Comprehensive Geriatric Assessment

Part -1

For CHO/SN

LEARNING OBJECTIVES

By the end of the Session participants will

- Describe the Components/Domains that come under Comprehensive Geriatric Assessment

- Practice using the Comprehensive Geriatric Assessment (CGA).

- Discuss the role of CHO/SN MPW (M/F) and ASHA in CGA.

VIDEO –WHO INTEGRATED CARE

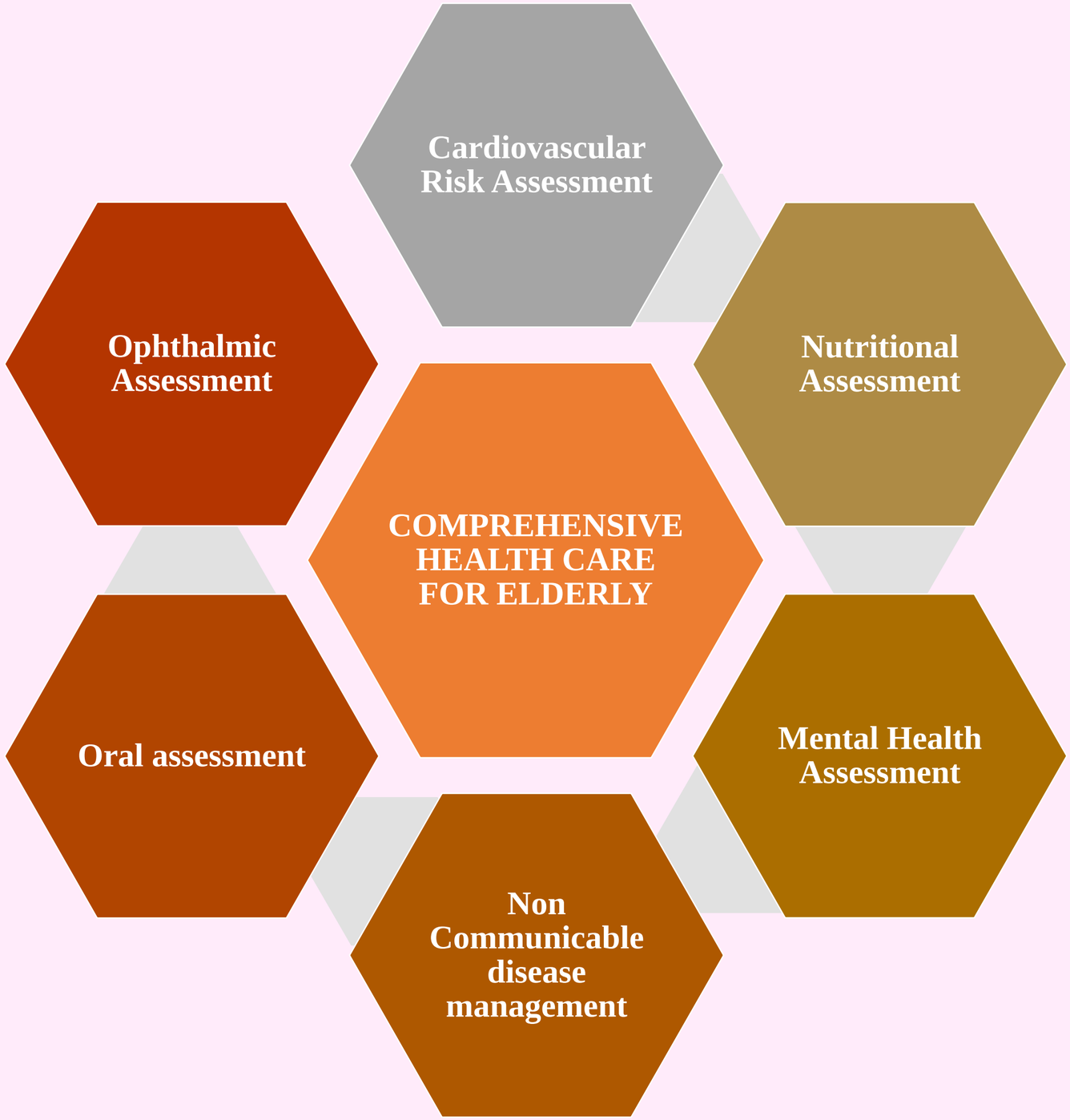
https://youtu.be/q2SdjlFQn3I

COMPREHENSIVE GERIATRIC ASSESSMENT (CGA)

- CGA is a multi-disciplinary process where the information captured is used as a basis to plan care and treatment.

- It includes short term and long-term goals, follow up and rehabilitative services.

- CGA has 6 Sections to be completed by MPW, CHO, MO/Specialist


Cardiovascular Risk Assessment
Ophthalmic Assessment
Nutritional Assessment
COMPREHENSIVE HEALTH CARE FOR ELDERLY
Oral assessment
Mental Health Assessment
Non Communicable disease management

ASHA identifies any elderly in need of further assessment if the answer to any of the questions in Part B3 of the CBAC is 'Yes', and informs MPW(F/M).

MPW(F/M) conducts section 1 and 2 CGA-CPHC of these identified elderly individuals which includeschief complaint, past medical history, drug history, consumption of addictive substance, nutritional history, family history, social & spiritual history, personal history, home safety environment and informs CHO.

CHO conducts session 3 and 4 of CGA-CPHC of the identified elderly individuals which includes screening for geriatric syndromes, screening for other age related problems, functional assessment, general examination systemic examination. If required, CHO refers the individual to Medical Officer for detailed assessment.

Medical Officer conducts section 5 of CGA-CPHC detailed assessment of referred elderly individuals. if the individual has greater than 3 red flags.

If the individual presents to the PHC directly, **Staff Nurse** will conduct facility-based CGA and refer to the Medical Officer.

RISK ASSESSMENT: ROLE OF ASHA

- Completion of Community based assessment checklist (CBAC) for all the elderly for each village in the SHC-HWC area will be done by ASHA.

- The section B3 is specific to the elderly. (persons 60 years and above)

SECTION B3 OF CBAC:

B3: Elderly Specific *(60 years and above)*	Y/N	B3: Elderly Specific *(60 years and above)*	Y/N
Do you feel unsteady while standing or walking?		Do you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?	
Are you suffering from any physical disability that restricts your movement?		Do you forget names of your near ones or your own home address?	
Note: A “YES” in any of the questions mean the ASHA must refer person to MPW			

COMPREHENSIVE GERIATRIC ASSESSMENT: WHO DOES WHAT ?

ASHA- identifies any elderly person in need of comprehensive assessment if the answer to any of the questions in Part B3 of the CBAC is '**Yes**

MPW (M/F)- preliminary assessment using Section 1 and 2 of the Comprehensive Geriatric Assessment (CGA) on these identified elderly individuals

CHO- **assesses using Section 3 and 4 of the** Comprehensive Geriatric Assessment (CGA)

<u>MO/Specialist : If required</u>- CHO refers elderly individuals to the Medical Officer or Specialist who uses **Section 5** of the CGA and required tests for further assessments

Overview of Components of CPHC-CGA		
Section	**Contents under each section**	**Person Responsible for each section**
Section 1: Basic details	A. Registration details B. Identification data of elderly person	MPW(M/F)
Section 2: History taking	A. Chief complaints B. Details of complaints C. Past medical history D. Drug history E. Consumption of addictive substance F. Nutritional history G. Family history H. Social & spiritual history I. Personal history J. Home safety environment	MPW(M/F)
Section 3: 10 Minute comprehensive screening	A. Screening for geriatric syndromes B. Screening for other age-related problems C. Functional assessment	CHO or SN at PHC
Section 4: physical examination	A. General examination B. Systemic examination	CHO or SN at PHC
Section 5: Syndromic specific toolkit for assessment of the problem identified in section 3	A. Memory loss B. Screening for cognitive impairment C. Screening for depression D. Fall risk evaluation E. Incontinence assessment & management guide	MO at PHC
Section 6: Comprehensive Geriatric Assessment Report		CHO or SN/MO at PHC

COMPREHENSIVE GERIATRIC ASSESSMENT TOOLKIT

Section I – (To be filled by MPW-F/M)

A. Registration details
   - The date of first assessment, name, designation and contact details of assessor

B. Identification data of elderly person
   - Identification of elderly including education, financial status of the elderly and family, health insurance benefits

Section II: History Taking (To be filled by MPW-F/M)

A. Chief complaints including detailed collection of complaints concerning eye, ear, nose, throat, cardiovascular, gastrointestinal, genitourinary, skin, neurological, musculoskeletal, gynecological.
B. Details of Complaint

C. Past Medical history

- Duration of illness, current medication with dosage, verified through records including completion of treatment.

D. Drug history

- Current medication history including over the counter medications history, drug side effects, medicines other than allopathy .

E. Consumption of addictive substances

- Type, duration and the extent of addiction by updating the quantity consumed on daily, weekly and monthly basis and duration since last consumption.

F. Nutritional history

- Decline in food intake and weight loss over past 3 months, mobility, psychological stress, neurological problems, BMI, calf circumference which are to be categorized as malnourished, risk for malnourishment and normal nutritional status.

G. Family history

- Details of illness that the family members are undertaking treatment.

H. Social and spiritual assessment

- Sociodemographic and Spiritual details including type of house, place of worships and information regarding meditation.

I. Personal history

- Habits, frequency of exercise and care giver fatigue details

J. Home safety environment

- This includes trouble with lighting or stairs inside and outside the house, condition of bathroom floor, ramp at home or elderly using wheelchair and walking aids, handrails in staircase and bathroom and the provision of care giver at home.

SECTION 3

A: Screening for geriatric syndromes

- An elderly undergoes screening for depression, risk of falls, urinary incontinence and memory recall

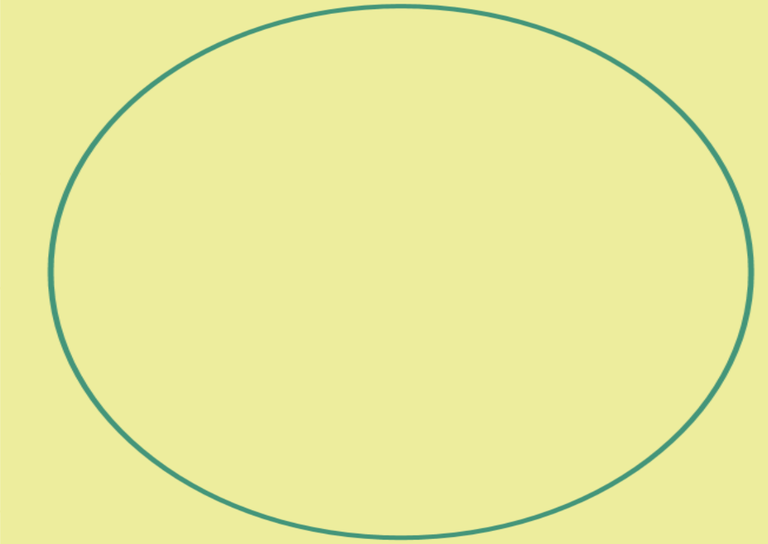
B. Screen for other age-related problems

- CHO undertakes the screening with respect to vision, hearing, change in weight, constipation and insomnia.

C. Functional Assessment

- An elderly will be assessed based on assessment tool on activities of daily living and categorizing into dependent and independent patients.

Section 3: 10-minute Comprehensive Screening : A: Screening for Geriatric Syndromes

*Memory	3 Objects named	Yes	No	Clock Draw Test	
DEPRESSION (if yes to the question proceed to the Depression Management toolkit at section 5c)	Are you often sad/ depressed?	Yes	No		
FALLS (if yes to first question and not able to walk around chair/if unsteady proceed to fall risk assessment toolkit at section 5d)	Fallen more than twice in last 1 year	Yes	No		
	Able to walk around chair? (Check if unsteady)	Yes	No		
URINARY INCONTINENCE (if yes to any one of the above questions, proceed to toolkit on management of Urinary incontinence at section 5e)	Lost urine/got wet in past one year/ week?	Yes	No		
*MEMORY RECALL	One object	Two objects	Three objects	None	
MiniCog Score					

B. Screening for other age- related problems:

Vision	**Ask:“ Do you have Vision difficulty reading using - Snellen’s/ or doing any of Finger Counting your daily activities because of your eyesight?" (even with wearing glasses)**	**If, Yes, Test**	**Right eye**	**Left eye**	**If visual impairment present, refer to medical officer/specialist for further assessment**
Hearing		Right ear	Left ear	If hearing
6,1,9 test (Stand behind the patient	Normally			impairment present, refer
and speak softly and then in normal voice - 6,1, 9 and check for hearing)	Softly			to medical officer/specialist for further assessment
Have you noticed a change in your weight over the past 6 months?	Yes	No	If YES, Increase= -----kg or Decrease =----kg	
Constipation		Yes	No	Refer to medical
Insomnia		Yes	No	officer for further assessment

COMPREHENSIVE GERIATRIC ASSESSMENT: FUNCTION ASSESSMENT

- Quality of life of elderly are the ability in evaluating Activity of Daily Living (ADL) performance.
- ADL refers to activities oriented toward taking care of one's own body.
- These activities are fundamental to living in a social world; they enable basic survival and well-being, such as bathing, toileting, dressing and eating.
- Score 6 = High (patient independent)
- Score 0 = Low (patient very dependent)

Section C: Functional Assessment: Assessment tool for Activity of Daily Living

Activities Points (0 or 1)	Independence (1 point) NO supervision, direction or personal assistance	Dependence (0 point) WITH supervision, direction, personal assistance or total care
Bathing	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Needs help with bathing more than one part of the body, getting in or out
Dressing	(1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
Toileting	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode
Transferring	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
Continence	(1 POINT) Exercises complete selfcontrol over urination and defecation	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
Feeding	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding

TOTAL POINTS = _____ 6 = High (patient independent) 0 = Low (patient very dependent)

COMPREHENSIVE GERIATRIC ASSESSMENT

Section 4: Physical Examination

A. General Examination

B. Head to toe Examination

C. Systemic Examination

D. Current Treatment Details

COMPREHENSIVE GERIATRIC ASSESSMENT- PHYSICAL EXAMINATION

General Instructions:

- Make the elderly subject lie down or sit on a chair.
- Make a preliminary examination of the general appearance of the elderly
- Possibly all physical measurements should be conducted in a private area.
- Prior to taking physical measurements, explain that you will be taking the measurements.
- Physical examination should focus more on specific diseases or conditions for which any curative, restorative, palliative or preventive treatment may be available.
- During home visit, detailed geriatric assessment must be made.

COMPREHENSIVE GERIATRIC ASSESSMENT- GENERAL EXAMINATION

A. General Examination:

- Measurement of weight:
- Ask the elderly to remove their footwear
- Instruct him/her to step on to scale with one foot on each side of the scale and to stand still, face forward, place his/her arms on the side and wait until asked to step off.
- Record the weight in kilograms to one decimal point.
- In case the person is bedridden or unable to stand up then skip weight Measurement.

COMPREHENSIVE GERIATRIC ASSESSMENT- GENERAL EXAMINATION

<u>Measurement of height:</u>

In standing position (using a stadiometer):

- The elderly person should be instructed to remove footwear and head gear.
- Inform about the procedure.
- Instruct the elderly to stand on the footboard facing the healthcare worker.
- Ask elderly to stand with feet together, heels, buttocks and upper back against the vertical backboard, knees straight and arms hanging free by the side.
- Instruct elderly person to look straight ahead.
- Move the head rest of the stadiometer gently down onto the head of the subject.

COMPREHENSIVE GERIATRIC ASSESSMENT- GENERAL EXAMINATION

Recumbent length

- The elderly person to lie in supine position on hard mattress.
- Instruct the person to look upwards, and place one cardboard against the top of the head. Keep the right leg aligned with the elderly person's hip. Keep another cardboard touching the sole of the elderly person's foot. Ensure that the toes of the foot are pointing straight towards the ceiling.
- If the person is unable to straighten both his legs or if the ankle joint is not in correct position, manually assist him/her
- Measure the length (in cm) of the person in this position by keeping one end of the measuring tape on the inner side of the cardboard placed on the head and the other end of the tape touching the inner surface of the cardboard placed at the foot.

COMPREHENSIVE GERIATRIC ASSESSMENT- GENERAL EXAMINATION

Measurement of body temperature (using automated thermometer):

- Switch the ON button on thermometer and place in the armpit.
- Remove the thermometer on hearing the beeping sound after 1 minute and check reading.

Measurement of respiratory rate:

- Simultaneously record the respiratory rate while measuring blood pressure/pulse rate.
- Make sure the elderly subject is comfortable.
- Observe the rise and fall of the chest- this counts as one breath.
- Count the number of breaths for an entire minute.

COMPREHENSIVE GERIATRIC ASSESSMENT- GENERAL EXAMINATION

Measurement of blood pressure (using automatic blood pressure monitor):

- Place the right arm of the elderly person on the table with the palm facing upward.
- Remove or roll up clothing on the arm.
- Position the cuff above the elbow aligning the rubber tubing of the cuff with the inner part of the elbow (where brachial artery pulsation can be felt).
- Wrap the cuff comfortably on to the arm and securely fasten with the Velcro.

COMPREHENSIVE GERIATRIC ASSESSMENT- GENERAL EXAMINATION

- Note: The lower edge of the cuff should be placed 1.2 to 2.5 cm above the inner side of the elbow joint.
- Keep the level of the cuff at the same level as the heart during measurement.
- Press the START button to measure the blood pressure.

Measurement of pulse rate (using automated blood pressure monitor):

- Record the pulse rate while measuring blood pressure

COMPREHENSIVE GERIATRIC ASSESSMENT- GENERAL EXAMINATION

Measurement of waist circumference

- Measurement should be done at the end of a normal expiration.
- Ask the person to relax his/her arms at the sides and measure the waist circumference at the level of the midpoint between the lower part of the last rib and the top of the hip.

Measurement of hip circumference

- To remove clothing except for the undergarments.
- Tight clothing and belts should be loosened and the pockets should be emptied.
- Tape should be placed around the point with the maximum circumference over the buttocks.
- The person should stand with his/her feet placed close together and measurement should be taken at the end of a normal expiration

COMPREHENSIVE GERIATRIC ASSESSMENT: HEAD TO TOE EXAMINATION

B. Head to toe Examination

Aspects to be examined	Findings (tick wherever applicable)
Level of consciousness	Alert-oriented-cooperative
Build	Thin/average/large
Stature	Small/average/tall
Nutrition	Undernourished/average/obese
Facial Appearance	Absence of wrinkling of forehead/deviation of angle mouth
Hair	Loss of hair Colour of hair-white/grey/brownish discolouration
Eyes	Drooping of eyelids Pallor Yellow discolouration (of sclera) Bitot's spots Cataract

Mouth	**Dryness of lips** **Soreness in angle of mouth** **Dryness of tongue** **Ulcer in mouth/tongue** **Presence/absence of teeth** **Staining of teeth** **Swelling/bleeding from gums** **Any growth seen in mouth** **Pallor/bluish discolouration (of tongue and lips)**
Neck	Swelling
Chest	Abnormal shape of chest Fats breathing (respiratory rate, 20/minute)
Abdomen	Distension of abdomen Change in shape of abdomen
Hands and nails	Change in shape of nails, pallor (nails and palms)
Feet and toes	**Bow legs/knocked knees/claw foot**
Skin	Yellowish discoloration Dryness Any change in colour of skin Any growth on skin
Any obvious deformity (of skull, spine, limbs or swelling of abdomen/feet/face/entire body)	

COMPREHENSIVE GERIATRIC ASSESSMENT: SYSTEMIC EXAMINATION

C. Systemic Examination

	What to look for?	Description
Joints	1. Redness 2. Swelling 3. Degree of movements 4. Increased local temperature 5. Tenderness	
Cervical Spine	1. Pain 2. Stiffness 3. Tenderness	
Thoracic Spine	1. Curvature 2. Scars 3. Discolorations	

Lumbar spine RS	1. Respiratory rate 2. Respiratory rhythm Palpate the following: a. Size and shape of the thorax during respirations b. Intercostal spaces (for bulging or retractions) c. Any scars or other skin abnormalities (skin temperature as well) d. Tenderness or pain (palpate gently) e. Breath sounds (normal/abnormal-adventious sounds)			
CVS	a. Chest Pain b. S1/S2 c. Murmurs d. Palpitation			
P/A	a. Shape b. Position of umbilicus c. Dilated veins			
Neurological examination				
			Right	**Left**
Muscle strength	Upper limb	Shoulder		
		Elbow		
		Wrist		
		Small muscles of hand		
	Lower limb	Hip		
		Knee		
		Ankle		
Tone	Rigidity/Hypotonia/ Spasticity	Describe		
Balance	**Normal/Abnormal**	**Sensory**	**Cerebellar**	**Vestibular**
Gait				
Timed Up and Go test (secs)				

COMPREHENSIVE GERIATRIC ASSESSMENT:

D. Current Treatment Details:

[Document all prescription and nonprescription drugs including over the counter medications and alternative medications]

Drug with dose and schedule		Drug with dose and schedule	
1. **3.** **5.** **7.** **9.**	2. 4. 6. 8. 10.		
Polypharmacy (any use of >4 drugs including over the counter drugs and alternative medicines)		YES	NO

Section 5 – Syndrome specific Toolkit for assessment of the problems identified during section3

Assessment for:

- Memory
- Cognition (GPCOG)
- Depression (GDS)
- Fall
- Incontinence
- Elderly abuse (EASI)

Section 6: Comprehensive Geriatric Assessment Report

Acute Illness
Comorbidity
Geriatric Giants/Syndromes
Other age-related problem
Social problems
Economic problems
Suggested Prescription modification

NUTRITION ASSESSMENT SCALE

Screening	
A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? 1. = severe decrease in food intake 2. = moderate decrease in food intake 3. = no decrease in food intake	
B. Weight loss during the last 3 months 1. = weight loss greater than 3 kg (6.6 lbs) 2. = does not know 3. = weight loss between 1 and 3 kg (2.2 and 6.6) 4. = no weight loss	

C. Mobility

1. = bed or chair bound

2. = able to get out of bed / chair but does not go out

3. = goes out

D. Has suffered psychological stress or acute disease in the past 3 month?

0 = yes

2 = no

E. Neuropsychological problems

1. = severe dementia or depression

2. = mild dementia

3. = no psychological problems

F. 1 Body Mass Index (BMI) (weight in kg) / (height in m)^2

1. = BMI less than 19

2. = BMI 19 to less than 21

3. = BMI 21 to less than 23

4. = BMI 23 or greater

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1WITH QUESTION F2. DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in cm

0 = CC less than 31

3 = CC 31 or greater

Screening score (max. 14 points)

12-14 points: **Normal nutritional status**

8-11 points: **t risk of malnutrition**

0-7 points: **Malnourished**

COMPREHENSIVE GERIATRIC ASSESSMENT: ELDERLY ABUSE

- Elderly abuse can be defined as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person".
- Elder abuse may happen in various forms like financial, physical, psychological and sexual.
- Abuse is suspected with the standard questionnaire “EASI- Elderly Abuse Suspicion Index”

Caregiver & Elderly abuse assessment
Part 1: Caregiver abuse assessment

(to be administered to elderly person's caregiver)

Please answer the following questions as a helper or caregiver:
(fill the name of the elderly person in the blank spaces)

1	**Do you sometimes have trouble making control his/her temper of aggression?**	**Yes/No**
2	Do you often feel you are being forced to at out of character or do things you feel bad about?	Yes/No
3	Do you find it difficult to manage ('s) behavior?	Yes/No
4	Do you sometimes feel that you are forced to be rough with?	Yes/No

5	**Do you sometimes feel you cant do what is really necessary or what should be done for?**	**Yes/No**
6	Do you often feel you have to reject or ignore?	Yes/No
7	Do you often feel so tired and exhausted that you cannot control meet (‘s) needs?	Yes/No
8	Do you often feel you have to yell at?	Yes/No
Total Score		

A score of even 1 is indicative of abuse and a score greater than 4 is suggestive of a higher risk of being abused

EASI (ELDERLY ABUSE SUSPICION INDEX) :

1. Has anyone tried to force you to sign papers or to use your money against your will? -1. Yes 2. No 3. Did Not Answer

2. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? -1. Yes 2. No 3. Did Not Answer

3. Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months? - 1. Yes 2. No 3. Not sure

4. Has anyone tried to force you to sign papers or to use your money against your will? -1. Yes 2. No 3. Did Not Answer

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? -1. Yes 2. No 3. Did Not Answer

6. Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months? - 1. Yes 2. No 3. Not sure

Note:

Q.1-Q.5 : asked of patient;

Q.6 : answered by doctor (within last 12 months)

While all six questions should be asked, a response of “yes” one or more of questions 2-6 may establish concern

ACTIVITY

- Participants to be divided in 3 groups
- Each group will be allotted a Case- Study

  Group-1 : Nutritional Assessment- Raju's Story

  Group-2 : Assessment tool for ADL- Lovisha's Story

  Group-3 : Caregiver & Elderly Abuse- Malti's Story
- The group will discuss the case- study and practice to fill the Form
- Each group will find the Score and suggest Action
- Group leader will present in plenary- Time: 5 minutes

GROUP 1 - Nutritional Assessment – Raju's story

Raju, a 70 year old man was brought by the community to the Health and Wellness clinic on a stretcher. He had gone to the well to collect water and had fallen on the way. His right leg and body was in pain.

Three months later, after a hip replacement he was back home. ASHA goes on a house visit to meet him. She finds him lying alone in a corner floor mat. ASHA notices that he has lost weight and his clothes are torn. She noticed that his plate of food (rice and greens) was still on the floor, untouched, next to him. It was 3pm. She did not see any water nearby.

GROUP 1 - Nutritional Assessment – Raju's story

Raju smiled at seeing ASHA. Just then Raju's son barged in from outside and said, " Once again your pension is late. Such a burden you are." The son stopped on seeing ASHA. He left the room.

Raju smiled silently at ASHA. When he is alone, Raju shares, "Can you imagine, it was my son that pushed me and that's how I fell and broke my hip!" He gets angry very often. But he is my son. I still love him. He will be happy when my pension comes."

ASHA calculated his BMI to be 17 kg/m2. **He said that he knows he has got thinner but does not know how much weight he has lost. His eating has been very less. He say it is because he is mostly in the bed after the fall.**

Group 2-Activities of Daily Living– Lovisha’s Story

- 70 years old Lovisha is staying with husband Ramesh and has a domestic help Indrani in the family. She gets up early in morning where Indrani takes her on a wheelchair to the toilet where she can clean herself and then Indrani brings her back . then she takes her for bathing . She is not able to get her clothes from closets and Indrani helps her in changing her clothes and taking bath too as she can't clean herself. She feels bad about not being able to move in and out of the bed without help but Indrani says" it is good that you at least have complete control over urination and defecation , moreover you can eat yourself from your own plate without my help and I am always there to cook for your family" .
- Calculate the ADL score of Lovisha

Group- 3: Caregiver & Elderly Abuse- Malti's Story

Malti is 76 years of age and lives in Rampur village with her son Ramu and his family. She lost her husband 5 years back and since then she feels quite lonely. Ramu goes to city daily for his work and returns back late in the evening. While asked regarding his mother's health Ramu revealed that for last one rear she is behaving different, often forgets the things and does not take medicines properly. It is being increasingly difficult for him to look her after. Sometimes he feels that he should ignore her and also feels like yelling at her for her behavior. He also told that he often feels tired to meet her needs and can not do what is really necessary for her due to his own problems

Group- 3: Caregiver & Elderly Abuse- Malti's Story

While being assessed for any abuse Malti answered that she loves her son and always relies on her family and gets everything what she desires. Sometimes her son's wife comments that she is a burden on her family. She does not have any money or property and not afraid of anyone, everyone in the family loves her. Doctor notices some malnourishment and medicine compliance issues.

1- Is there any abuse in Malti's case ?

2- Suggested action?

EVALUATION

- **Fill in the Blanks:**

1. Comprehensive geriatric assessment (CGA) is a multi-disciplinary process where the information captured is used as a basis to plan _____ and _____.

2. Completion of CBAC for all the elderly for each village in the SHC-HWC area will be done by the _____.

3. Preliminary assessments of these identified elderly individuals will be done by _____.

4. Name four "**Geriatric Giants**"

a. _____.

b. _____.

c. _____.

d. _____.

EVALUATION

- **Fill in the Blanks:**

1. Comprehensive geriatric assessment (CGA) is a multi-disciplinary process where the information captured is used as a basis to plan care and treatment.

2. Completion of CBAC for all the elderly for each village in the SHC-HWC area will be done by the ASHA.

3. Preliminary assessments of these identified elderly individuals will be done by MPW (M/F).

4. Name four "**Geriatric Giants**"

a. Immobility

b. Instability

c. Incontinence

d. Impairment of Intellect

EVALUATION

State TRUE or FALSE:

1. Elderly individuals who need specialized management will be referred to the Medical Officer or Specialist by CHO.

2. For symptoms and signs which are suggestive of cardiovascular disease MPW will measure BP and RBS.

3. A score of 6 points in Assessment tool for ADL suggests that the person is ‘Independent’.

4. Measurement of Blood Haemoglobin is not needed in addition to Mini Nutritional Assessment Scale (MNA) to correlate with the Nutritional status.

EVALUATION

State TRUE or FALSE:

1. Elderly individuals who need specialized management will be referred to the Medical Officer or Specialist by CHO. TRUE

2. For symptoms and signs which are suggestive of cardiovascular disease MPW will measure BP and RBS. TRUE

3. A score of 6 in Assessment tool for ADL suggests that the person is ‘Independent’. TRUE

4. Measurement of Blood Haemoglobin is not needed in addition to Mini Nutritional Assessment Scale (MNA) to correlate with the Nutritional status. FALSE

Thank You