriatric Medicine*, vol 3 no 1.
- South Australian Disability Services Act (DSA) 1993, *Disability Services Act*, The Government of South Australia, Printed by the Government of South Australia.
- World Health Organisation 1980, *International Classification of Impairments, Disabilities, and Handicaps. World Health Organisation: A manual of classification relating to the consequences of disease*, World Health Organisation.