

A guide for assessing  
older people in hospitals

# Quick Guide

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## What is comprehensive assessment? (Section 3.1)

### Key points

- 3.1.1 Comprehensive Assessment is the detailed evaluation and/or measurement of health status that leads directly to diagnostic conclusions and assignment to interventions strategies.
- 3.1.2 Comprehensive Assessment is an interdisciplinary multidimensional process that includes medical health as well as physical, social and psychological functioning.

## Why should older people in hospital be assessed? (Section 3.2)

### Key points

- 3.2.1 Comprehensive Assessment leads to improved diagnostic accuracy and effectiveness of interventions.
- 3.2.2 Comprehensive Assessment leads to other improved patient outcomes, including:
  - reduced medication use
  - improved functioning or reduction in functional decline
  - improved quality of life and mental health
  - improved client/carer satisfaction and a reduction in carer burden
  - reduced use of hospital services
  - reduced need for residential care
  - decreased annual health care costs
  - prolonged survival.
- 3.2.3 Comprehensive Assessment informs the development and implementation of individualised care plans.
- 3.2.4 Comprehensive Assessment facilitates discharge planning.
- 3.2.5 Comprehensive Assessment helps avoid potential complications of hospitalisation

## Who should be assessed? (Section 3.3)

### Key points

- 3.3.1 The primary focus of comprehensive assessment is on older people in hospital with complex, often interacting, medical, physical and psychosocial problems who are at significant risk of poor health outcomes.
- 3.3.2 Not all older people in hospital need to be comprehensively assessed.
- 3.3.3 Screening should involve the use of predetermined selection criteria to identify those patients most likely to benefit from Comprehensive Assessment.

## When should comprehensive assessment occur? (Section 3.4)

### Key points

- 3.4.1 Comprehensive Assessment should begin as soon as possible after screening indicates that it is required.
- 3.4.2 Comprehensive Assessment should be seen as an ongoing process throughout the episode of care.
- 3.4.3 Monitoring is a more focused form of ongoing assessment which determines if the care plan is improving health status.

## What information should be collected in a Comprehensive Assessment? (Section 3.5; See Table 1)

### Key points

- 3.5.1. The four main health dimensions covered by comprehensive assessment are medical health, and physical, psychological and social functioning.
- 3.5.2. Medical assessment includes presenting complaint, past medical history, systems review, review of medications, smoking and alcohol, nutritional status, dentition, immunisation status and advanced directives.
- 3.5.3. Physical assessment includes personal activities of daily living, instrumental activities of daily living, as well as balance and mobility.
- 3.5.4. Psychological assessment includes cognition and mood.
- 3.5.5. Social assessment includes living arrangements, social support, carer burden, financial circumstances, services and living environment.

## How should assessment be approached? (Section 3.6; See Table 2 – Key Elements of a CA)

### Key points

- 3.6.1 Comprehensive Assessment can be conducted using standardised ‘global’ tools, structured or semi-structured proformas or a more unstructured ‘ad hoc’ approach.
- 3.6.2 The four key approaches that can be used for collecting assessment information are self-report, informant report, direct observation of function by trained health professionals, and accessing medical records.
- 3.6.3 Comprehensive Assessment should incorporate information collected using all four approaches.
- 3.6.4 Comprehensive Assessment should ideally use an ‘interdisciplinary team’ approach.
- 3.6.5 In hospitals where access to the full range of interdisciplinary team members is limited, a more structured assessment approach should be adopted, with available health professionals assuming a broader (multidimensional) assessment role.
- 3.6.6 The Comprehensive Assessment process should be properly coordinated and should not place undue burden on either patients or staff.
- 3.6.7 The outcomes of the Comprehensive Assessment process should be clearly communicated to older people and, where appropriate, their carers.

## How should assessment information be recorded, stored and communicated across clinical settings? (Section 3.7)

### Key points

- 3.7.1 Assessment information should be consolidated, recorded and stored in a readily accessible, easily read format.
- 3.7.2 Systems for the accurate and timely communication of assessment and associated care planning information across clinical settings should be developed and implemented to enhance care continuity.
- 3.7.3 When communicating information, Commonwealth and state laws governing the handling of personal information should be adhered to at all times.

Table 1: Key elements of a Comprehensive Assessment

Dimension/ domain	Approach <sup>1</sup>				Assessor <sup>2</sup>	Tools (Refer to Section 4)	Comments
	SR	IR	DO	MR			
<b>Medical health</b>							
Reason for admission	+++	++		++	Doctor, nurse		Always ask the patient what is troubling them the most because it might differ from the reason for admission to hospital.
Past medical history	+++	+++		++	Doctor, nurse	Cumulative Index Rating Scale	Contact with the patient's general practitioner is generally advisable.
Systems review	+++	+		++	All clinical staff		See footnote 3.
Medication review	++	++	++	++	Doctor, pharmacist, nurse		Include details of prescription and non-prescription medication (name, dose, frequency) and usual administration arrangements. Have all medication brought in or contact general practitioner for details.
Smoking and alcohol	++	+++		+	Doctor, nurse		Inquire about consumption and examine for signs of organ damage.
Nutritional status	++	++	+++	+	Dietician, doctor, nurse	Mini-nutritional assessment; Body Mass Index	Look for signs of significant malnutrition or obesity.
Skin integrity	++	+	+++	+	Nurse, doctor	Norton Scale; Waterlow; Braden Scale	Look for evidence of rashes or cellulitis and signs of redness or ulceration, particularly over pressure points.
Dental health	++	+	+++	+	Doctor, nurse	DENTAL Screening Tool; Brief Oral Health Statement Assessment	Include teeth, mouth, gums and dentures.
Immunisation status	+++	++		++	Doctor, nurse		Include influenza, tetanus and pneumococcus. Might need to contact general practitioner for vaccination details.
Advance care planning	+++	+++		+++	Doctor, nurse, SW, pastoral care worker		Include details of existing advance care plans, limitation of medical treatment orders or proxy decision makers ('agents').

Dimension/ domain	Approach <sup>1</sup>				Assessor <sup>2</sup>	Tools (Refer to Section 4)	Comments
	SR	IR	DO	MR			
Personal activities of daily living	+++	++	+++	++	Occupational therapist, nurse	Modified Barthel Index; FIM; Katz Activities of Daily Living	Include feeding, toileting, dressing, grooming and bathing.
Instrumental activities of daily living	+++	++	+++	++	Occupational therapist, nurse	Lawton–Brody Instrumental Activities of Daily Living	Include using a telephone, cooking, housework, taking medications, handling finances, shopping, transportation.
Balance	+++	++	+++	++	Physiotherapist, doctor, occupational therapist	Berg Balance Test; Tinetti POMA	Include both 'static' (while standing) and 'dynamic' (while mobilising) balance.
Mobility	+++	++	+++	++	Physiotherapist, occupational therapist, doctor	Timed Up and Go; 6 Minute Walk Test	Include details of indoor and outdoor mobility, ability to negotiate stairs and the use of gait aids.
<b>Psychological function (Always compare current functional status with pre-admission status if patient is confused or depressed.)</b>							
Cognition	+	++	+++	+	Doctor, nurse, psychologist, occupational therapist, speech pathologist	MMSE; AMTS; CAM; Clock Drawing Test; Delirium Rating Scale	Look for signs of delirium as well as dementia in confused patients.
Mood	+++	++	++	+	Doctor, nurse, psychologist, social worker	Geriatric Depression Scale; Short Zung; Cornell Score; Beck Anxiety Index	Depression can mimic dementia ('pseudo-dementia').
<b>Social function</b>							
Living arrangements	+++	+++		++	Social worker, occupational therapist, nurse		Include details of usual residence, domestic status (alone or accompanied) and whether the person is caring for others.
Services	+++	+++		+	Occupational therapist, social worker, nurse		Include range and frequency of community and private services, hospital outreach services, case management and financial support services.
Social support	+++	+++		+	Social worker, occupational therapist, nurse	Duke Social Support Index	Include availability and adequacy of social input and emotional support from others.

Dimension/ domain	Approach <sup>1</sup>				Assessor <sup>2</sup>	Tools (Refer to Section 4)	Comments
	SR	IR	DO	MR			
Financial circumstances	+++	+			Social worker, nurse		Need to identify limitations to financial resources that might impact on quality of life or health behaviours.
Living environment	++	++	+++	+	Occupational therapist, nurse, social worker		Access, home modifications and environmental hazards are best assessed by occupational therapist's home assessment.
Elder abuse	++	++	++	+	All clinical staff		Can be physical, psychological, financial or social. Might need to refer to staff with special skills or training if suspected.

### Footnotes

<sup>1</sup> SR = self-report; IR = informant report; DO = direct observation; MR = medical record. The utility of each approach is rated from + (less) to +++ (more) for each domain.

<sup>2</sup> Health professionals likely to have domain-specific assessment expertise. Where access to these staff is limited, other staff should be nominated to assess the particular domain.

<sup>3</sup> The aim of the systems review is to identify problems that are commonly associated with older age and that might be unreported or unrecognised. Make sure to inquire about:

- loss of appetite
- weight loss or gain (amount, time period)
- fatigue
- poor exercise tolerance
- pain (location, character, intensity)
  - tools: Verbal Descriptor Scale, Visual Analog Scale, Faces Pain Scale, Numeric Rating Scale (refer to Supplement 1)
- dizziness (postural, vertigo, dysequilibrium)
- falls (number in past six months, location, time of day, and mechanism: slip/trip, overbalancing, legs giving way, dizziness or syncope)
- cardiorespiratory symptoms (including chest pain, palpitations and shortness of breath)
- musculoskeletal symptoms (including arthritis, stiffness and weakness)
- neurological symptoms (including loss of sensation or power)
- hearing (including availability and use of aids)
  - tools: Clinical Scale to Detect Hearing Loss, Whisper Test (refer to Section 4)
- vision (including availability and use of glasses: reading or distance, uni/bi/multifocal lenses; when vision last tested)
  - tool: CERA Vision Screening Test (refer to Supporting tools section)
- feet and usual footwear
- swallowing (solids and liquids)
- communication (speech, handwriting)
- sleep habits (including pattern, duration, use of hypnotic medication)
- elimination (including usual pattern of bladder and bowel function, continence, use of aids)
- sexual function (including libido, symptoms of dysfunction).

**Table 2: Key considerations in conducting a Comprehensive Assessment of an older person**

KEY CONSIDERATIONS	USEFUL TIPS
<b>General</b>	
Person-centred focus	<ul style="list-style-type: none"> <li>• Treat the older person with respect and dignity at all times.</li> <li>• Assume the older person is well placed to provide accurate information about their health status, unless you suspect a medical issue is significantly impacting on their ability to do so (refer to health section below).</li> </ul>
Establishing rapport	<ul style="list-style-type: none"> <li>• Introduce yourself by name and title.</li> <li>• Ask if the older person would like to be addressed by their first name or not.</li> <li>• Explain the purpose of the assessment (that is, to identify problems impacting on health so an appropriate care plan can be developed).</li> <li>• Ask the older person what they consider their main problems to be because this might be different from their reason for admission to hospital.</li> <li>• Ask the older person about their immediate goals (that is, what they would like to see happen from here on).</li> </ul>
Environment	<ul style="list-style-type: none"> <li>• Try to conduct the assessment in as private and quiet an environment as possible.</li> <li>• Draw screening curtains around the bed if assessing in a multi-bed ward.</li> <li>• Have the older person sit out of bed for the assessment if possible and try to sit facing them at a similar level.</li> </ul>
Timing	<ul style="list-style-type: none"> <li>• Try to conduct the assessment when there is the least likelihood of disruption by meals, rounds, procedures, visitors and so on.</li> <li>• Try to assess older [persons earlier in the day when they are less tired.</li> <li>• Leave yourself sufficient time to complete as much of the comprehensive assessment as required.</li> <li>• Complete the assessment over several visits if necessary.</li> </ul>
Obtaining information from other sources	<ul style="list-style-type: none"> <li>• Seek permission from the older person to obtain additional information from family, carers and other health professionals.</li> <li>• Make every effort to obtain relevant information from primary caregivers and general practitioners.</li> <li>• Assess physical function by directly observing what the older person can do in hospital or on a home visit.</li> <li>• Use hospital medical records, reports and correspondence wherever available.</li> </ul>
<b>Health</b>	
Acuity and severity of illness	<ul style="list-style-type: none"> <li>• The acuity and severity of an older person's illness might compromise the assessment process if they are physically discomforted, unwilling or unable to participate meaningfully.</li> </ul>
Atypical disease presentation	<ul style="list-style-type: none"> <li>• Older people might present with ill-defined complaints or unexplained deterioration in function rather than with 'text book' manifestations of disease.</li> <li>• Always think of asymptomatic infection (particularly of the chest or urinary tract) or medication effects as possible causes of an otherwise unexplained change in health status.</li> </ul>

KEY CONSIDERATIONS	USEFUL TIPS
Cognition	<ul style="list-style-type: none"> <li>• Where impaired cognition is suspected, ask the older person early in the assessment if they have had any problems with their memory and if they would mind you checking by asking them a few questions.</li> <li>• Administer a short screening test of cognition, such as the Abbreviated Mental Test, to establish if the older person is likely to be a reliable historian or not (refer to Supplement Tools section).</li> </ul>
Depression	<ul style="list-style-type: none"> <li>• Consider depression (as well as cognitive impairment) as a possible explanation for an older person appearing 'flat', not making good eye contact, giving non-committal responses to questions or not responding at all.</li> </ul>
Hearing	<ul style="list-style-type: none"> <li>• An older person has functional hearing if they can hear you speak at a conversational level from one metre away.</li> <li>• If an older person has hearing impairment, arrange to have their ears checked for the presence of significant wax build-up.</li> <li>• If the older person uses a hearing aid, make sure it is accessible, they are wearing it and it is operational (cupping a hand over the in situ aid to elicit a feedback 'screech' is one means of doing this).</li> <li>• Sit directly in front of the older person so they can see your mouth, speak clearly, slowly and only slightly louder than usual.</li> </ul>
Communication	<ul style="list-style-type: none"> <li>• If concerned about a person's receptive language ability, particularly after a neurological event such as a stroke, ask them to follow a one-stage command (for example, 'shut your eyes'), followed by a two-stage command (for example, 'lift up your arm then poke out your tongue').</li> <li>• Check expressive language ability by asking the older person to repeat a simple phrase (for example, 'no ifs, ands or buts') and to name common objects (for example, a watch, pen or book).</li> </ul>
Cultural	
Culturally and linguistically diverse background	<ul style="list-style-type: none"> <li>• Organise access to appropriate interpreter services if a patient of a culturally and linguistically diverse background cannot meaningfully participate in the assessment. A professional interpreter should be used whenever possible. Failing this, try to use a member of clinical staff rather than a family member or friend.</li> <li>• Consider having a family member present during the assessment because an older person with limited proficiency in English might feel particularly vulnerable in a hospital environment.</li> <li>• Ensure assessment processes take account of differences in culturally determined attitudes to health and illness, understanding of information and illness related behaviours.</li> </ul>
Aboriginal and Torres Strait Islander background	<ul style="list-style-type: none"> <li>• Ensure assessment processes of older Aboriginal and Torres Strait Islander people in hospital take account of different culturally determined attitudes, understanding and behaviours.</li> <li>• Seek assistance from a suitably qualified person (for example, an Aboriginal and Torres Strait Islander liaison officer, Indigenous health worker or local elder) who can provide support in undertaking or interpreting various elements of the comprehensive assessment.</li> </ul>



