The power of carrying out a Comprehensive Geriatric Assessment (CGA): 5 Case Studies from across Wessex

The Wessex AHSN Healthy Ageing Comprehensive Geriatric Assessment (CGA) recommendation task and finish group identified 5 case studies of where a CGA was carried out in different settings, describing the holistic approach to their assessments; illustrating the importance of commencing, contributing and sharing an of assessment to provide person-centred care within geriatric and non-geriatric settings.

These case studies can be used an educational piece for local conservations to explore where the CGA has provided value to an individual. Additionally, these resources can be used to help describe the “compelling why” in implementing the Wessex wide CGA recommendations and to illustrate that CGAs are live documents and can be enacted within any setting and by any clinician.

The case studies provided are real world examples, names have been altered to maintain patient confidentiality.

Following the use of the Wessex wide CGA recommendations within your setting, if you have any case studies you would like to share to evidence the impact on local practice and person-centred care, please email healthyageing@wessexahsn.net and we will publish and share your insights.

The power of carrying out a Comprehensive Geriatric Assessment (CGA):
The impact on patient experience and outcomes in the community

Case Study 1: Elspeths' Story

"Elspeth, aged 86, was admitted to the hospital four times in seven months. Significant postural hypotension was causing her to fall. It was medically treated but still causing significant problems before her last discharge and on this admission, she had sustained lacerations and had been admitted for several days. The CGA process started on the Acute Medical Unit with a comprehensive multidisciplinary assessment. The postural drop was making some members of the multidisciplinary team feel that Elspeth was not safe to return home. Elspeth was desperate to get home to her two dogs. The comprehensive team approach, which put at the centre Elspeth's wishes, planned her discharge home with the urgent response team, additional equipment, and a follow up visit from a therapist.

Once settled at home, Elspeth was visited by an Advanced Clinical Practitioner from the hospital. The CGA process continued and identified that the planned endocrine appointment was causing Elspeth anxiety due to the need for a 24-hour urine collection requiring trips to the GP, so home collection was arranged, and the Advanced Clinical Practitioner checked that the planned falls monitor had been delivered. Elspeth was losing weight and nutritional supplements were discussed. Elspeth had been told to stop driving and was feeling isolated and lonely, so the Advanced Clinical Practitioner made a request on her behalf to the AgeUK befriending service.

Finally, the Advanced Clinical Practitioner contacted the community matron to discuss Elspeth's vulnerability and to request regular monitoring.

Elspeth had had no further falls or admissions 4 months later."

Pippa Collins, Clinical Doctoral Research Fellow & Advanced Clinical Practitioner in Frailty University of Southampton & University Hospital Southampton

Case Study 2: A perspective from the Physiotherapist in the community

" I saw a 83-year-old female retired teacher at home with her husband for a CGA following a referral from the rehab team regarding falls. She had, had 5-6 falls in the past year, all due to dizziness on standing with several syncopal episodes, and most likely related to orthostatic hypotension. She was not on any antihypertensives or culprit medications. She had significant symptomatic postural drop on assessment.

She had deteriorating cognition over the lockdown period with a MOCA of 6/30, increasing care needs and strain on husband, as his wife was reluctant to accept any formal carers. She had been diagnosed with Alzheimer's 4 years earlier and was attending Memory Café prior to lockdown. Referral made to OPMH to review sundowning, capacity and future plans around care needs, to support husband with Admiral Nurse.

A 24hr tape was arranged for completion, which was normal. GP asked to prescribe Fludrocortisone and husband able to assist with compression hosiery. The rehab team were visiting and able to follow up on monitoring postural blood pressures, with significant improvement and no further falls. The lady was already on bone protection.

As part of the CGA assessment, referrals made to continence service for pads, careline, care agency info sent and a discussion was held with the rehab team about strength and balance exercises and writing an AACP to try and avoid future hospital admissions unnecessarily with recurrent falls.

Recommendations of future planning discussions around power of attorney, resuscitation, future care needs and planning discussed. CGA process viewed as the link to all other services, with comprehensive assessment able to identify what was important to the couple and respectful of their wishes for the future.

John Frosdick, Advanced Practitioner Physiotherapist, Solent NHS Trust

The power of a Comprehensive Geriatric Assessment (CGA):
The impact on patient experience and outcomes in primary care and care homes

Case Study 3: Jim's story from a GPs perspective

"A 94-year-old gentleman moved into a nursing home in April 2021, as part of his initial assessment he had a modified CGA.
He had been living in sheltered housing but prior to his admission to the nursing home he had been admitted to the local acute hospital following a fall. He was then stepped down to the community hospital for rehabilitation. He was discharged back to his flat but unfortunately, he fell the same day and he was discharged from the community hospital so was readmitted to A&E and then back to the community hospital.

During his time in hospital his medications had been changed to liquids as his compliance had been poor and he said that he could not swallow them, and his levothyroxine dose was increased as his bloods suggested that he was under replaced.

Whilst completing the comprehensive geriatric assessment we explored his issues with regard to taking his medications and it became clear that he did not have any problems swallowing his tablets but instead that he did not see the point in taking any of his tablets and he did not feel that they were helping him. As part of the assessment, we then also discussed his mental health and established that his mood was very low and was part of the reason he did not take his tablets as he did not want to be alive anymore and he had been having suicidal thoughts since his wife passed away a few years before. He had also become much more sedentary as a result of his low mood as he couldn't motivate himself to get up and do things.

By the end of the assessment the patient expressed how helpful he found the process as he felt it showed that we were taking an interest in all aspects of his health and exploring his concerns, he stated that he did not feel that he had had the opportunity to do this before.
As a result of the CGA assessment we were able to rationalize his medications and change back to tablets educating him as to the importance of taking his levothyroxine. He agreed to starting an antidepressant which has helped his low mood and improved his compliance with his regular medications.
For this gentleman completing a CGA brought to light the ongoing issues with his mental health which had been having a significant impact on his physical health, overall wellbeing as well as his mobility and ability to undertake his activities of daily living."

Dr. Elizabeth Jones, Dorset GP, Weymouth and Portland Frailty Service, Two Harbours Healthcare

The power of carrying out a Comprehensive Geriatric Assessment (CGA):

The impact on housebound patients and their families

Case Study 4: Rose and her family's story

"I visited a patient, Rose, in March 2021, a 91-year-old lady, being cared for by her daughter and son in law since discharge from hospital in Jan 2020. After an initial CGA assessment, I identified her as to be living with severe frailty and kept on caseload with four weekly reviews.

Following the assessment, I made a referral to memory support due to high 6 item cognitive impairment test 6CIT (https://patient.info/doctor/six-item-cognitive-impairment-test-6cit) and to the local speech and language therapy team due to unsafe swallow.

Over a few months, she experienced rapid progression in cognition and functional decline; through active review of the assessment, I expedited the support from the memory assessment services.
I supported the family with 2-4 weekly visits or phone review, referring Rose to District Nurses who are involved in supporting the family 2-3 times a week due to extensive tissue necrosis and infection on sacrum. The tissue viability nurse is now involved with her care.

The family were keen for her to remain at home as this is where she wanted to be, they also declined external help from care agencies.

Dorset care plan in place for the lady to remain and die at home with anticipatory medications in place. The family feel supported and happy with plan."

Lesley Oakes, Frailty Nurse, Weymouth and Portland Frailty Service, Two Harbours Healthcare

The power of carrying out a Comprehensive Geriatric Assessment (CGA): **What matters to me, my family and involving the individual in care decisions**

Case Study 5: Peter's journey

"A 81-year-old gentleman, Peter was referred through the rehabilitation MDT due to a fall. He had experienced recurrent falls, due to trips, poor balance, and excessive alcohol intake over many years, but had worsened since wife was diagnosed with dementia. He was displaying low mood as he was struggling to adjust to wife's dementia diagnosis, and increased care demands on him. Does not feel he can leave her alone due to risk of wandering. He felt his main role was to be her carer, so had lost his social life and any hobbies.

He had a past medical history of hypertension, chronic kidney disease, asbestos related pleural plaques, and depression. Having discussed problems and his thoughts and wishes, he agreed to a referral for Admiral Nurse support, day centre/coffee morning/befriending for wife. I sent him information on steps to wellbeing counselling, as well as care booklet so daughter could arrange formal care package as self-funders. I arranged rehabilitation team input for strength and balance exercises and arranged DEXA scan to check bone mineral density due to alcohol and other risk factors.

I had a long discussion with him and his daughter regarding his low mood and his physical health. He had started drinking more alcohol than he should which was likely to be impacting on his health e.g. frequency of urination, mood, memory as well as maybe the cause of some of his falls. Peter was very tearful when discussing his wife's dementia and the impact this has had on day to day life and he was clearly in need of a change and some respite. Peter agreed for me to make some referrals for him to day centres and befriending for his wife, and I sent his daughter a booklet to help arrange a sitting service. I had a long discussion about his medication, and he described that he would rather try alternatives if possible. We agreed that he would try to put things in the calendar to give him something to look forward to such as going to the driving range or out for dinner. I gave him some exercises to work on his balance as he stated he would rather do them alone and I asked the rehabilitation team to call him in a couple of weeks to review this. I gave him a call within the month to monitor your low mood.

Peter attended the local emergency department a few weeks later, following a fall in the garden at home, when he was watering the plants in the garden, stood up, felt dizzy and fell. Had been drinking at the time. He fractured his fingers. I received a call from Emergency Department to Advanced Clinical Physiotherapist (ACP) to explain Peters' attendance. They could view my CGA on their electronic record, and I was able to discuss input for Peter. As the main carer for his wife with dementia, we were able to sort discharge home same day following a discussion with his daughter. Peter has reduced his alcohol intake by half, and family will support further reductions. A formal care package now in place each morning, with plans for further sitting service being arranged twice a week for wife to see hairdresser/nails at home, to allow patient respite whilst his wife was looked after."

John Frosdick, Advanced Practitioner Physiotherapist, Solent NHS Trust