OCCASIONAL PAPER 59

Health Checks for People Aged 75 and Over

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The Royal College of General Practitioners

Charter

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Contents

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THIS *Occasional Paper* has been written to help members of the primary health care team to carry out effective health checks on their patients aged 75 and over. The need for such a package was identified at a study day held at the Royal College of General Practitioners on 1 November 1990 (Appendix 10). The authors have been helped by comments and suggestions made by people following the meeting and would particularly like to thank the following for their expert advice:

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Editor's preface

ELDERLY people are one of the few groups in the population whose numbers are growing and those over the age of 75 now form about 7%. General practitioners have a remarkably high contact with this group since the most recent *General Household Survey* shows that the face-to-face contact rate is as high as 7 per person per year (OPCS, 1991). In addition the NHS contract introduced in 1990 the obligation to offer all registered patients over this age a consultation, specifying six aspects of health and care which should be reviewed, and an annual home visit as well.

The College has already published two *Occasional Papers*, Buckley and Taylor's *Preventive Care of the Elderly, Occasional Paper 35*, and *Care of Old People: A Framework for Progress, Occasional Paper 45*, the report of a College working party, which have responded to this development and the second of the two papers included an outline of how health checks for the elderly could be done.

Occasional Paper 59 has been developed particularly since 1990 following a study day held at the Royal College of General Practitioners in November of that year. There was a clear endorsement of the need for such a publication and a large amount of development work has been done by Professor Idris Williams and Professor Paul Wallace. There have also been discussions with interested colleagues in other academic organizations such as the Royal College of Physicians of London.

This document provides a clear and practical working approach to this important responsibility for primary health care teams. This is not just an issue for doctors, a growing number of health professionals are likely to become involved. The prime clinical responsibility of the doctor, however, must not only be to organize the system, but as always in medicine, to detect and treat disease both of the body and the mind as quickly and as effectively as possible.

Occasional Paper 59 thus represents the latest step in the history of raising standards of care for one of the most vulnerable age groups in the populations.

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DENIS PEREIRA GRAY
Honorary Editor

April 1993

Health Checks for People Aged 75 and Over

Introduction

THE new general practitioner contract places particular responsibility on general practitioners and members of their teams to screen (or scan) patients aged 75 and over. This procedure has come to be known as a 'health check'. The contract does not state the purpose of such a check although it does indicate six areas of enquiry. It has been left to the profession to state the purpose and define how such checks are most sensibly to be carried out.

It would seem that the *purpose* is to identify impairments which are producing, or could produce in the future, disability or handicap which might be helped or prevented by action which has not already been taken. A simple example would be hearing loss caused by wax in the ear which, once identified, could be removed with beneficial effects. The impairment might be simple or complex and the help needed either medical or social, long term or short term. The overall aim is to preserve functional ability and to allow patients to live in good, effective health in the environment of their choice for as long as is both possible and practical. This fits in with basic primary care philosophy.

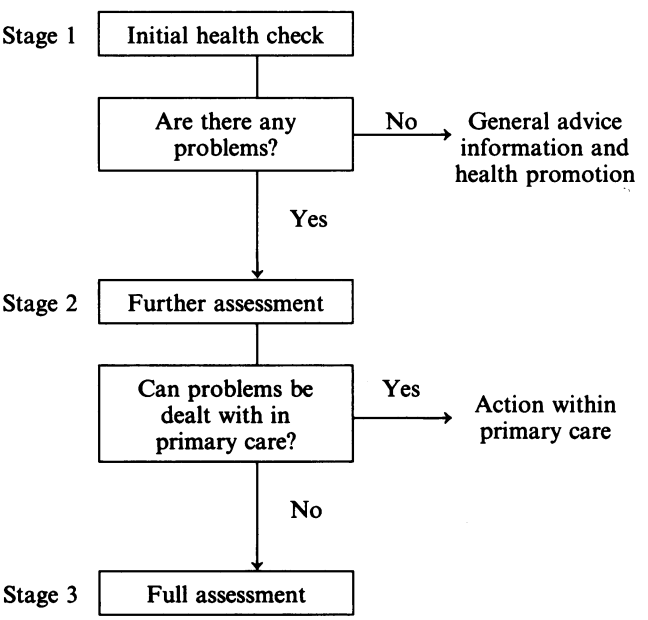
However, if any sense is to be made of the contractual obligation it cannot be seen just as a health check. Apart from identifying health and social problems the check also provides an opportunity to undertake health promotion, health education, review of medication, review of carers' needs, and possibly primary and secondary prevention. It also allows the construction of a useful database of information on health status and needs. The gathering of information is not, however, enough to make the check meaningful: the data need to be interpreted so that problems may be clearly defined and possibilities for action realistically assessed. This is an important part of the process, requiring skills in which health workers are not always well trained.

In practice the yearly assessment has turned out to be a three-stage process. All patients aged 75 or over undergo the initial health check, and this is followed where necessary by a second, fuller assessment of the problems found by the initial check. Most of these can be dealt with in primary care. Where the situation is found to be complex, a third stage follows which consists of a full interdisciplinary assessment (see Figure 1).

Many health check protocols and questionnaires have been produced for standardizing what happens when health checks are undertaken. Feedback from general practitioners and other team members has, however, indicated a need for guidance about what sort of questions to ask and how comprehensive the assessment should be. A need has also been expressed for help with interpretation of findings and sensible action policies that fit into the overall principles of primary care medicine.

The three-stage approach provides a useful framework for such guidance and is the basis of this package (Appendix 1). The stage 1 (health check) schedule provides guidance on relevant information which needs to be gathered and appropriate questions which might be used under each heading. *It is not meant to be a check-list or protocol but it can be used as such and modified to suit individual circumstances.* Information gained can be stored on a record sheet similar to that presented in *Occasional Paper 45* (RCGP, 1990), or an updated version such as the example in this *Occasional Paper*, which fits into the format of the stage 1 schedule. The aim is to provide a system which is user friendly and provides data which can easily be stored in the medical record. The stage 1 schedule also contains indications on how to proceed when a problem is identified and this leads to the stage 2 schedule where fuller assessments are described.

In the same way the stage 2 (primary care) assessment is *not necessarily a check-list* but provides indications for further questioning which may help when a problem is identified and needs to be clarified. The aims of this further assessment are clearly stated under each heading and indications are given of further resources available if the problem cannot be helped within the primary health care team. These procedures represent the normal pathways of problem identification and solution in primary care and stage 2 may be recorded in the normal note system. The findings can be recorded on a summary sheet as shown in Appendix 2.



Source: Williams EI (1992) *Care of Those Aged 75 and Over: Teaching Modules*. Oxford, Radcliffe Medical Press.

Figure 1 The three stages of the health check

The package begins with some background material about organizing a programme and some common difficulties encountered. A section is included about full assessment (stage 3). The number of patients seen at a health check who require this is very small — experience so far suggests somewhere between 2% and 5%. About 50% of all patients require some form of further assessment within the field of primary care, although the proportion is likely to decline in future years. There is evidence that screening produces an increase in the use of almost all services and more general practitioner contacts (Hindmarsh and Black, 1991).

The rationale for undertaking health checks is based on the tendency for old people not to report illness and disability and not to be aware of what can be achieved in the way of treatment and rehabilitation. Pathology and socio-economic problems amongst old people are often multiple, and even if individually minimal can cumulatively lead to loss of function, a problem aggravated by being unrecognized and unreported. The aim of health checks is therefore to identify and alleviate established disease and social problems at an early stage in order to improve or maintain functional status. The important point is to prevent disability and handicap rather than the impairment itself and to maintain independence and integration in society.

The information collected at health checks for those aged 75 and over is useful for assessment of both the health status and the needs of this age group. Individual practices may be interested in aggregating information about their old patients and using this to plan services. The use of computers makes this much easier, but a standardized check-list is essential. Discussions about using this information for wider planning purposes have not yet taken place, but this is a possible development.

As indicated earlier, the health check gives an opportunity to do more than just identify problems. Other forms of preventive activity can take place, for instance immunization, breast screening and cervical cytology. There is evidence that both the latter procedures are beneficial even in old age (DHSS, 1986; Fletcher, 1990). There are also opportunities for health promotion such as advice about diet, exercise, smoking, alcohol intake, accident avoidance, preservation of autonomy and social contact, and self-care. Information can be given about local and practice services.

No attempt is made here to give the theoretical base and rationale for undertaking tertiary prevention and anticipatory care for old people. This is described very fully in *Occasional Paper 45* (RCGP, 1990) which, together with *Occasional Paper 35* (Taylor and Buckley, 1987), provides theoretical and practical background. ***This package should be used in conjunction with these two publications.***

Contractual requirements

In the *Terms and Conditions of Service for General Practitioners*, paragraph 13D states that a doctor shall:

- invite annually each patient on his list who has attained the age of 75 years to participate in a consultation; and
- offer to make a domiciliary visit to each such patient for the purpose of assessing whether he needs to render personal medical services to that patient.

Any consultation may take place in the course of a domiciliary visit.

An invitation or offer of a visit may be oral or in writing, but must be confirmed in writing and recorded in the patient's notes, together with the patient's response (paragraph 13B(3)). The doctor shall, when making an assessment following a consultation, record in the patient's records the observations made and any matter which appears to be affecting the patient's general health including, *where appropriate*:

- sensory functions
- mobility
- mental condition
- physical condition including continence
- social environment
- use of medicine.

It is the view of most family health services authorities (FHSAs) that the doctor may delegate the routine assessment of patients 75 years and over to suitably qualified practice staff or, with the agreement of the district health authority, to attached district nurses and health visitors. Neither the contract nor the FHSAs stipulate that assessors should be trained but because doing health checks is a skilled and responsible procedure, proper training is essential. Old people deserve to have their checks undertaken in a committed way. As long as training is carried out effectively, staff such as link workers (Wallace, 1990), who do not necessarily have professional qualifications, may be employed. There is, however, no place for untrained volunteers.

Organizing the programme

1. The practice will need an up-to-date age/sex register so that patients of 75 years and over can be easily identified, and a record system which can absorb new information collected on a yearly basis. *This will mean extra administrative work for practices.* Computers will be helpful but not essential.

2. The initial health checks are often undertaken by the general practitioner, but can also be done by the practice nurse, community nurse, health visitor, or other professionally qualified members of the practice team such as an occupational therapist or link worker. It is important that each should have training and an understanding of the principles involved. The general practitioner must of course be involved even when the check is done by another member of the team. The check can take place in the patient's home, or the surgery, although the patient must have been offered a home visit. The offer may be made by letter, birthday card, or directly to the patient. Some doctors do the health check and home visit opportunistically. If nurses are not well trained, then they should be given training. This would involve careful monitoring of their work until they are proficient.

3. Consideration needs to be given to the logistics of the programme, the degree of delegation, the time and expense involved and the position of patients who refuse the offer.

4. It is important that the minimum contractual requirements are not viewed in isolation. There is a risk that they may deflect time and energy away from other effective ways of improving the health and functional status of old people. It is necessary to integrate health checks into the overall policy of health care. Good acute care is important, for example, in securing good functional ability.

5. When practice nurses are used for undertaking visits to the over-75 year old patients, special note needs to be taken of the paper *Practice Nursing and the 1990 Contract for General Practice* issued by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1990). A full account and discussion of this is given in *Occasional Paper 45* (RCGP, 1990).

6. The postgraduate educational programme for general practitioners should provide opportunities for doctors to develop skills in providing anticipatory care for patients aged 75 years and over. Often courses are put on jointly for general practitioners and practice nurses. General practitioners, however, have the specific responsibility of ensuring that nurses undertaking health checks have the necessary competence.

As a guideline it would be expected that staff carrying out the health checks would have:

1. An understanding of the background to life in old age in the community and the normal ageing process
2. Knowledge of the medical and social resources available to care for old people in the community
3. An understanding of the principles of anticipatory care of old people in the community
4. The ability to undertake effectively assessment procedures involved in health check screening of the elderly and in particular the assessment of disability
5. An understanding of the purpose and extent of full comprehensive screening of old people
6. Knowledge of the organization of general practice
7. Knowledge of the important medical, nursing and social problems associated with old age
8. Skills for visiting people at home, including communication skills
9. Positive attitudes to old people and their problems.

Using the schedules

The schedules are presented as a sequence — the three-stage approach (Appendix 1). They have been developed on the basis of previous work with screening programmes and have been piloted in the Kensington, Chelsea and Westminster Family Health Services Authority area. Stage 1 is being more extensively evaluated as part of a major multi-centre randomized controlled trial carried out under the auspices of the Medical Research Council.

Stage 1

The *health check* schedule provides a guide to the information which might usefully be collected at the first, problem-defining stage. It is presented under 12 headings, which are more than are listed in the contract but which are arguably needed to make the check more helpful to both patient and health worker. Apart from enabling important facts to be recorded, the aim is to alert the interviewer to problems which demand further assessment.

Stage 2

This is the suggested *further assessment* which is required as a result of identification of problems at stage 1. This further assessment takes place in primary care and can take the form of further information and where appropriate examination and investigation. Actions at this stage may mean referral to specific agencies or specialists, but usually are confined to primary care.

Stage 3

This involves full *interdisciplinary assessment* of a complex problem and may mean referral by the primary care team to a hospital consultant, social worker, nursing, or other services. It can take place in the patient's home, or at the surgery, or in hospital. The primary care team will usually initiate such an assessment, but a general practitioner may prefer to delegate the responsibility for these assessments to a department of health care of the elderly.

Making it work

Patients who are fit

A proportion of those eligible to have health checks will be fit or have conditions under active supervision by the doctor and will need no extra help. What can a programme of health checks offer the fit patient?

- Confirmation that all is well
- Reassurance that the practice is concerned about elderly patients
- Information about a service which might be needed later, even if it is not needed now
- Further information about practice organization and personal contact with a member of the team the patient has not met before
- Opportunity for health promotion.

The benefits of routine assessment are as follows (Williams, 1992):

- Problem identification
- Therapeutic opportunity
- Early recognition of impairment leading to reduction of handicap
- Health promotion

- Primary and secondary prevention
- Giving information about services
- Construction of a data set
- A medication review
- A review of carers
- Vulnerable group identification
- An examination of environmental and social problems
- The professionalization of a complete care programme.

Patients with problems

Many patients, even those already under active supervision by doctor or district nurse, can have additional problems which are unknown to the practice. Despite evidence that patients not regularly seen by the doctor are in good general health it cannot be safely assumed that they do not have unreported need (Ebrahim et al., 1984). Health checks on both these types of patient cannot therefore be perfunctory.

Patients may not always perceive a problem as a 'problem'. It is necessary to look at the situation through the old person's eyes and to understand his or her view of the situation. Some patients may have adapted to a particular difficulty and see no reason to involve services in an attempt to effect change. General practitioners are good at perceiving these situations and judging when it is best to let things be. Time, however, spent listening to patients talking about these issues is usually time well spent.

Ethnic minorities

Practices with a wide range of ethnic minority communities are unlikely to have representatives of each community in their team. It will therefore be particularly important to listen carefully to the older patient from such a minority group, arranging for interpretation if necessary; people who are sick or fragile are likely to find their mother tongue easier even if they have learnt English. It is also important to listen to relatives. Some of the more obvious pitfalls to avoid are:

1. Assuming the family will 'look after their own'. There may be great willingness, and guilt about the difficulties of achieving this. Housing to take three-generation households is, however, very expensive and many families cannot afford this.
2. Offering services that are not flexible to cope with cultural variation, for instance:

- Showers not baths should be offered to Asian patients.
- Some foods offend religious or cultural principles or are simply unfamiliar. Frail or sick people need food to be comforting and appealing.

3. Ignoring or disparaging self-medication within the cultural tradition.

A further aspect of ethnic minority groups is that many of them are referred to various services but do not use them. It is commonplace to assume that this implies that the problems are not severe and therefore may be ignored. Non-acceptance of services does not necessarily mean the need does not exist.

General practical points

Most patients of 75 years and over welcome a health check: poor response is often due to the way an invitation is made, or through failure to explain the purpose of the service. Old people, however, vary considerably in their history-giving ability and assessors need to have good communication skills to maximize the benefits. Time is a constraint, so ability to keep to the central point is important.

The purpose of the visit is not to undertake comprehensive assessment but to identify those areas where patients are experiencing problems, so that further work can be done, if necessary, by a more appropriate person. This means that the assessor should avoid probing in sensitive areas and encouraging the expression of emotional distress at an assessment designed for other purposes. For instance, patients who are experiencing problems to do with relationships, self-esteem, loneliness, bereavement, anxiety or depression will need skilled help. The health check is intended to identify this need, not to meet it.

It should not be assumed that everyone of 75 and over has a carer. Many patients will be fit and independent. But if there is a carer it may not be possible to obtain a clear picture of his or her needs and if there is suspicion that this is the case it may be necessary to do a separate *carer* assessment. Carers have tolerance limits and factors such as sleep disturbance, faecal incontinence and mental illness in those they are caring for are hard to cope with. The carers may also have their own problems such as illness, other commitments, or may experience feelings of frustration.

It is also important to give the *old person* an opportunity to speak to the assessor alone. Elder abuse is a topic of growing importance. Carers with limited coping abilities are probably those most likely to resort to abuse, but even the most resilient carer looking after highly confused and dependent elderly people may also be driven by stress, drudgery and frustration to physical abuse.

It may appear superficially that an old person's functional status is adequate, but often it is necessary to look carefully at mobility, eyesight and hearing, as first impressions can be deceptive. A loss of sight in particular is important to identify as it is common in old people and it is not just part of the normal ageing process but more seriously a result of eye disease. The incidence of glaucoma and diabetes in some ethnic minority communities is higher than average. Identification of early depression or dementia can also be difficult. An old person offered a health check may expect a physical examination, a blood pressure measurement, and a urine test. Convention has it that these are done as routine (for instance, as in an insurance examination) and not to do them may disappoint the old person and lay the health worker open to charges of being perfunctory or uninterested. Some doctors undertake a full examination and each practice needs to judge for itself the level of the assessment. It is

important to explain to the patient the purpose of the check and why, for instance, a blood pressure check is not being carried out if that is the case.

Two questions are frequently asked: what should be done about raised blood pressure and is it worth testing the urine? No definitive answer can be given about treating high blood pressure in those aged 75 and over. There is some evidence that it is worth treating raised blood pressure up to the age of 80 (Staesson et al., 1989), but each practice must really decide its own policy on blood pressure testing and treatment. Equally practices will have to determine their own approach to urine testing — there will inevitably be differences of opinion, all firmly defended and held.

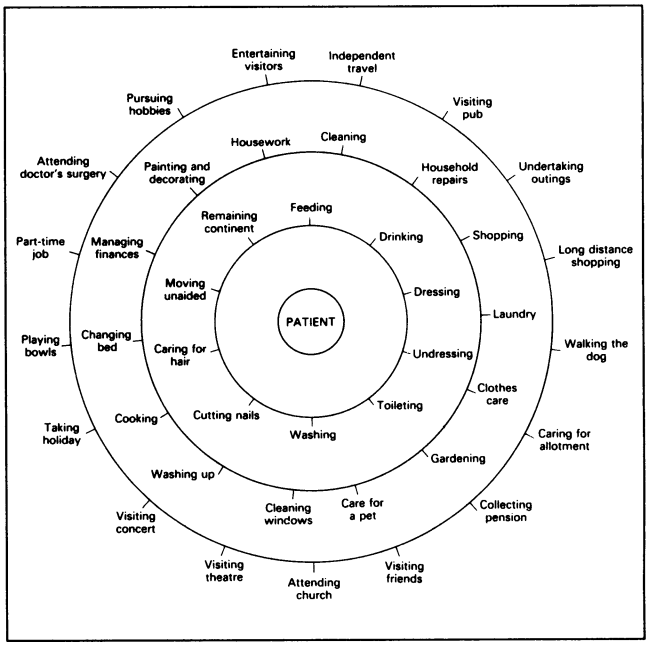
Health checks on patients in nursing or rest homes

Some confusion exists about whether general practitioners are contractually required to perform checks on residents of nursing and rest homes. They are not specifically excluded in the contract and are still patients on a general practitioner's list so it would seem appropriate that they should be receiving health checks. There is a view, however, that these assessments are not worth doing on resident patients as they are already under constant supervision, which in the case of nursing homes is by a qualified nurse, and many get regular visits from the general practitioner as well. Maintenance of effective health is, however, no less important in residents of homes. If deterioration in function is gradual it is easy for staff in constant contact to miss it. Periodic review of medication is essential and the annual health checks give an opportunity for this.

However, the health checks will need to be modified and questions will have to be appropriate to the home environment. Questions relating to activities of daily living, medication, finance and lifestyle will need to be modified.

The importance of activities of daily living

It is now generally agreed that a *functional approach is best when assessing old people*. This can be measured in terms of, for instance, mobility, visual and hearing competence, and effective mental state. It is important to remember that many visually impaired people in particular have great difficulty even with the simplest household tasks. However, a good guide to what an old person can actually do is given by ability to perform certain activities of daily living. These can be separated into three levels of activity: sociability (activities outside the home), domestic, and personal (Figure 2). A refinement is to describe also instrumental activities of daily living, for example use of telephones, or washing machines. Sociability includes activities which an old person does in the outside world, for example visiting friends, clubs, places of worship, shops, and so on. Domestic means work done in the house, for example laundry, cooking, cleaning, and repairs. Personal means individual tasks, such as dressing, washing, bathing, feeding, and toileting.



Source: Adapted from Williams (1986) with permission from the Editor of the *British Journal of General Practice*.

Figure 2 Activity of daily living levels

The normal biological ageing process is imperceptible, but slowly a decline in the ability to undertake activities of daily living takes place as age advances, although there are often long periods of stability. When decline occurs, however, it usually starts with sociability, then ability to undertake domestic and finally personal tasks. Illness or social difficulty often speeds up the process, but this can often be reversed by treatment or social help. The important point is that assessment of the *extent* of loss of function can trigger the search for a cause and result in appropriate remedial or support action. For a fuller discussion see Williams (1986).

In April 1993 the proposals in *Caring for People* (Secretaries of State for Health, 1989) will come into effect and all local authorities will have a community care plan in place. The effect will be to produce considerable changes in the way in which social care is provided for many sections of the community. The need for co-operation between the primary health care services and local authority social services departments is clear. An important area will be the care of old people and it will be necessary for general practitioners and other health workers to develop close working relationships with care managers, both in providing current services and developing and improving care in the future. Where such managers will be based and how they will link with practices is at present unknown and there is likely to be considerable variation. In any event general practitioners are likely to be involved in identification of social problems amongst old people, and in their assessment, and possibly also as providers of care. General practitioners will be particularly involved with assessments associated with movement into nursing homes and rest homes. Clear procedures for such assessments will be necessary and it is hoped that the guidelines contained here will produce a basis for such activities.

Dangers of assessment

Screening is not without dangers, which include the following:

- Over-medicalizing old age
- Making old people over dependent
- Missing problems
- Causing intrusion on privacy
- Neglecting quality of life issues
- Poor motivation of professional carers
- Making old people unnecessarily aware of problems
- Reducing commitment to other aspects of care
- Raising false expectations about possible solutions
- Risking iatrogenic disease
- Encouraging check-list medicine
- Risking the finding of false positive results.

Medical audit

Health checks on those aged 75 and over need to be monitored and are a good subject for audit. At a national level it is important to know what is happening as a result of the intervention so that changes can be made if these are found to be needed.

Possible information to be gathered would be:

- Who does the health checks?
- What is the uptake?
- Where are they undertaken?
- What is the time expenditure and cost to the practice?
- How does the practice organize the checks?

A sample audit form showing how to obtain this information is included as Appendix 3.

Other information which it would be useful to collect would be:

- What need is found?
- Are resources available to meet this need?
- What is the uptake of services offered?
- What is the evidence of benefit to patients?
- What could be done to improve current practice?
- How frequently are referrals made?

However, this information is more difficult to obtain than that on the audit form. How individual practices explore these issues will vary.

The gathering of information is a monitoring exercise and the findings should be examined critically. To undertake true medical audit some initial criteria of acceptable practice should be constructed and then compared against what is actually happening. Modification of practice can then ensue.

Services

Probably most needs identified in the health check can be dealt with in primary care, for instance investigation, treatment, health visitor action or nurse surveillance, but it will also be necessary on occasion to contact specific services for help. These will be reviewed briefly but local variations may exist.

SERVICES WITHIN THE NHS

Chiropody

The different categories of disability for which chiropodists assume responsibility may be broadly defined as follows:

1. Foot disabilities associated with medical or surgical conditions. These cases are often chronic and produce severe disability and high risk of sepsis or gangrene
2. Structural and functional disturbances of the feet themselves, which may be associated with other physical handicap
3. Infections
4. Preventive care including foot health education.

Whenever it is possible and safe to do so, patients are encouraged to practise self-help and consequently they may only be offered counselling and advice.

Chiropody services usually operate on a district basis covering both hospital and community needs. The aim is to provide service in health centres, residential homes for the elderly, day centres and patients' own homes. Community units of district health authorities are usually responsible for these services and can provide information. A patient's self-referral system often operates, but professional referral should include a note explaining the problem that gave rise to the referral and the degree of urgency involved. Problems, however, occur due to shortage of staff.

Chiropodists who work within the National Health Service are required by law to be state registered. By contrast there is no statutory requirement for chiropodists working in the private sector to hold state registration.

Dental

Elderly patients will normally get dental treatment through their own general dental practitioners. It is, however, sometimes necessary to check whether the patient has a dentist and whether the dentist is willing to continue treatment, which may involve domiciliary visits.

In case of difficulty most districts do have a community dental service whose role is to monitor the dental health of all age groups, provide for a full range of treatment to patients who have experienced difficulty in obtaining treatment in the general dental service, and provide dental health education and preventive programmes.

Dietitians

The role of the dietitian is to assess, recommend and advise on implementation of dietary regimes appropriate to the individual patient's needs. Most district health authority community units have dietetic and nutrition

services and referral from a general practitioner is usually by letter. Constraints due to staff shortage may be a problem. Referral may be for such conditions as diabetes, swallowing or feeding difficulties particularly after stroke and surgery, weight loss, suspected deficiencies of minerals and vitamins through factors such as prolonged poor eating or poor dentition, and dietary assessments.

Hearing

New patients with hearing problems usually need to be referred to the hospital ear, nose and throat department. Those whose long-term management is by hearing aid will be referred to a hearing aid centre for appropriate hearing aids and moulds. Instruction in the use and explanation of the advantages and limitations of hearing aids will be given. Centres for repair to hearing aids are available in most districts and are often situated conveniently at health centres. Referral may be because of loose or uncomfortable ear moulds, damage to, or poorly fitting, hearing aids, hearing deterioration or change, or general advice and counselling.

Loan of equipment

Short-term loans of equipment to support nursing work in the home are available through the nursing loan services. Checks are made by district nurses every six months on whether the equipment is still needed. A catalogue of *possible* nursing equipment is as follows:

1. *Toileting aids*
   Commodes
   Urinals (male and female)
   Non-spill adapter
   Bed pans
2. *Beds, pressure care and accessories*
   Hospital beds, various heights
   Mattresses
   Anti-decubitus mattresses
   Anti-decubitus cushions
   Sheepskins
   V-shaped pillow
   Elbow/heel pads
   Cone mattress covers
   Bed cradles
   Cot sides
   Self-lifting poles
   Bed blocks
3. *Walking aids*
   Pulpit frames, adjustable and non-adjustable
   Walking stick, adjustable, metal
   Crutches, elbow and axilla, metal and wooden
   Quad walking aids
   Ferrules
   Requests for special walking aids will usually be considered
4. *Electrical equipment*
   Compressors (nebulizers)
   Suction machines
   Enuresis alarms
   Liquidizers
   Fans
5. *Wheelchairs (6-month loan only)*
   Wheelchair, self-propelled
   Wheelchair, attendant propelled

   Permanent loans are supplied for patients with long-term disability through the local Disablement Services Authority (previously the Artificial Limb and Appliance Centre).
6. *Other*
   Feeding cups
   Helping hands
   Back rests, foam and canvas
   Patient handling slings
   Mini-lift sheets
   Fracture boards
   Drip stands

Nursing services

Referrals to the community nursing services are made by general practitioners and their staff, from hospitals, social services, carers and patients themselves, and any other agency. District nurses are often attached to general practices. Referral is usually by personal contact or by leaving messages at suitable places.

The range of services is wide. Normal services are particularly relevant to elderly people, but there are also specialist services which, for instance, look after stroke patients, stoma patients and incontinent patients. Macmillan nurses and Marie Curie nurses are associated with care for patients with cancer.

Occupational therapy

Occupational therapists provide a treatment service to people with physical or psychiatric conditions, using selected activities in order to help people reach their maximum level of function and independence in all aspects of daily life. They are particularly skilled in assessment and retraining in activities of daily living. Patients who can be helped are those with problems in motor/sensory performance, co-ordination, manual dexterity, cognitive function, or occupational performance including play and leisure activities. There is a national shortage of occupational therapists and this may restrict availability of local resources.

Opticians

Patients requiring care from an optician may be unable to travel to the optician's premises for sight testing. The optician may be able to visit the patient at home. The domiciliary visiting scheme is available under the general ophthalmic services, but eligibility should be checked with the local family health services authority.

Physiotherapy

Physiotherapy is a systematic method of assessing musculoskeletal and neurological disorders of function, including pain and those of the respiratory system, and of treating or preventing those problems by methods based essentially on movement, manual therapy and physical agencies. A wide range of clinical skills is available providing a comprehensive service of assessment, treatment, education and advice. The provision of

services locally is variable. They can be obtained from the local hospital system either through a consultant or, if available, by open access. There is a growing demand for physiotherapy services, particularly for the elderly in the community. Facilities do not always meet demand. The services of private physiotherapists are also available; there is no requirement for them to be state registered, nor are they necessarily members of the Chartered Society. Referrals may be made to private practitioners directly or by self-referral.

Speech therapy

Speech therapists provide a service to all communication-impaired people and are usually hospital based. Speech therapists assess and treat the whole range of speech and language disorders including those associated with swallowing or eating problems. They work, for instance, with patients presenting with stroke, Parkinson's disease, motor neurone disease, multiple sclerosis or early degenerative diseases.

SERVICES OUTSIDE THE NHS

Money problems

Older people with money problems may well not be claiming all the benefits to which they are entitled. The details of benefits change frequently so that a knowledge of helpful advice services may be more important to acquire than a detailed grasp of current benefits. The Department of Social Services' Freeline Services (0800 666555), with no charge for calls, provides a good way into the system for people who do not understand the benefits. Expert advice is available from staff trained to know not only the benefits available from the social security system, but also about help from other agencies. Clients are helped to claim what is their right and are offered a full explanation. There are several welfare rights organizations in particular localities and these are usually widely advertised. Citizens advice bureaux can also offer advice on benefits. Age Concern has local offices which are available for similar advice. A computerized benefits assessment package specially designed for use in general practice is also available (Appendix 4).

Benefits most likely to be relevant to elderly people are income support, social fund, housing benefit, attendance allowance, invalid care allowance and help with NHS treatment.

Social services

Most contacts with social services will be made through the local area office, although some practices have a social worker either attached or with whom the practice is in direct contact. The social services departments are at present in the throes of coping with major government-initiated changes. These will affect general practice which will have the responsibility for giving advice as appropriate so that patients can use the services provided by a local social services authority. It seems sensible for doctors to keep themselves informed of developments and to watch to see how the new arrangements develop.

The social services available include:

- Community care assistants who help with personal care, shopping, cooking, cleaning and night sitting
- Meals on wheels, which are provided at low cost
- Day centres to provide care, company and some stimulation for frail old people
- Lunch clubs
- Sitting services
- Incontinence laundry services
- Aids and adaptions
- Specialized social workers dealing with the elderly.

Social workers are responsible for assessment for social services day centres, residential care, short-term and respite care, disabled car badges, holidays for elderly people who cannot afford one, and in some circumstances help towards telephone and television licence costs.

Voluntary organizations

There are a large number of voluntary organizations concerned with the elderly. A wide range of services is provided. Age Concern exists to improve the quality of life for the elderly population and is the largest voluntary sector provider of direct services. They provide advice and information, lunch clubs and day clubs, transport for elderly people, hospital after-care services, advice on home improvements and grants, holidays, insurance services, social activities and alarms for housebound people. CRUSE is a national organization for widows, widowers, and their families which offers counselling, information on practical matters and opportunities for contact with other bereaved people. Help the Aged is a charity whose aim is to improve services with the elderly at home and abroad. Self-help groups include a variety of special interest groups and details are often available in a local directory of self-help groups. Special disease-focused organizations such as the Alzheimer's Disease Society, the Parkinson's Disease Society and the Motor Neurone Disease Association all have very active welfare branches and are helpful in the community.

This information has been drawn from a pack produced by the Nottingham Community Unit, which applies specifically to the Nottingham district. A considerable amount of detail is included in this pack, much of which would be helpful to practices.

Health Checks for the Over 75's — A Handbook for General Practitioners and Associated Staff, edited by Elizabeth Perkins, is available from:

Nottingham Health Promotion
Community Unit
Memorial House
Standard Hill
Nottingham NG1 6FX
Price: £10.

Many other charities are also available for help. The details of these are often available from local social services.

APPENDIX 1

Health checks for people aged 75 and over

STAGE 1

Health check schedule

The stage 1 health check schedule is intended to be used by any appropriately trained health care professional. It can be used in the person's home and/or opportunistically at the surgery.

The schedule has been developed on the basis of previous work with screening programmes and has been piloted in the Kensington, Chelsea and Westminster Family Health Services Authority area. It is being more extensively evaluated as part of a major multi-centre randomized controlled trial carried out under the auspices of the Medical Research Council.

The health check sheets should be used as a guide to the questions asked and the information obtained recorded on a summary card. It is recommended that this be filled in as each section is completed.

There are 10 sections in all, each containing a set of questions designed to identify problems which should trigger further assessment. The stage 2 primary care assessment schedule sets out the recommended further primary care assessments in sections which correspond to the stage 1 health check.

SOCIAL ASSESSMENT

1. Does someone else live at home with you?
   . . . . . If **Yes**
2. Do you generally look after him/her (I mean help to wash, dress, get around)?
   Yes**
   . . . . . If **No**
3. Do you see relatives, friends or neighbours at least two or three times a week?
   . . . . . No*
4. Do you have a relative, neighbour or friend who you can call on for help when required?
   . . . . . No*

***Further social assessment indicated (see page 13)**
****Further carer and social assessment indicated (see pages 13–14)**

HOME ENVIRONMENT

1. In the last year, have you had difficulty keeping your home warm?
   . . . . . Yes*
2. In the last 6 months have you had any falls at home?
   . . . . . Yes*
3. Is there anything about your home that needs changing?
   . . . . . Yes*

   Independent of subject's view, do you believe there is anything about his/her home environment that needs modification?
   . . . . . Yes*

***Further home assessment indicated (see page 14)**

MOBILITY

Do you, or could you if you had to:

1. Go up and down stairs and steps on your own (if necessary using a frame, tripod or stick)?
   . . . . . No*
2. Walk 50 yards down the road on your own (if necessary using a frame, tripod or stick)?
   . . . . . No*

***Further functional and home assessment indicated (see pages 14–15)**

GENERAL FUNCTION

Do you, or could you if you had to:

1. Do the shopping by yourself? . . . . . No*
2. Do light housework or simple repairs by yourself? . . . . . No*
3. Cook a hot meal by yourself? . . . . . No*
4. Cut your own toenails? . . . . . No*
5. Wash all over on your own (including bathing or showering)? . . . . . No*
6. Dress yourself including zips and buttons? . . . . . No*

***Further functional/physical and home assessment indicated (see pages 14–15)**

SENSES

1. Do you have any difficulties hearing and understanding what a person says to you (even if you are wearing a hearing aid) in a quiet room if they speak normally to you? . . . . . Yes*
2. Do you have any difficulty in seeing newsprint, even when you are wearing your glasses? . . . . . Yes**

***Further hearing assessment indicated (see page 16)**
****Further visual assessment indicated (see page 16)**

CONTINENCE

1. Do you ever wet yourself if you are not able to get to the toilet as soon as you need to, when asleep, or if you cough or sneeze? . . . . . If **Yes**
2. Does this usually happen at least once a week? . . . . . Yes*
3. Do you ever soil or mess yourself? . . . . . Yes*

***Further continence and home assessment indicated (see pages 14–15)**

MEDICATION

1. Do you usually take any medication prescribed by your doctor? . . . . . If **Yes**
2. How many different ones? List:
   . . . . . (if >3*)
3. Do you have difficulty in remembering when to take them? . . . . . If **Yes***
4. Are the medications on repeat prescription? . . . . . If **Yes***

***Further medication review indicated (see page 16)**

MENTAL FUNCTION

Some practices may prefer to use the Geriatric Depression Scale and Abbreviated Mental Test Score to assess mental function in stage 1 (see below).

1. Do you feel sad, depressed or miserable?
. . . . . Yes*
2. Do you have problems with your everyday memory?
. . . . . Yes*

Does the elderly person's attitude or behaviour suggest agitation, depression or mental impairment?
. . . . . Yes*

***Further mental assessment indicated (see page 17)**

SCREENING QUESTIONNAIRE FOR DEPRESSION
Geriatric Depression Scale (GDS) (shortened form)

- Are you basically satisfied with your life? yes/**No**
- Have you dropped many of your activities and interests? **Yes**/no
- Do you feel that your life is empty? **Yes**/no
- Do you often get bored? **Yes**/no
- Are you in good spirits most of the time? yes/**No**
- Are you afraid that something bad is going to happen to you? **Yes**/no
- Do you feel happy most of the time? yes/**No**
- Do you often feel helpless? **Yes**/no
- Do you prefer to stay at home, rather than going out and doing new things? **Yes**/no
- Do you feel you have more problems with memory than most? **Yes**/no
- Do you think it is wonderful to be alive now? yes/**No**
- Do you feel pretty worthless the way you are now? **Yes**/no
- Do you feel full of energy? yes/**No**
- Do you feel that your situation is hopeless? **Yes**/no
- Do you think that most people are better off than you are? **Yes**/no

For each answer in bold type score 1. Scores > 5 indicate probable depression.

Source: Shelk and Yesavage (1986). See also Appendix 8.

SCREENING QUESTIONNAIRE FOR COGNITIVE FUNCTION
Abbreviated Mental Test Score (AMTS)

May I ask you some routine questions to gauge your memory?

- How old are you?
- What is the time (to nearest hour)?
- Give the patient the following address to recall at end of test: 42 West Street. This should be repeated by the patient to ensure it has been heard correctly.
- What year is it?
- What is your address?
- What jobs do these people do? (Show the patient two pictures: a postman or a cook.) *or* Who are these two people? (Show photographs of Pope and Queen)
- What is your date of birth?
- What year did the First World War start?
- What is the name of the present monarch?
- Please count backwards from 20 to 1.

Then don't forget the address for recall.

Score 1 only for each correct answer. 0–3 indicates severe impairment. 4–6 moderate impairment. > 6 is normal.

Source: Hodgkinson HM (1972). See also Appendix 9.

FINANCES

1. Do you have any difficulty in making ends meet, I mean is it difficult to find the money to pay your bills?
   . . . . . Yes*

2. Do you have any difficulty in managing your own finances, I mean things like paying for bills, working out change, etc?
   . . . . . Yes*

***See Appendix 4 and possibly refer to Department of Social Security.**

LIFESTYLE

1. In general, how often do you have a drink of alcohol?
   . . . . . Every day*

2. Do you smoke cigarettes?
   . . . . . If **Yes**

   About how many do you usually smoke?
   . . . . . [>20]*

***Further lifestyle review indicated (see page 17)**

Health checks for people aged 75 and over

STAGE 2

Primary care assessment

This section contains 12 suggested areas for further assessment within primary care which would be triggered off by problems identified in stage 1. They include: social, carer, home, functional, physical, continence, visual, hearing, medication, mental and lifestyle assessment.

The sheets are intended as a guide to the general areas of enquiry. However, in the case of the assessment of activities of daily living, cognitive function and depression, the use of the specific standardized scales (included in the appendices) has demonstrable advantages and it is recommended that these be used.

The further assessments suggested in stage 2 may indicate the need for referral to specific agencies or specialists, but for most actions will be confined to primary care. A general guide to the services offered by different agencies is provided on page 6 above, but as there may be considerable variation from one area to another, it is recommended that a local directory be obtained.

SOCIAL ASSESSMENT

Aims

1. To alert a practice to 'at risk' situations for note in record or computer system.
2. To identify the possibility of poor diet which may need health visitor advice.
3. To identify isolation which may need social worker help.
4. To identify problems with getting help in emergency which may need social worker help.
5. To determine unsatisfactory social contacts which may need social worker help.

Suggested areas for enquiry/examination

- Details of social network (neighbours)
- Suffers loneliness
- Communication problems, eg speech, language
- Recently bereaved
- Recently moved house
- Problems with diet
- Nutritional state
- Ability to use telephone if present
- Transport availability
- Contact with family and friends
- Services used
- Involvement with social groups
- Plans for emergency

CARER ASSESSMENT

Aims

1. If the person is a carer, to identify stress which may herald breakdown of care.
2. If person is being cared for, to ascertain whether care is adequate.

   This assessment usually needs a separate interview. The following questions are a guide. If a social worker is involved, a fuller separate assessment scale may be needed.

Suggested areas for enquiry/examination

If person is a carer:

1. Does caring duty affect the person's:
   — health . . . . . .
   — free time. . . . . .
   — mobility . . . . . .
   — sleep. . . . . .
   — emotional state? . . . . . .

2. Does level of caring suggest that the person is:
   — coping . . . . . .
   — coming under pressure . . . . . .
   — at the end of his/her tether? . . . . . .
3. Is additional help required? . . . . . .

If person is being cared for:

1. Look at carer and ask questions 1, 2, 3 above . . . . . .
2. Is caring adequate for needs of the person? . . . . . .
3. Additional help required . . . . . .

HOME ASSESSMENT

Aims

1. To identify problems with housing which could create problems for the old person.
2. To identify accident hazards.

Further areas for enquiry

1. Problems with:
   — stairs
   — access to bedroom
   — access to toilet
   — heating
   — damp
2. Need for repairs or adaptions:
   — unsuitable position or size
   — difficulties with access
   — poor cooking facilities
   — poor laundry facilities
   — accident hazards

FUNCTIONAL ASSESSMENT

Aims

1. To measure extent of functional ability.
2. To identify problems which may be amenable to intervention.

Suggested areas for enquiry/examination

There is a range of activities of daily living which may be considered under three headings: sociability (activities outside the home), domestic activities and personal activities.

Sociability
A number of aspects of sociability may already have been covered in the first section of the stage 2 check.
Further aspects include:
   — doing the shopping
   — walking the dog
   — attending church
   — visiting theatre or concert
   — taking a holiday
   — pursuing a hobby.

Domestic activities
Domestic activities to be assessed encompass:
   — doing the washing
   — housework
   — household repairs
   — gardening
   — decorating
   — doing the cooking
   — washing up.

Personal activities

Personal activities of daily living are the individual tasks of vital importance to each elderly person, including:

- mobility around the house
- transferring from bed to chair
- managing the stairs
- dressing
- grooming
- bathing
- using the toilet
- bladder control
- bowel control
- feeding.

The recommended instrument of further assessment for personal activities of daily living is the Barthel Index (see Appendices 5 and 6). This standardized instrument is widely used and has the advantage of a scoring system.

GENERAL PHYSICAL ASSESSMENT

Aim

1. To discover causes for the functional disability found.

Suggested areas for enquiry/examination

This assessment should involve full physical examination by a doctor, perhaps with emphasis on a particular system, for example neurological, musculoskeletal; and would probably include urine test, blood pressure measurement and certain investigations.

Falls and poor mobility are the most common triggers to full physical examination. There are a large number of causes for both these problems. Problems may be dealt with in primary care or may need referral to appropriate specialists or full independent assessment.

CONTINENCE ASSESSMENT

Urinary continence

Aims

1. To determine the degree and type of incontinence.
2. To determine the level of control achieved.
3. To search for any possible treatable cause.

Suggested areas for enquiry/examination

Examination should include a search for possible causes, including urinary tract infection, vaginitis, faecal impaction, tumours, mechanical causes, diabetes, heart failure, medication problems, and central nervous system disease. The examination would include urine test, genital and rectal examination and a review of the medication. A full history is needed of the timing, symptoms, degree of control, reaction to activity and the volume of urine passed. Incontinence of urine, particularly if short term, may be reversible, for instance that due to diureses, infection, psychological or iatrogenic causes. Longstanding incontinence will need advice from appropriate specialists. Continence charting may be helpful.

Faecal continence

Aims

1. To determine the type of incontinence.
2. To search for any possible treatable cause.

Suggested areas for enquiry/examination

A general examination as well as rectal examination should be carried out as causes may not necessarily be local. A common cause of incontinence is faecal impaction producing spurious diarrhoea. Short-term incontinence may be due to infection or dietary disturbance. Any serious illness may be associated with faecal incontinence and some drugs may also be responsible, for example antibiotics. Self-prescribed laxatives may be the cause. Recognition of carcinoma of the bowel is important.

VISUAL ASSESSMENT

Aims

1. To determine whether vision can be improved.
2. To see if any problems present can be treated.
3. To determine whether new spectacles are needed.
4. To determine whether special aids are needed.

Suggested areas for enquiry/examination

In primary care an assessment of vision using a Snellen chart and a field of vision test would probably be all that was necessary. Problems associated with visual defect and field of vision would probably be referred to an ophthalmologist.

HEARING ASSESSMENT

Aims

1. To ascertain whether hearing can be improved.
2. To determine whether wax is present in the ear.
3. Where a hearing aid present, to ascertain whether it is working adequately.

Suggested areas for enquiry/examination

The assessment should involve a simple hearing test such as a whisper test (see Appendix 7), examination of the ear for wax, and referral to an ENT surgeon if specific problems are discovered.

MEDICATION REVIEW

Aims

1. To make adjustments to medication as a result of the review.
2. To make realistic arrangements for repeat prescriptions.
3. To explain to the elderly person and carer(s) the reasons for the medication.

Suggested areas for enquiry/examination

Consideration should be given to the following points:

- Appropriateness
- Dosage
- Compliance
- Understanding of purpose
- Non-comprehension
- Over medication
- Side-effects
- Iatrogenic effects
- Containers
- Clarity of instructions
- Over-the-counter drugs
- Ethnic remedies
- Repeat prescription schedule.

MENTAL FUNCTION ASSESSMENT

Aim

1. To identify the presence of mental problems particularly depression and dementia.

Tact is needed for this kind of assessment.

Identification of dementia or depression can be difficult, because many older people attempt to disguise the presence of either condition. Ideally a full present state examination should be carried out, but in practice this is likely to be beyond the scope of the health check.

A number of standardized scales have been developed for the detection of depression and dementia. These have the advantages of being brief and effective in identifying problems. It is recommended that the Geriatric Depression Scale (Appendix 8), and the Abbreviated Mental Test Score (Appendix 9), be used for the detection of depression and dementia respectively. These may seem awkward to use at first, but with a little practice they can usually be administered without problems. The scales can be administered at interview, or given to the elderly person for self-completion.

It is important not to restrict assessment to the use of the scales, but to supplement the findings with information gained from further enquiry, observation of the person's attitude or behaviour and if possible details provided by someone who knows them well, such as a spouse or a carer.

Where depression is identified, the opinion of a psychiatrist may be sought, or alternatively treatment instigated as appropriate with an antidepressant.

In the case of dementia, underlying causes for reduced cognitive function should be sought and it may be necessary to seek the opinion of a psychiatrist.

FURTHER REVIEW OF LIFESTYLE

Aim

1. To seek to promote a healthy lifestyle, especially with regard to diet and exercise/activity.
2. To explore aspects of lifestyle which may place the elderly person at risk, or may be causing problems, especially smoking, drinking and diet.

Suggested areas of enquiry

Diet
- Fresh fruit
- Vegetables
- Cooked meals
- Fibre

Smoking
- Number of cigarettes smoked
- Attempts to stop
- Smoking-related disease/symptoms

Alcohol
- Frequency of consumption
- Type and amount consumed on average on each occasion
- Evidence of alcohol-related problems (e.g. sleep disturbance, dyspepsia, anxiety, memory loss etc.)
- Evidence of concealed drinking (e.g. hidden bottles and cans)

Exercise
- Walking
- Active exercise, e.g. swimming.

Health checks for people aged 75 and over

STAGE 3

Full assessment

The final stage is full assessment, which often includes a number of disciplines and usually secondary care facilities. The number of persons requiring this assessment will be relatively small.

Indications

A full assessment in the community is indicated when medical or social breakdown is imminent as perceived by health workers, social workers, or a carer; at discharge from hospital for patients with high dependency; and for patients about to be admitted to nursing home or rest home.

Following a health check, full assessment is needed when incipient breakdown is recognized; where problems are multiple and complex; where the load on carers is becoming intolerable; where a move to institutional care is being considered; and finally where a situation is identified which demands resources outside the domain of primary health and social care.

Objective

The team must define the old person's problems, include the person and carers in the process, and arrange appropriate action plans which in turn should be followed up.

The aim is to maximize choice for individual people rather than to make decisions for them. Communication within the team and with the person and carer is all important.

Content

1. A complete medical check-up, including history, physical examination and appropriate laboratory studies. Specific attention to status of vision, hearing, dentition, nutrition and medications, including information on accuracy of medication-taking.
2. Mental assessment including objective measures of memory and cognition, mood/affect, evidence of alcohol or drug addiction.
3. A functional assessment, which should include both actual performance as well as ability to perform personal activities of daily living and domestic daily activities.
4. Social history and social status, which should include the support network available, primary as well as secondary carers, and evidence of emotional as well as physical support, financial status, coping ability and formal and informal services already being used.
5. Environmental assessment including housing conditions, heating, cleanliness, telephone, safety hazards, neighbourhood suitability, availability of transport and likelihood of relocation.

The overall aim is to obtain a complete inventory of the person's strengths and weaknesses. The result should be a problem list that is then related to what services are needed to restore and maintain the greatest possible independence and the choice-of-living arrangements as preferred by the old person.

It is recommended that the format and instruments used for the assessment should be those advocated by the Royal College of Physicians Working Party on Assessment in the Elderly (1992). It is important that there should be conformity between instruments used when full assessments are undertaken in both primary and secondary care.

The team

The composition of the team will vary according to circumstances. The important difference between this assessment and that carried out in stage 2, which is problem specific, is its comprehensive nature. The core members are likely to be a physician, a nurse and a social worker. Additional members may include a physiotherapist, occupational therapist and speech therapist. The assessment can take place in primary care where the physician will be the general practitioner, but often a specific specialist, for example a psychogeriatrician or an ophthalmologist will need to be included.

Setting up a full assessment

When there is an indication for full assessment of a patient in the community, a general practitioner is likely to be the instigator. Almost certainly such an assessment will need secondary care expertise and the first contact point is likely to be a consultant physician with expertise in health care of the elderly. Discussion will usually determine the place of the assessment, other contributors, and the timing. Admission to hospital may ensue, but it will be helpful if at least part of the assessment has taken place at home.

When to refer to a specialist

Finally, on a very pragmatic note, here is a brief guide for reasons for referral to a specialist:

1. To clarify a diagnosis
2. For advice about treatment
3. To gain access to a specific treatment or procedure
4. For further investigation
5. For a second opinion either at the patient's or carer's behest, or for the professional's own reasons
6. To gain access to other services such as physiotherapy or day care
7. To link with hospital outreach services.

Reference

Royal College of Physicians Research Unit and British Geriatrics Society Research Units (1992) *Standardised Assessment Scales for Elderly People*. Report of joint workshops. London, RCP and BGS.

APPENDIX 2

Patient summary card

HEALTH CHECKS FOR PEOPLE AGED 75 AND OVER

Summary card

Name: _____

Date of birth: _____

Living arrangements: _____ (eg. lives alone, with spouse, etc.)

Contact person: _____

Address: _____

Post code: _____ Tel No: _____

(Specify whether relative/neighbour, etc.) _____

Receipt of services

	Mon	Tues	Wed	Thu	Fri	Sat	Sun
1. District nurse							
2. Home help							
3. Meals on wheels							
4. Health visitor							
5. Voluntary visitor							
6. Day centre							
Name / Tel No:							
7. Other(s)							

FOLLOW-UP				
Agency	Date of referral/ information (R/I)	How long until response/ input received? *	Was response/ input appropriate? **	Comments (eg. reason for referral/ information/nature of response)

*Suggest: Not received (N/R), < 3 months, 6 months –1 year, > 1year

**Suggest: Yes, No, Don't know

Date last seen by practice _ /_ /_

Date of last medication review _ /_ /_

SUMMARY

	No problem	*Comments*
Social		
1. Living arrangement	☐	
2. Seeing others	☐	
3. Availability of help	☐	
Home environment		
4. Heating home	☐	
5. Falls at home	☐	
6. Need for modification	☐	
Mobility		
7. Use steps	☐	
8. Go out	☐	
General function		
9. Shopping	☐	
10. Housework/repairs	☐	
11. Cook meal	☐	
12. Cut toenails	☐	
13. Wash all over	☐	
14. Dressing	☐	
Senses		
15. Hearing	☐	
16. Vision	☐	
Continence		
17. Urinary	☐	
18. Faecal	☐	
Medication		
19. Number of medications	☐	
20. Recall/compliance	☐	
Finance		
21. Making ends meet	☐	
22. Management of finances	☐	
Mental function		
23. Feeling depressed	☐	
24. Problems with memory	☐	
25. AMTS	☐	
26. GDS	☐	
Lifestyle		
27. Alcohol	☐	
28. Cigarettes	☐	

APPENDIX 3

Surveillance of elderly people in general practice

AUDIT FORM

Category	*Number*
Elderly people (75+) registered with the practice on 1 April 19.....	.....
Elderly people (75+) offered an assessment as per the contractual requirement between 1 April 19..... and 31 March 19.....	.....
Active refusals	.....
Non-responders	.....
Assessments achieved	.....
Seen at home	.....
Seen in the surgery	.....
Estimated average length of time for each assessment (including travelling time)	.....

Principal assessor	*Number assessed*
General practitioner	.....
Practice nurse	.....
District nurse	.....
Health visitor	.....

Other (please specify)

.....

Has a standard assessment card/package been used? No Yes

If Yes, please specify .....

[Further audit relating to needs found, services arranged and taken up, and evidence of benefit are helpful. Advice should be taken about the mechanisms of auditing from the local MAAG.]

APPENDIX 4

The Lisson Grove Benefits Program

The Lisson Grove Welfare Benefits Program is designed to help advisers determine entitlement to welfare benefits. Most means-tested and other benefits are covered, with explanatory material detailing the remainder. The program is developed at St Mary's Hospital Medical School, part of Imperial College in London. The project receives support from the Paul Hamlyn Foundation.

Each client is asked sufficient questions to determine their benefits entitlement. Guidance on using the program is available on screen at all times. Answers to questions are checked for validity before being accepted. Results are not held over to the end of a consultation: each is shown as soon as possible.

Over 500 fully cross-referenced help screens provide relevant advice on answering questions, offer interpretation of results, and give guidance on the operation of the program. The help screens also contain general information on the welfare benefits system. A comprehensive manual accompanies the package.

The program incorporates a sophisticated review and recalculation feature allowing for any new calculations to be made at any time. If the user changes an answer, the case is recalculated. Any new questions which become necessary are asked, and irrelevant information is discarded. The program shows any changes to the results and ensures that each case remains consistent. This makes it possible to explore a range of options in just a few keystrokes, for example to show a client how entitlements change on retirement, or to demonstrate the effects of taking part-time work.

Comprehensive print-out facilities are also provided. Any result or help message can be printed while on screen. Summaries can be printed at any time, not just at the end of a case. Where answers have been changed and cases recalculated, this is indicated on the print-out.

The program is currently used at over 800 sites in more than 500 organizations, including Citizens Advice Bureaux, Social Services, Health Authorities and Local Authority Welfare Rights Units. Regular updates follow each change in social security legislation.

Technical details

The current program is available for IBM-compatible micros running MS-DOS.
The computer should be equipped with the following:

- 640K of RAM
- 2×360K floppy drives; or
  1×720K floppy drive; or
  a hard disk drive.

Virtually all IBM-compatible micros are equipped to this specification.
The system should run successfully over MS-DOS-compatible networks.

Pricing and availability

The program is sold on a subscription basis. This fee covers all updates over the subscription period and includes a manual and telephone support. The subscription for 1992/93 is £70 plus VAT for a single copy. Multiple copies attract increasing levels of discount. Organizations which may require many copies or that wish to run the program over a network should contact Lisson Grove for further information. Evaluation copies are available free of charge.

Initial enquiries should be made to Debra Weston, Administrator, Lisson Grove Benefits Program, Department of General Practice, Lisson Grove Health Centre, Gateforth Street, London NW8 8EG. Tel: 071 724 0480; Fax: 071 724 0995.

APPENDIX 5

Barthel Activities of Daily Living (ADL) Index

Instructions:

- Scoring: When the assessment is complete, total the score.
- Specify the informant when the Barthel Index is done in the community.

Patient ☐ Main support person ☐ Both ☐ Other ☐

If other, specify who

Mobility indoors
0 Immobile
1 Wheelchair independent (including corners/doors)
2 Help of one untrained person, including supervision
3 Independent (may use aid) ☐

Transfers
0 Unable – no sitting balance, two to lift
1 Major help: physical help, 1 strong/skilled or 2 normal. Can sit
2 Minor help: 1 person easily or supervision for safety
3 Independent ☐

Stairs
0 Unable
1 Needs help (verbal/physical, carrying aid)
2 Independent up and down, carrying walking aid ☐

Toilet use
0 Dependent
1 Needs help but can do something (including wiping self)
2 Independent: can reach toilet/commode, undress, clean self and leave ☐

Bladder
0 Incontinent or catheterized and unable to manage
1 Occasional accident (maximum once / 24 hours)
2 Continent over 7 days ☐

Bowels
0 Incontinent (or needs to be given enema)
1 Occasional accident (less than 1 / week)
2 Continent ☐

Bathing
0 Dependent
1 Independent
Bath: must get in and out unsupervised, wash self
Shower: unsupervised/unaided ☐

Grooming
0 Needs help with personal care
1 Independent: implement can be provided by helper ☐

Dressing
0 Dependent
1 Needs help but can do half unaided
2 Independent including buttons, zips, laces, etc. ☐

Feeding
0 Unable
1 Needs help in cutting up food, spreading butter, etc, but feeds self
2 Independent (food cooked, served and provided within reach but not cut up.
Normal food [not only soft food]) ☐

Total score ☐ / 20

Source: Wade DT and Collin C (1988) The Barthel ADL index: a standard measure of physical disability. *International Disability Studies* **10**, 64–7.

APPENDIX 6

Instrumental Activities of Daily Living (IADL) Scale

	No	*With help*	*On my own with difficulty*	*On my own*
	Score	*Score*	*Score*	*Score*
1. Do you walk around outside?	0	0	1	1
2. Do you climb stairs?	0	0	1	1
3. Do you get in and out of the car?	0	0	1	1
4. Do you walk over uneven ground?	0	0	1	1
5. Do you cross roads?	0	0	1	1
6. Do you travel on public transport?	0	0	1	1
7. Do you manage to feed yourself?	0	0	1	1
8. Do you manage to make yourself a hot drink?	0	0	1	1
9. Do you take hot drinks from one room to another?	0	0	1	1
10. Do you do the washing up?	0	0	1	1
11. Do you make yourself a hot snack?	0	0	1	1
12. Do you manage your own money when you are out?	0	0	1	1
13. Do you wash small items of clothing?	0	0	1	1
14. Do you do your own housework?	0	0	1	1
15. Do you do your own shopping?	0	0	1	1
16. Do you do a full clothes wash?	0	0	1	1
17. Do your read newspapers or books?	0	0	1	1
18. Do you use the telephone?	0	0	1	1
19. Do you write letters?	0	0	1	1
20. Do you go out socially?	0	0	1	1
21. Do you manage your own garden?	0	0	1	1
22. Do you drive a car?	0	0	1	1
			Total Score	/ 22

Source: Nouri F and Lincoln NB (1987) An extended activities of daily living scale for stroke patients. *Clinical Rehabilitation* 1, 301–5.

APPENDIX 7

The 6-inch whispered voice test

- Stand behind the person at a distance of 6 inches.
- Take a deep breath in, breathe right out and whisper Three-A-Two.
- Ask the person to repeat this.

The test is passed if the sequence is repeated correctly.
If the person responds incorrectly or not at all, repeat the test once more using One-F-Three.

Passed [ ]
Failed [ ]

If the person fails, examine the ears.

Source: Swan IRC and Browning GG (1985) The whispered voice as a screening test for hearing impairment. *Journal of the Royal College of General Practitioners* **35**, 197.

APPENDIX 8

Geriatric Depression Scale (GDS)

Instructions:

1. Please ask the patient all of the following questions. Ask him/her to choose the best answer for how he/she has felt over the last week.
2. Scoring: Record the patient's response by circling either Yes/No for each question. Total the score obtained when the assessment is complete.

		Yes	No
1.	Are you basically satisfied with your life?	0	1
2.	Have you dropped many of your activities and interests?	1	0
3.	Do you feel that your life is empty?	1	0
4.	Do you often get bored?	1	0
5.	Are you in good spirits most of the time?	0	1
6.	Are you afraid that something bad is going to happen to you?	1	0
7.	Do you feel happy most of the time?	0	1
8.	Do you often feel helpless?	1	0
9.	Do you prefer to stay at home rather than going out and doing new things?	1	0
10.	Do you feel you have more problems with your memory than most?	1	0
11.	Do you think it is wonderful to be alive now?	0	1
12.	Do you feel pretty worthless the way you are now?	1	0
13.	Do you feel full of energy?	0	1
14.	Do you feel that your situation is hopeless?	1	0
15.	Do you think that most people are better off than you are?	1	0
	Total score		/ 15

A score of > 5 indicates probable depression.

Source: Shelk JI and Yesavage JA (1986) Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. In Brink TL (ed) *Clinical Gerontology: A Guide to Assessment and Intervention.* New York, Haworth Press.

APPENDIX 9

Abbreviated Mental Test Score (AMTS)

Instructions:

1. Please ask the patient all of the following questions.
2. Scoring: A score of 1 is obtained for every correct answer given by the patient. When assessment is complete, total the score.

	Score
1. How old are you?	☐
2. What time is it (to nearest hour)?	☐
3. Give the patient the following address for recall at end of test: 42 West Street This should be repeated by the patient to ensure it has been heard correctly.	☐
4. What year is it?	☐
5. What is your address?	☐
6. What jobs do these people do? (Show the patient two pictures: a postman and a cook) *or* Who are these two people? (Show pictures of Pope and Queen.)	☐
7. What is your date of birth?	☐
8. What year did the First World War start?	☐
9. What is the name of the present monarch?	☐
10. Count backwards from 20–1.	☐

DON'T FORGET THE ADDRESS FOR RECALL!

Total Score ☐ / 10

0–3	Severe impairment
4–6	Moderate impairment
> 6	Normal

Source: Hodgkinson HM (1972) Evaluation of a mental test score for assessment of mental impairment in the elderly. *Age and Ageing* 1, 233–8.

APPENDIX 10

List of participants in study day
Royal College of General Practitioners
1 November 1990

Dr David Armstrong
Mr Paul Aylward
Mr Richard Beaver
Dr Martin Blanchard
Professor Nicholas Bosanquet
Dr Ann Bowling
Dr Graham Buckley
Dr Martin Busk
Dr Iain Carpenter
Dr A K Coates
Dr Timothy Dant
Dr Edward Dickinson
Professor Shah Ebrahim
Dr Charles Freer
Dr John Grace
Dr Nori Graham
Professor Andrew Haines
Mr Richard Hollingbery
Dr Stephen Iliffe
Dr M Impallomeni
Dr S J Jachuck
Mr John James
Professor Brian Jarman
Dr Dee Jones
Professor Karen Luker
Dr Punam Mangtani
Professor Anthony Mann
Dr Peter Mayer
Dr Robert McEwan
Dr Iain McIntosh
Dr W Miller
Ms Sue Newberry
Professor Denis Pereira Gray (Chairman)
Professor Brice Pitt
Dr Geoffrey Rivett
Dr Paul Saunders
Ms Leah Spencer
Dr A J Tulloch
Dr Norman Vetter
Dr Christina Victor
Dr Paul Wallace (Convenor)
Dr David Wilkin
Professor E Idris Williams (Convenor)
Dr Alastair Wright
Ms Elizabeth Young

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