

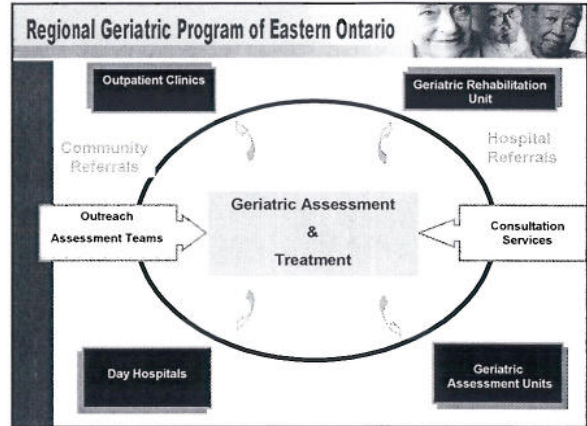


Regional Geriatric Program of Eastern Ontario
Programme gériatrique régional de l'Est de l'Ontario

Early Intervention the Key to Geriatric Assessment: Geriatric Assessment Outreach Teams

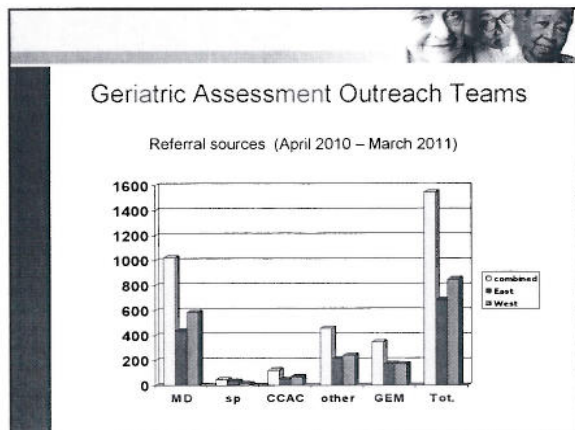


Geriatric Assessment Outreach Teams

- East GAOT: East of Bronson
- West GAOT: West of Bronson

Who we are

- Healthcare Professionals
- We visit people 65 and over in their home for a comprehensive assessment. (Bilingual/Cultural Interpretation)
- We accept referrals from physicians, relatives, healthcare professionals (GEM, CCAC...) and individuals themselves.
- Only one team member visits the person in their home.



Geriatric Outreach Assessment Team Members

Office Support

- Intake Co-ordinator

Assessors:

- Nurses
- Occupational Therapists
- Physiotherapists
- Social Workers

Clinical Consultant

- Geriatrician

Major Functions

- Entry point for referrals from the community to access Specialized Geriatric Services.
- Clinical teaching/training
- Education (Seniors and caregivers)
- Evaluation and research

Our Goal

- To help improve quality of life and to promote health, independence and safety in order to help seniors to remain in their own surroundings as comfortably and as long as possible.

What we Do

- Provide comprehensive multidimensional screening assessment
- Work with other health services, community agencies and Family Physician to **help keep seniors as independent as possible in the community for as long as possible.**
- Refer client for further assessment and treatment.

When to refer

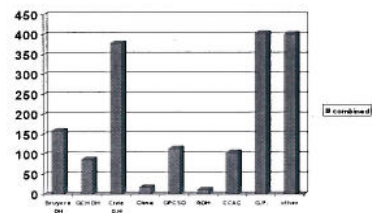
1. Recent onset of one or more of the "Geriatric Giants"
 - Cognitive Impairment
 - Falls
 - Incontinence
 - Impaired mobility
 - Decreased function
 - Polypharmacy
2. Major changes in support needs
3. Safety concerns
4. Frequent use of the health care system
5. Multiple complex medical problems


What to expect from the visit

- Multi-dimensional screening assessment incorporating aspects of physical, cognitive, psychosocial factors, functional abilities and environment.
- Consultation with Family Physician, Community Services, Family Members/Caregivers and others as needed.
- Case Conference with Geriatricians and Team Members
- Written Summary and Recommendations

Geriatric Assessment Outreach Teams

Post recommendations (April 2010 – March 2011):






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Case study #1 Mr. M.

Referral from Family Physician




Situation at time of referral

- 85 y.o. gentleman living with wife
- Supportive children in area
- Referred by family physician for assessment of function
- Client's concerns:
 - Mobility and balance
 - Tremors
 - Difficulty swallowing
- Wife and son's concerns:
 - 2 year decline in STM
 - Increased appetite and strong craving for sweets




Medical history:

- CVA & MI - previous year
- Bipolar disorder
- AAA
- Hip fractures
- Peptic ulcer disease
- Irregular heart beat




Medications:

- Lithium carbonate
- Vitamin B1
- ASA
- Calcium with Vit D




Issues identified during GAOT assessment:

- Cognition
- Behaviour
- Mobility
- Falls
- Tremors
- Swallowing difficulty
- Function



Recommendation from case conference:

- Geriatric Day Hospital




Geriatric Day Hospital

Seen by :

- Geriatrician
- Nurse
- Occupational therapist
- Physiotherapist
- Speech therapist
- Social Worker

Family conference prior to being discharged from Day Hospital.




Geriatric issues addressed:

Cognition:

- New diagnosis – Stroke dementia

Mobility and Fall risk:

- Severe gait and balance changes
- ADP papers completed – walker
- Exercise program provided
- Fall prevention strategies given
- Paratranspo application completed




Geriatric issues addressed (cont)

ADLs:

- Found to have fine motor strength and control issues
- Recommendations given re: equipment needs and cueing for hygiene routine and consistent, structured daily and weekly routines.

Swallowing changes:

- Swallowing assessment done/videofluoroscopy
- Found to have mild to moderate dysphagia
- New upper dentures recommended
- Softer chewable foods and regular liquids recommended





Geriatric issues addressed (cont)

Community Support and Future planning

- CCAC referral for weekly bathing and Day Program application
- Telephone number for Abbotsford House
- Recommendation for relocation
- List of retirement homes given to family
- Referral to Alzheimer Society's First Link Program

Safety


- Blister pack with monitoring
- Assistance with financial activities
- Post 911 by all phones
- Have upper denture replaced
- Follow swallowing guidelines

Case study #2


Mrs. D.

Referral from CCAC




Situation at time of referral

- 72 y.o. married woman
- Husband in hospital awaiting placement
- Son lives on 2nd floor of home in a separate apartment
- First language is Portuguese
- Referred by CCAC case manager for assessment of cognition, multiple medical problems, caregiver stress and risk
- Services in place: Help with bathing once per week
- She denied any problems. Focused on her husband.
- Son concerned about her mood.




Medical history

- Breast cancer
- Osteoarthritis
- Osteoporosis
- Right total hip replacement
- Fractured foot




Medication:

- Calcium
- Femara
- Zopiclone
- Lenoltec No. 1
- Lorazepam




Issues identified during GAOT assessment:

- Mood
- Cognition



Recommendations from case conference.



- Psychiatric consultation.
- Geriatrician suggested blood work and CT of head for family physician to consider.



Outcome


Psychiatric consultation:

- Diagnosed with Major depressive disorder with prominent anxiety symptoms.
- She was enrolled in the ROMHC day hospital
- A trial of Mirtazapine was started
- Follow up appointment was booked
- Geriatric psychiatrist planned to follow Mrs. D. until she had a good response to her antidepressant and her depression was in remission.




Case study #3 Mrs. X

Referral from Director of Care of a retirement home




Situation at time of referral

- 84 y.o. widowed woman
- Supportive brother and sister-in-law
- Living at a retirement home x2 months
- Referred by Director of care for assessment of Behaviour, Cognition, Mood, Function and Medication review. ???Need for Long term care
- Brother and s-i-l's concerns: Mood and Cognition
- Mrs. X.'s concerns: Unable to identify




Medical history:

- Stroke
- Atrial fibrillation
- CAD with chest pain at night when off the Nitro patch
- Hypertension
- "Dementia"
- Recent UTIs
- OA
- OP
- GERD
- Diverticulosis
- Zenker's diverticulum
- Left mastectomy




Medication

- Haloperidol
- Lorazepam
- Trazodone (PRN)
- Aricept
- ASA
- Norvasc
- Metoprolol
- Nitro-Dur patch
- Nitro spray (PRN)
- Omeprazole
- Domperidone
- Acetaminophen (PRN)
- Ibuprofen (PRN)




Issues identified during GAOT assessment

- Behaviour
- Mood
- Function
- Cognition
- Weight loss
- Tremor
- Pain
- Falls/mobility
- Fatigue
- Future planning




Recommendation from case conference

- Geriatric Day Hospital for assessment of possible delirium, possible depression and medication review.



Geriatric Day Hospital

At first visit to the Day Hospital it was determined that her presentation was too complex to sort out on an out-patient basis therefore an admission to the In-Patient geriatric assessment unit was arranged within the next week.




Issues addressed by GAU (In-patient)

- Cognition
- Mood
- Cardiac status
- Mobility

Plan at discharge:


- Follow up with Geriatric Psychiatry as out-patient



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Case study #4 Mrs. L.

Referral from GEM




Current situation

- 72 year old woman with MS living in a retirement home
- Has assistance with the majority of her IADL's from staff.
- Presented at the ER following a fall transferring from chair to wheelchair and sustained a injury to her right shoulder.
- Issues identified by GEM:
 - Pain
 - Falls and Mobility
 - Polypharmacy
- Concerns identified by Mrs. L.: None
- Concerns identified by her daughter: Cognitive changes and possible side effect to Nitro-patch (now discontinued)




Current situation (cont)

- **Formal Supports:**
 - Assistance by staff for a.m and p.m care (ADL's)
 - Physiotherapy through the retirement home
 - Dependent for most IADL's
- **Informal Supports:** 2 sons and a daughter living locally and involved.
- **ER x 2 in the last 12 months:**
 - Diaphoresis
 - A fall
- **One admission in the last 12 months to the Heart Institute for a myocardial infarct**




Medical Hx

- Diagnosis of Multiple Sclerosis (x10 years)
- Diabetes – NIDDM
- Two previous MI's (recent admission to the Heart Institute).
- Peptic ulcer Disease.
- Chron's Disease
- Osteoarthritis
- Vitamin B12 deficiency
- Appendectomy, tonsillectomy and cholecystectomy.




Medications

- Omeprazole
- Folic Acid
- Entrophen
- Nicoderm patch
- Glyburide
- Plavix
- Vitalux
- Vit B12 injections
- Acetaminophen
- Carbamazepine
- Loperamide
- Metformin
- Slazopyrin
- Calcium
- Metoprolol
- Vasotec
- Vit D
- Atorvastatin
- Trazodone
- Nitro spray
- Acetaminophen with codeine
- Statex




Issues identified during GAOT assessment

- Cognition/?resolving delirium
- Mobility/falls
- Pain
- Polypharmacy




GAOT Recommendation

- Geriatric Day Hospital




Geriatric Day Hospital

- Review of information provided in the GAOT assessment.
- Impression: Probability of some component of delirium now resolved (one month later). Acknowledgment of pre-existing cognitive problems.
- Review by Occupational Therapy (Cognition and function) and Physiotherapy
- Review of medications and lab work ordered.




Outcomes from Civic Day Hospital

- New diagnosis of dementia: Likely etiology is mixed Alzheimer's and vascular dementia.
- Severe gait and balance changes. Advised to use walker at all times.
- Recommended decreased ETOH intake
- Seen by the Pharmacist and medications reviewed and recommendations made.
- Recommendations made re: pain control.
- Hemoglobin was 98. MCV was 103. B12, thyroid and folate all normal. Recommended GP follow this. ?Reticulocytosis. May require a hematology consult in future.



Feedback to the Client and Caregivers

- At increased risk of falls due to decline in memory and planning skills and severe gait and balance changes.
- Recommend a regular toileting schedule throughout the day.
- Consistency in daily and weekly routines.
- No specific pathology for the right shoulder pain was found.
- Installation of a superpole in the living room area
- Continued participation in regular PT



Summary

Key Messages:

- Ask WHY?
- Early identification leads to early intervention/ treatment (reversibility)
- Potential delay/avoidance of placement (LTC) or relocation.
- Decrease in hospital utilization (ED visits and hospital admissions).
- Ensuring that caregivers know what they are dealing with (facing) and what to expect in the future so that they know where to get the necessary supports for themselves and their loved ones preventing crisis situations.



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