

Assessment of the elderly in general practice

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Introduction

In his chapter on the care of the elderly in general practice, Currie (1975) states that "old age should be anticipated and prophylactic geriatric care should be given in middle life." He emphasised the problems of unreported illness and the methods needed for detection. Williamson *et al.* (1964) showed that elderly people over the age of 65 have an average of three disabling conditions, half of which were unknown to the family doctor and the majority of which were treatable.

This is not simply an academic statistic—when translated into the reality of a general practice there will be approximately 1,000 disease entities in the population of elderly patients and of these the doctor will be unaware of 500 unless he has devised some method of seeking out this iceberg of morbidity.

The problem extends beyond the individual patient or practice: 14 per cent of the population of Glasgow, or 126,000 people, are over the age of 65 and this represents a forbidding quantity of undetected illness, unknown disability, and unmet need.

It is being increasingly realised that the geriatric services of a district or an area need to be planned with foresight and such planning must take account of the community as well as hospital aspects of geriatric care. If planning is to be meaningful, however, it must be based on information: as yet no system has been developed by which information about the needs of the elderly in the community can be collected and used in planning geriatric care.

There have been many reports on screening programmes for the elderly in general practice (Williamson *et al.*, 1964; Thomas, 1968; Burns, 1969; Lowther *et al.*, 1970; Irwin, 1971; Currie *et al.*, 1974): these uniformly confirm that ill health in old age is made up of many and varied problems, a significant number of which can be alleviated, if not solved. The ability of the health visitor to screen the elderly patient has been stressed by many authors (Anderson and Cowan, 1955; Williamson *et al.*, 1964; Irwin, 1971; Currie *et al.*, 1974), but health visitors have other work apart from caring for the elderly, and a continuous screening programme in a group practice of three doctors would require the full-time involvement of one health visitor, additional to the normal service commitment (Ness and Reekie, 1970; Currie *et al.*, 1974).

With the resources that are now available in general practice, screening programmes pose a difficult dilemma for the doctor and health visitor. Screening should be continuous if it is to realise its long-term potential, but it can be incompatible with the other demands on the staff unless it is pared to a minimum—it may then become ineffectual because of its simplistic approach.

The most practical scheme might include an initial simple and quick method of detecting those patients who would be likely to benefit from a more detailed health-visitor

assessment. The health visitor would then be able to select those problems in patients whom the general practitioner should examine in greater depth. The use of a 'team approach' can thus ensure that the problems that are identified can be optimally tackled. The advantages of such a system might be that screening and assessment could become continuous and the abilities of the health visitor, the district nurse, and the doctor would be used optimally, and as a by-product, information would be continuously collected on which those responsible for planning geriatric services could act.

This paper describes a scheme in which the health visitor did the assessment and collected the information. Work is also being done on the important, and in some ways more difficult, subject of adapting screening of the elderly and subsequent care to the reality of general practice.

The practice

Woodside Health Centre is situated in an area of urban development in the north of the City of Glasgow. Eight practices with a total of 22 doctors work from the centre serving a population of 45,000 patients of whom about 5,000 are over the age of 65. The number of patients over this age in each practice is shown in table 8.

Each practice has one attached district nurse and one health visitor, regardless of the size of the practice and its case load: there are in addition two full-time and one part-time geriatric visitors (registered general nurse) who work with the larger practices and one enrolled nurse (geriatric visitor) who works for two smaller practices. The Centre has two dental surgeons and two social workers, one of whom has a commitment to teaching.

Specialists from Stobhill Hospital hold regular consulting clinics in the Centre and physiotherapy, dietetics, and chiropody are also represented; the specialist in geriatric medicine holds one session each week and the Centre thus offers many of the skills necessary for the care of the elderly.

Aims

Although there are several points of similarity with many other surveys, our study had the following aims:

- (1) To establish comprehensive baselines of the symptoms and problems of elderly patients already in contact with the general practitioner or health visitor.
- (2) To devise recording forms which would allow periodic assessments to become an integral and continuing part of the services given by the general-practitioner team.
- (3) To enable a team approach to be applied to the problems of the elderly which would use the appropriate skills of each member of the team.
- (4) To develop an information system on the problems and needs of the elderly which would be of value in terms of planning community geriatric care.

Method

The assessment programme was based on work done in 1972 by Dr Barry B. Taylor, a Research Fellow in the University Department of Geriatric Medicine, who carried out research on a questionnaire for geriatric assessment. In 1975 this questionnaire was adapted by one of the authors (J. W.) from its research format into one which was more compatible with normal work. The new recording form was intended to be a working document which would remain in the keeping of the health or geriatric visitor, but provision was made for the information obtained to be transcribed on to a problem list in the medical record, and to be computer-compatible, so as to form a continuing information system on the problems and needs of the elderly.

The form contains several sections: the first page contains demographic data about the patient and details of the acceptance of the interview by the patient. The next section includes questions of such medical complaints as mobility, vision, and hearing, which are socially important. For each main area of enquiry (for example hearing) there are several specific points listed which have been given numerical scores ranging from 0–6. The figure 0 always implies that the information is not known or is unobtainable; 1 that there is no problem present associated with the topic of enquiry; 2 that there is a problem but that it is inactive; and 3 and above represent increasingly severe active problems.

The section on medical and social needs has a similar scoring system—0 means not known; 1 means no need; 2 indicates need present but met; 3 means need unmet. The final section is a system/symptom questionnaire which contains 57 questions and is scored; 0 means not known; 1 indicates no symptoms; 2 means symptoms known and/or recorded in the medical notes (inactive); 3 means action is required for a 'new' or active problem.

The assessment programme is at present restricted to those patients who are referred to the health visitor by someone in the practice team. In practice this means that the patient already has contact with the doctor or nurse who has then recommended that a detailed assessment should be made. The health visitor is therefore known to the patients and is identified with the practice: this means that the assessment visit is likely to be acceptable.

The health visitor completes the assessment in the patient's home on one or more visits, and enters the appropriate numerical score for each question. The first of the six available vertical columns is used—the remainder are for subsequent assessment. The two blank pages at the back of the booklet are for progress notes—with the re-grading of problems when effective action has been taken. After the assessment has been completed, all problems or symptoms which have been identified with a score of 2 or more are entered on to a problem sheet in the medical case notes (figure 1).

This provides all members of the practice team with a baseline on the patient's active and inactive problems and the progress of the patient is kept up to date by re-grading each problem when indicated. The assessment is discussed at the practice meeting when the problems identified are referred to the most appropriate person for follow-up, and the date of the next full assessment is decided. The information on the assessment booklet is punched on cards for computer storage and analysis.

Results

Since September 1974, about 150 assessments have been completed and details of the analysis of the first 100 patients are given below. The age distribution of the 26 men and 74 women assessed is shown in table 1; 73 patients lived in corporation houses, 19 were private tenants, and four were owner-occupiers. Four patients lived with some other

TABLE 1
AGE DISTRIBUTION OF PATIENTS ASSESSED (n=100)

	<60	60–69	70–79	80–89	90+
Males	—	8	12	5	1 26
Females	3	9	46	16	— 74
	3	17	58	21	1
	20		80		

TABLE 2
THE CARING RELATIVE (n=100)

	<i>Male</i>	<i>Female</i>	<i>Total</i>
Lives in same house	19	23	42
Lives nearby	1	7	8
Provides regular visits (reliable)	2	30	32
Visits patient at irregular intervals	2	10	12
No caring relative	2	4	6

Table 2 shows the proximity of the *caring* relative, (not necessarily the relative with whom the patient lives): in 41 cases, the caring relative lived in the same house, but six patients had no such relative available. Table 3 shows that 18 men (69 per cent) and 30 women (40 per cent) were dependent on others for domestic or personal care. Clothing, bedding, and heating were considered by the health visitors to be inadequate in 13 of the houses. Only 35 per cent of all patients were fully mobile; 45 per cent found difficulty in getting out of the house; 15 per cent were housebound and five per cent either chair or bed-bound.

TABLE 3
DEPENDENCE ON OTHERS (n=100)

	<i>Male</i>	<i>Female</i>	<i>Total</i>
No dependence	5	24	29
Dependent on others for shopping	3	20	23
for domestic care	13	21	34
for personal care	5	9	14

Thirteen per cent of patients had some degree of incontinence while 34 per cent had inadequate or deteriorating vision and 22 per cent had a significant problem with hearing. Weight, hygiene and diet showed problems: 27 per cent of patients were thought, subjectively, to be overweight and 19 per cent underweight; personal hygiene was considered deficient in 17 per cent and diet inadequate or deficient in 25 per cent. Table 4 shows that apart from the district nurse and health visitor services (supportive visits) just over 50 per cent of the identified needs were found to have been met at the time the assessment was made.

TABLE 4
NEEDS IDENTIFIED IN 100 PATIENTS ASSESSED

<i>Needs</i>	<i>Unmet need</i>	<i>Need has been met</i>	<i>Total</i>	<i>Percentage with need where need has been met</i>
Supportive visits	30	45	70	60
Housing	20	12	32	37
Chiropody	18	25	43	58
Home help	15	21	36	58
Contacts with other people	14	16	30	53
Meals on wheels	7	2	9	22
District nurse	1	4	5	80

TABLE 5
PREVALENCE OF KNOWN AND UNKNOWN SYMPTOMS

<i>Symptoms identified</i>	<i>Number of symptoms</i>	<i>Percentage of symptoms not previously known, or requiring action</i>
General health	47	34
Gastrointestinal tract	60	37
Skin	11	27
Genitourinary tract	57	28
Locomotor	75	10
Cardiac and respiratory	247	22
Neurological	157	27
Memory	37	68
Psychiatric	98	56

Table 5 shows the results of the symptom enquiry. Seven hundred and eighty symptom complaints were identified (7.8 per patient) of which 309 (39 per cent) were not previously known to the doctor or were sufficiently troublesome to make the health visitor consider that further action should be taken. The percentage of existing symptoms previously unknown ranged from ten per cent (locomotor conditions) to 68 per cent in respect of memory loss or depression. Table 6 shows the average number of symptoms per patient in each of the five age groups. The number of unknown symptoms increased with age.

TABLE 6
MEAN NUMBER OF SYMPTOMS KNOWN AND UNKNOWN BY AGE

	<60	60-69	70-79	80-89	90+
<i>Males</i>					
Number of patients	—	8	12	5	1
Number of symptoms/patient	—	8	7	8	6
Number of unknown symptoms/patient	—	2.7	3.1	3.4	—
<i>Females</i>					
Number of patients	3	9	46	16	—
Number of symptoms/patient	12	5	7	8	—
Number of unknown symptoms/patient	2	0.8	2	2.5	—
<i>All patients</i>	>70		<70		
Number of patients	20		80		
Number of symptoms/patients	7		7		
Number of unknown symptoms/patient	2		2.3		

Discussion

Screening or assessment programmes for the elderly fall broadly into two groups—those that are initiated in a general practice and which are directed towards all patients in particular pre-determined age groups, and those that take a sample of the elderly population in one or more practices and which are originated either by hospital specialists or by general practitioners.

Thomas (1968) described a study in which he selected two groups of patients: those who had just attained the age of 65 years, and those over 65 who were referred for screening by general practitioners in two group practices. This latter group of patients is most closely comparable with the screening programme described in this paper. Most published papers describe schemes in which stress is placed on physical examinations

and investigations and the identification of specific diseases: however Burns (1969) used health visitors to complete a medicosocial survey which included a less comprehensive physical examination by the general practitioner.

TABLE 7
NEW OR ACTIVE MEDICOSOCIAL (CODED 3 OR MORE)

Dependence on others	71
Mobility	65
Housing problem or hazard	63
Caring relative	59
Household	57
Weight	46
Vision	34
Diet	25
Hearing	22
Hygiene	17
Clothing, bedding, heating	13
Continence	13
Total 485 problems or 4.8/patient assessed	

TABLE 8
DISTRIBUTION OF ELDERLY PATIENTS BY PRACTICE (AT 1.4.74)

<i>Practice</i>	<i>Females >65</i>	<i>Males >65</i>	<i>Totals</i>	<i>Percentage of each practice list</i>
1	274	194	468	14.5
2	454	285	739	11.1
3	933	505	1438	16.1
4	667	390	1057	16.1
5	171	168	339	9.0
6	123	131	254	5.4
7	80	63	143	4.7
8	480	342	822	11.6
	3182	2078	5260	11.9

There are other fringe benefits in our approach. The doctor is provided with an updated problem list for each patient assessed on which problems are given a severity grading and are re-graded as and when action is taken. This record is also available to all members of his team. The health visitor has a more convenient system of recording her observations which avoids the need for an essay to be written after each visit to an elderly patient. The system gives the general practitioner a method of auditing his geriatric care through comparison of the size and content of individual problems lists from one assessment to the next.

The results of the first 100 assessments support Thomas's statement in 1968, about those patients aged 65 whom he screened: "... its great value (geriatric screening) lies in the discovery of a vast number of minor disabilities ... which, if left undiscovered, and untreated, will result in severe handicap and greatly limit their ability to cope with and enjoy life unaided." The patients assessed in this study were all known to the practice doctor and health visitor, but as problems and disabilities become multiple with advancing years, it is increasingly difficult for any one person to remain aware of the patient's total state of health or ill-health.

Thus for each patient there was a mean of 4·8 medicosocial problems (table 7), one unmet need and 2·3 unknown symptoms. The mean number of symptoms identified showed an increase with age in female patients and the percentage of symptoms not previously known, or which required action, increased with age in both men and women, giving a total mean of two per patient below the age of 70 and 2·3 in those above this age.

The health visitor's reaction to this scheme has been encouraging. Each assessment took approximately the same amount of time as does a normal visit to a patient and the health visitors considered that the use of the booklet meant that the visit was more useful and the assessment more comprehensive than was the previous practice.

Observations were easy to record and the grading system gave a qualitative as well as quantitative picture of the patient's health. The method of transferring active and inactive problems to the case notes and the system of updating the severity grades of problems gave a valuable and reliable baseline of information. The arrangement by which each assessment was discussed at the practice meeting meant that problems could be allocated for follow-up to the most appropriate member of the team.

By agreeing on a date for the next full assessment (for example six months or one year ahead) the health visitor and the district nurse were then able to concentrate on the problems identified without the need to attempt to complete an 'assessment' at each and every visit. Inevitably, this system identified new medical and social problems and thus increased the workload on doctor and nurse.

It must be anticipated however, that the total health of the patient may be improved to some extent, that crises may be prevented by early recognition, and that the general practitioner can give a more rational and complete service if he is aware at all times of all parameters affecting his patient. Needs and problems will be identified for which there are no answers but, as was stated by Williams (1972), "even if it is impossible to treat effectively all the conditions found, life can be made more tolerable if the condition is known to the doctor."

More experience of this scheme of assessment will be required before its potential as an information system can be judged. Some hint of its possible value can be obtained from the results of these 100 patients; 53 patients lived alone, 71 had some degree of dependence on others, housing problems were identified in 27 homes and hazards in 36. Mobility was a significant problem in 65 patients and the diet was considered to be deficient in 25. The provision of sheltered housing would to some extent help to eradicate all of these problems.

As for 'needs', the programme identified three groups of patients: those who had no need of a service, those who had need and the service was already being provided, and those for whom a service was thought to be necessary by the health visitors after they had completed the assessment. Of those patients who were thought to require a service, only 58 per cent were *already* attending chiropody clinics, 58 per cent *had* a home help, only 22 per cent *were* in receipt of meals on wheels, and 53 per cent *had* regular supportive contacts.

These figures represent the shortfall in the provision of social services for those patients assessed: a shortfall caused by previous ignorance of the need rather than a failure on the part of the authorities to provide a service to those who had been identified as requiring them.

Such data gathered on a wider scale, reporting the identified requirements of the elderly in a town or city, would indicate the types and quantities of services which are essential if elderly patients are to be able to continue to live in the community. When screening and assessment of the elderly patient becomes a standard part of general-practice work, when the needs and problems of a complete community can be determined,

and when this information can be made available to those responsible for the provision of services, a planned programme of geriatric care in the community will become more possible.

Acknowledgements

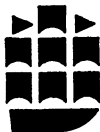
We wish to record our appreciation of the continuing help and assistance given by Professor Sir J. Ferguson Anderson and by the health visitors, geriatric visitors, and general practitioners of Woodside Health Centre.

Addendum

Copies of two appendices used in the survey can be obtained from Professor J. H. Barber, Department of General Practice, Glasgow University Woodside Health Centre, Bow Street, Glasgow.

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