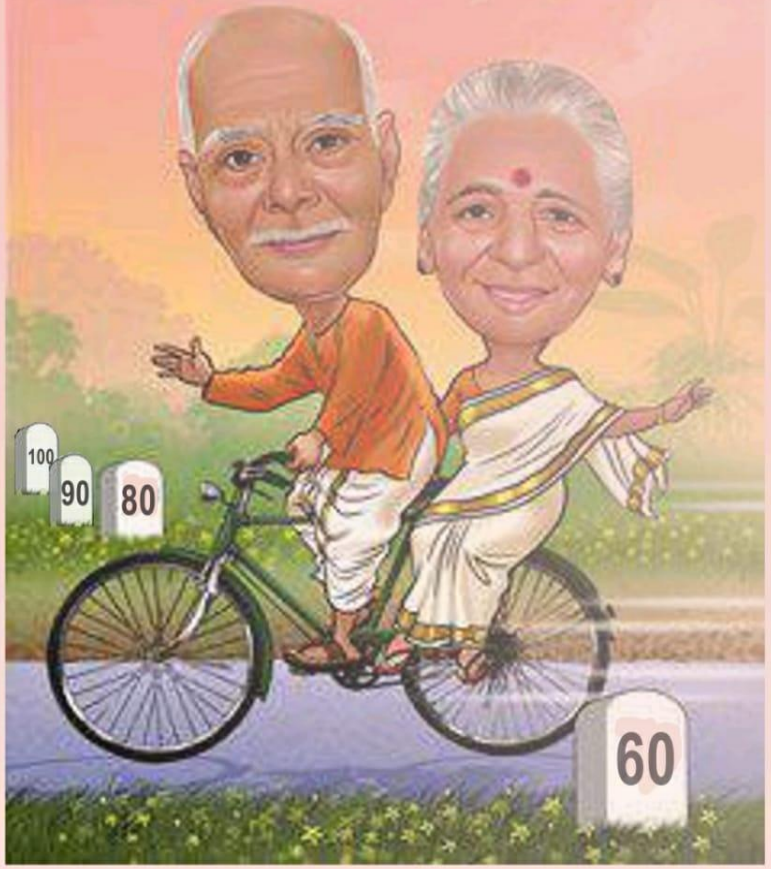
# Comprehensive Geriatric Assessment
# Part- 2
# For CHO/SN

# COMPREHENSIVE GERIATRIC ASSESSMENT BOOKLET

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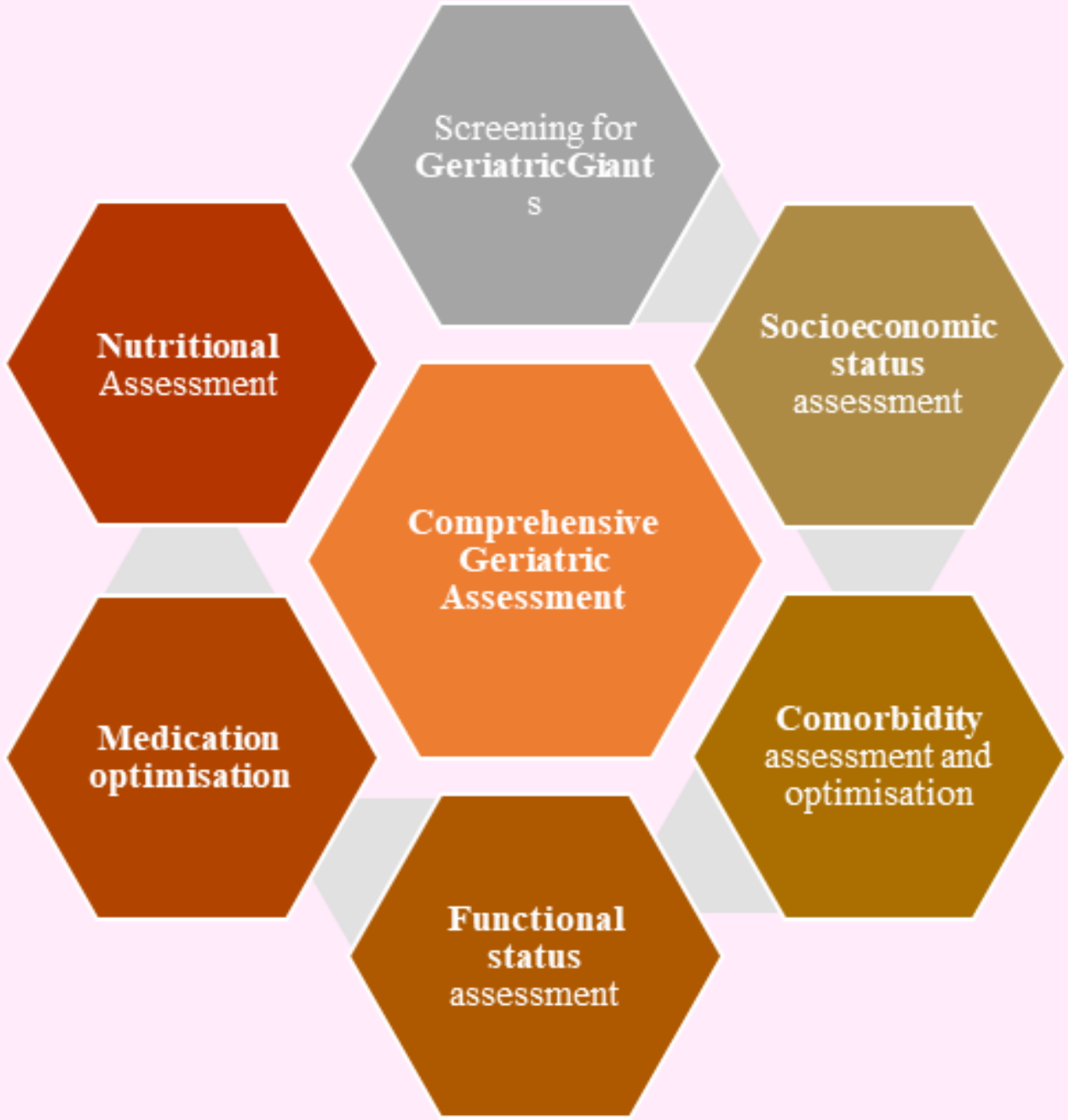
Screening for GeriatricGiants
Nutritional Assessment
Socioeconomic status assessment
Comprehensive Geriatric Assessment
Medication optimisation
Comorbidity assessment and optimisation
Functional status assessment

# COMPREHENSIVE GERIATRIC ASSESSMENT PROCESS

| | |
|---|---|
| ASHA | Part B3 of the CBAC is 'Yes', and informs MPW(F/M). |

## Field level

| | | |
|---|---|---|
| MPW(F/M) | conducts section 1 and 2 CGA-CPHC | section 1 and 2 CGA |

## SHC- HWC level

| | |
|---|---|
| CHO | conducts session 3 and 4 of CGA-CPHC |

## PHC-HWC level

| | | |
|---|---|---|
| Medical Officer | conducts session 3 | conducts section 5 |

# Who should get priority for CGA ?
# Elder with 1 or more “geriatric Giants” (Red Flag signs)

1. Age >75 years
2. Needs help with Activities of Daily Living
3. Lives alone
4. History of falls
5. History of delirium/confusion
6. History of incontinence
7. More than 2 admissions to acute care hospital/year
8. “Failure to thrive”

# Mini-Cog™

## Instructions for Administration & Scoring

ID: _____ Date: _____

## Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

| Version 1 | Version 2 | Version 3 | Version 4 | Version 5 | Version 6 |
|---|---|---|---|---|---|
| Banana | Leader | Village | River | Captain | Daughter |
| Sunrise | Season | Kitchen | Nation | Garden | Heaven |
| Chair | Table | Baby | Finger | Picture | Mountain |

## Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

## Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____ _____ _____

## Scoring

| | |
|---|---|
| Word Recall: _____ (0-3 points) | 1 point for each word spontaneously recalled without cueing. |
| Clock Draw: _____ (0 or 2 points) | Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored.<br>Inability or refusal to draw a clock (abnormal) = 0 points. |
| Total Score: _____ (0-5 points) | Total score = Word Recall score + Clock Draw score.<br><br>A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status. |

# GPCOG

General Practitioner assessment of cognition (GPCOG)

Developed in 2002 by Brodaty et al

For screening for dementia by GPs

Takes around 4 minutes to administer

Has two steps

- Patient interview
- Informant interview

# GPCOG-1

| Name and Address for subsequent recall test | | |
|---|---|---|
| 1. "I am going to give you a name and address, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: Sunil Kishan Mhaske Near Daulatabad Fort Aurangabad. | | |
| (Please tick appropriate box ✓) | Correct ✓ | Incorrect x |
| **Time Orientation** | | |
| What is the date? (exact only) | | |
| Clock Drawings — Use blank page | | |
| Please mark in all the numbers to indicate the hours of a clock (correct spacing required) | | |
| Please mark in hands to show a certain time ex. 11.10am. | | |

| Information | | |
|---|---|---|
| Can you tell me something that happened in the news in the last week. | | |
| **Recall** | | |
| What was the name and address I asked you to remember? | | |
| Sunil | | |
| Mhaske | | |
| Near Daulatabad Fort | | |
| Aurangabad | | |
| | | |
| (To get a total score, add the numbers of items answered correctly Total Correct (Score out of 9) | | / 9 |

# GPCOG

- Has total 9  points
- If patient scores 9 on 9 he is cognitively intact- no dementia
- If he scores 5 to 8 proceed to informant interview  step 2 - doubtful dementia
- If score is 4 or less than cognitive decline is very likely (no need to do step 2)- dementia most likely

# GPCOG-2

| CARER INTERVIEW | | | | |
|---|---|---|---|---|
| Carer's Name | | | | |
| Carer's relationship to patient i.e. carer is the patient's: | | | | |
| These 6 questions ask how the patient is compared to when s/he was well, say 5 -10 years ago: | | | | |
| (Please tick appropriate box ✓ ) | Yes | No | Don't Know | N/A |
| Does the patient have more trouble remembering things that have happened recently than s/he used to? | | | | |
| Does he or she have more trouble recalling conversations a few days later? | | | | |
| When speaking, does the patient have more difficulty in finding the right words or tend to use the wrong words more often? | | | | |

# Score 0-3 – Cognitive impairment indicated

| | | | | |
|---|---|---|---|---|
| Is the patient less able to manage money and financial affairs? (e.g. paying bills, budgeting) | | | | |
| Is the patient less able to manage his or her medication independently? | | | | |
| Does the patient need more assistance with transport? (either private or public)<br>If the patient has difficulties due only to physical problems e.g. bad leg, tick 'no' | | | | |
| | Scores | | | |
| To get a total score, only add the number of items answered 'no', don't know or Not Applicable | | | | |

# GDS -4

Patient name:.....Age/Sex.....MRD.....Date.....

Address.....Caretaker.....Contact.....

Consent: I have been informed about and giving my permission for the following assessment
Patient's Signature.....

4 ITEM GERIATRIC DEPRESSION SCORE (GDS-4) Score:

| | | | |
|---|---|---|---|
| 1 | Are you basically satisfied with your life? | Yes/**NO(1)** | |
| 2 | Do you feel your life is empty? | **Yes(1)/**NO | |
| 3 | Are you afraid that something bad going to happen you? | **Yes(1)**/NO | |
| 4 | Do you feel happy most of the time | Yes/**NO(1)** | |

4 Item depression score:..../4

# INTERPRETATION

GDS 4 : DEPRESSED

2-4 : DEPRESSION

1: UNCERTAIN (HAVE TO DO GDS 15 )

0: NOT DEPRESSED

# GDS -15

| | | | |
|---|---|---|---|
| **Instructions:** | Circle the answer that best describes how you felt over the past week. | | |
| | 1. Are you basically satisfied with your life? | yes | **no** |
| | 2. Have you dropped many of your activities and interests? | **yes** | no |
| | 3. Do you feel that your life is empty? | **yes** | no |
| | 4. Do you often get bored? | **yes** | no |
| | 5. Are you in good spirits most of the time? | yes | **no** |
| | 6. Are you afraid that something bad is going to happen to you? | **yes** | no |
| | 7. Do you feel happy most of the time? | yes | **no** |
| | 8. Do you often feel helpless? | **yes** | no |
| | 9. Do you prefer to stay at home, rather than going out and doing things? | **yes** | no |
| | 10. Do you feel that you have more problems with memory than most? | **yes** | no |
| | 11. Do you think it is wonderful to be alive now? | yes | **no** |
| | 12. Do you feel worthless the way you are now? | **yes** | no |
| | 13. Do you feel full of energy? | yes | **no** |
| | 14. Do you feel that your situation is hopeless? | **yes** | no |
| | 15. Do you think that most people are better off than you are? | **yes** | no |
| | **Total Score** | | |

| | | |
|---|---|---|
| **Scoring Instructions:** | ***Score one point for each bolded answer.*** A score of 5 or more suggests depression. | |
| | **Total Score:** | |

**If positive, follow the depression management flowchart.**

Source: Yesavage JA, Brink TL, Rose TL, Lum O, Huang V, Adey MB, Leirer VO. Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research 17:* 37-49, 1983.

**Score >=5**
**DEPRESSED**

# FALL RISK ASSESSMENT

- Part -1
- History of Your Falls
- (Description of the fall)
- We need to hear the details of your falls so we can understand what is causing them. Answer the following questions about your last fall.

I. When was the fall?.....Date and Time of the day.....

II. What were you doing before you fell?

.....

III. Do you remember your fall, or did someone tell you about it?

.....

IV. How did you feel just before?

.....

V. How did you feel going down?

.....

# FALL RISK ASSESSMENT

VI. What part of your body hit?

.....

VII. What did it strike?

.....

VIII. What was injured?

.....

IX. Anything else you recall?

.....

# FALL RISK ASSESSMENT

X. Do you think you passed out?

.....

XI. Do you have joint pain?

.....

XII. Do you have joint instability?

.....

XIII. Do you have foot problems?

.....

XIV. Do you use a cane/walker?

.....

XV. How often have you fallen in the last six months?

.....

# 3 IQ: (Incontinence Questionnaire)

- Single question
- Do you have urinary leak problems since last 3 months?
- If answer is no then end questionnaire
- If answer is yes then 3 Questions to be asked
    1. FREQUENT TRIPS TO BATHROOM ?
    2. LEAKING URINE ON WAY TO BATHROOM?
    3. LEAKING DURING COUGHING/ LAUGHING ?
- IF yes then ask, then detail questionnaire to be asked

# CASE 1

- A 70 years old female who is a diagnosed case of Type 2 DM on OHA since 10 years, presented with complaints of lethargy, deceased sleep and appetite, confined to her room since last 5 months. The patient's son comments that she seems uninterested in participating in family activities and looks gloomy. Her physical examination and laboratory tests are otherwise unremarkable.

- What is your diagnosis?
- What screening tool can be used in OPD to screen such patients and their cut offs.

# CASE 2

- A 68 years old , female was not able to perform her activities well, for the past few months. She speaks only regional language and is unable to read and write. She works as a housemaid with the same family since 16 years but recently she forgets her way to work and often is found wandering.

- Which Scale is to be used here?

# CASE 3

- A 75 year old, multiparous female, with H/O Hysterectomy done 5 years back, came to Geriatric OPD with C/O chest pain and palpitations. On screening for incontinence, she gives H/O leaking of some drops of urine during coughing and laughing, occurring occasionally since last 6 months.

- What questions are to be asked for screening for incontinence ?
- What is the type of incontinence in this female patient?

# CASE 4

- A 70 year old female patient, known case of Cerebro-vascular accident with left hemiplegia since 1 year, is unable to perform bathing, dressing, toileting, transfer to chair or self feeding but her bowel and bladder is continent.

- Which scale will you apply in this scenario?
- What will be score of this patient?
- What is your interpretation?

# SUMMARY

- CGA is an assessment tool to help get best help for the elderly as soon as possible
- Consists of a CGA tool with 6 sections
- Initial 10 min screening done at sub centre level
- CGA forms –
  - Minicog and GP Cog – for dementia
  - GDS -4 and GDS- 15 – for depression
  - Fall risk assessment questionnaire
  - Questionnaire for Urinary Incontinence
  - Katz index - for Activities of daily living
  - Mini nutritional assessment

# Thank You