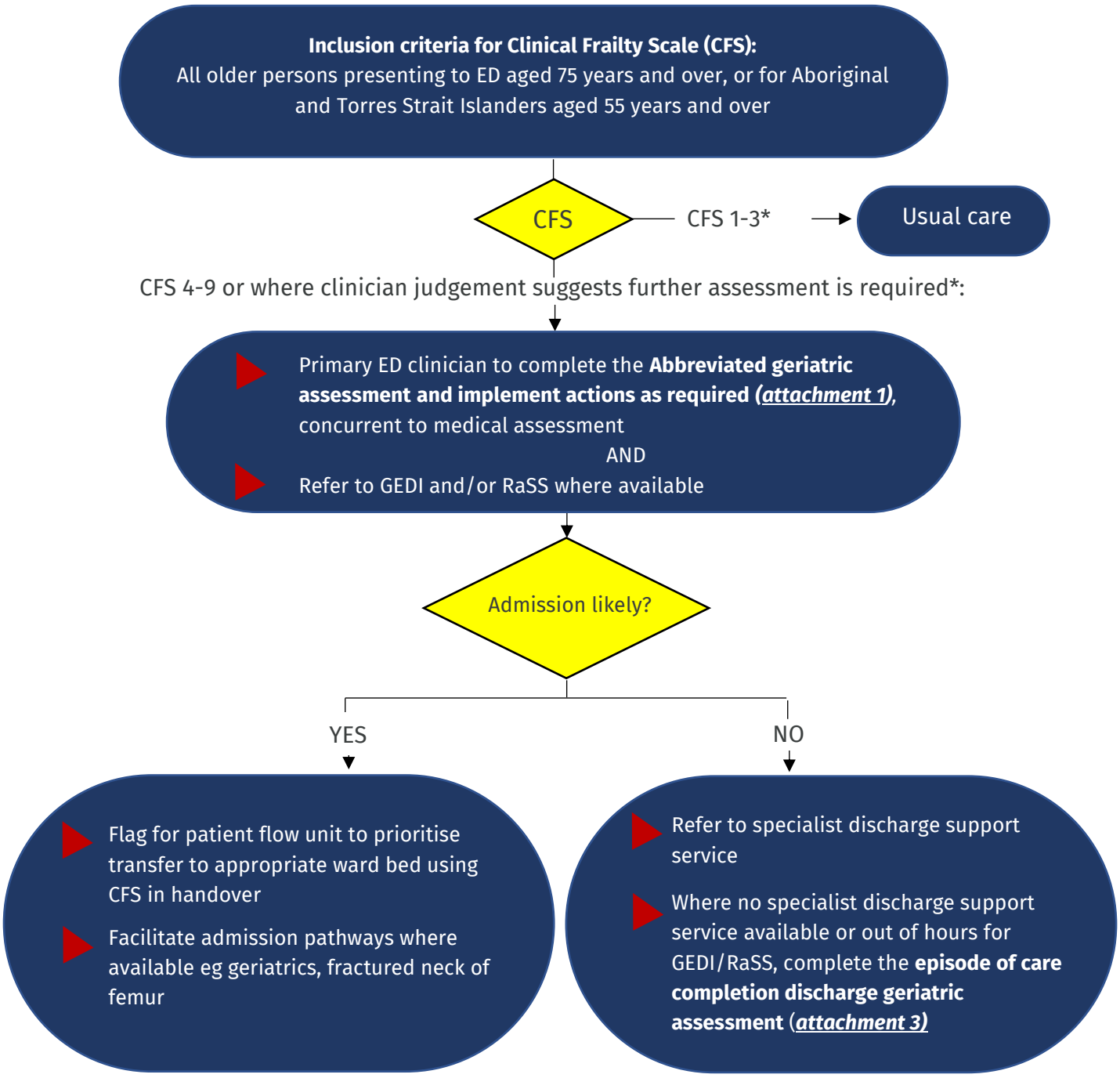
Queensland Health

Modified Comprehensive Geriatric Assessment

Older Persons presenting to Emergency Departments

Multidisciplinary ED team members to complete with older persons presenting to ED across the 24-hour spectrum



*Note: all older persons should receive care consistent with the Australasian College for Emergency Medicine policy for care of older persons.
It is important that, where no contra-indications exist, regular medications are administered in a timely manner.
Particular focus should be applied to TIMELY administration of regular medications for those with Parkinson's disease.

GEDI ED GERIATRIC ASSESSMENT

Note: Assessment done concurrently while supporting multidisciplinary primary care staff

Inclusion criteria for GEDI:

All older persons presenting to ED aged 75 years and over, or for Aboriginal and Torres Strait Islanders aged 55 years and over
WITH
A CFS 4-9 and or where clinician judgement suggests further assessment is required

The GEDI will:

1. Collect/access patient summary baseline information:
    a. Presentation information
    b. Medical history
    c. Medications list and management of medications (whether assistance is required to take medications or using webster pack)
    d. Patient goals of care
    e. Advance resuscitation plan or advance care plan availability
    f. Representation within 28 days
    g. Whether the patient is also a carer
    h. Community informal supports and / or formal approvals and adequacy of support

2. **AND** complete the **Brief geriatric assessment** (***attachment 2)*** in collaboration with the primary ED clinician completing the **Abbreviated geriatric assessment** (attachment 1), concurrent to medical assessment.

If Discharge is likely the GEDI completes the **Episode of care completion discharge geriatric assessment** ***(attachment 3).***

Attachment 1 – Abbreviated geriatric assessment

Domain	Assessment Tool	Actions
Delirium	4AT	**Positive for delirium:** **EARLY DISPOSITION DECISION and arrange timely transfer from the ED setting*** • Identify the cause **All frail older persons, cognitive impairment requires regular orientation, nutrition, toileting and the minimisation of tethers (IVC, IDC)**
Pressure injury identification	Skin integrity check	**All frail older persons are at risk of pressure injury** (Waterlow assessment does not add additional benefit in this population) **In all frail older persons,** use pressure injury prevention strategies including appropriate pressure relieving support surfaces and regular q2hrly turns if poor bed mobility **Where pressure injuries identified:** • Grade pressure injury • Document in Riskman
Cognition appropriate pain assessment	Numerical rating scale (NRS) and / or PAINAD	For pain that is >/= 4 on either NRS or PAINAD, ensure analgesia is offered Consider alternatives other than the use of opioids e.g. nerve blocks, heat packs, repositioning.
Oral food and fluid intake	N/A	Ensure the provision of texture modified diet and foods, where this is usual for the older person.
Falls risk	N/A	All frail older persons are considered to have a high falls risk • Ensure use of usual mobility aid • Accompany for at least the first mobilisation • Support regular toileting and nutrition

Attachment 2 – Brief geriatric assessment (in collaboration with the primary ED clinician completing the abbreviated geriatric assessment

Domain	Assessment tool	Actions
Repeat Delirium **if >2 hours since the ED 4AT and initial screen negative**	4AT	**Positive delirium:** *** EARLY DISPOSITION DECISION and arrange timely transfer from the ED setting*** • Identify the cause **Positive for new or existing cognitive impairment:** • Refer to GP or inpatient physician to undertake further cognitive assessment
Repeat pressure injury identification **if > 2 hours since ED assessment**	Skin integrity check	**All frail older persons are at risk of pressure injury** (Waterlow assessment does not add additional benefit in this population) **In all frail older persons,** use pressure injury prevention strategies including appropriate pressure relieving support surfaces and regular q2hrly turns if poor bed mobility; **Where pressure injuries identified:** • Grade pressure injury • Document in Riskman
Repeat cognition appropriate pain assessment **where required**	Numerical rating scale (NRS) and / or PAINAD	For pain that is >/=4 on either NRS or PAINAD, ensure analgesia is offered Consider alternatives other than the use of opioids e.g. nerve blocks, heat packs, repositioning.
Functional assessment	Mobility Transfers Showering/bathing	Patient or carer reported including baseline and current function Include aids and supports required
Elimination	Focus on new incontinence (urinary or faecal); dysuria; use of incontinence aids; last bowel motion	For new incontinence, dysuria or constipation, initiate assessment for underlying cause.
Caregiver burden (where relevant and where older person consents to contact of carer)	Is the older persons' carer feeling overwhelmed?	Where caregiver burden identified, review support services, respite care, social work review or admission

Attachment 3 - Episode of care completion discharge geriatric assessment

Domain	Assessment tool	Actions

Polypharmacy	Number of medications	• Refer for pharmacist review (community or ED) if:
		  ○ >10 medications
		  ○ >5 medications where presenting with a fall

Physical functional assessment	N/A	• Ensure the older person is able to able to mobilise and transfer to ensure ongoing care needs, with carer input if appropriate. • Refer to allied health team if new functional changes or clinician concerns.
Malnutrition screen	MST	• If positive MST consider referral to GP and / or dietitian for follow-up • If significant weight loss of recent onset, ensure medical assessment prior to discharge
Advance care plan	N/A	• Check Advance Care Directive, Advance Care Plan, Acute Resuscitation Plan or Enduring Power of Attorney documents have been uploaded to The Viewer. If not, confirm with older person that the wishes are current and seek consent to forward document(s) to the Office of Advance Care Planning, to have documents uploaded to The Viewer. • Where no Advance Care Plan exists, provide information pamphlet and suggest older person discuss further with GP if they wish to proceed.
Transport home	Assess transport needs	• Assess transport needs and ensure that transport suitable to functional and cognitive status is available
Discharge summary	N/A	• Ensure discharge summary (medical and specialist geriatric nursing) is given to the older person, GP and carer where relevant, and discharge instructions provided are understood.