Functional assessment: Group workshop (tables 5 & 6)

Instructions

Outcome - **Tables 5 & 6 consider what happens when an older starts to fail – how do you assess their function**

Table 5 – **Mrs Phipps - struggling at home** (discuss for 15 minutes)

Table 6 – **Mrs Ash – struggling to cope** (discuss for 15 minutes)

The two groups then combine and collaborate to compare notes in order to do a (not longer than) 5-minute presentation at the end on how doctors and patients deal with <u>functionally assessing in the elderly</u> and what it means to you.
This isn't about right or wrong answers in terms of management, much more about the patient's family's and your attitudes and feelings.

The presentation can involve all or just a few of you – can just be a summary of your discussion or innovative and entertaining. The Aim is to educate the res of the audience quickly

(If you have time to spare and you will have a total of an hour in total – go back into groups and discuss the other work).

Note - in the case for table 5, you are given the chance to work out what you would do.
In the case for table 6 – you are given some solutions but need to work out how practical this would be in general practice.

The material is on subsequent pages but don't feel you have to include this, think globally, think about your own families, young and old. Think about your own experiences and stories too.

Table 5. material

Mrs Phipps, 88, is brought to the surgery by a concerned neighbour- she is struggling to cope at home.
She has lived alone since the death of her husband 10 years ago and her children live in Australia.
She has osteoarthritis and controlled hypertension and is not a regular attendee.
She fell in the garden a few weeks ago and couldn't get up until her neighbor arrived and helped her. She has seemed a little more vague over the last year and sometimes forgets to bring the milk in.

Where do we start to unravel this?

How would you assess her functionally?

In the case for table 5, you are given the chance to work out what you would do. (is some resource material at the end)

Table 6 . material

Mrs Ash is an 84 year old woman with chronic health problems including cataract, osteoarthritis, and mild cognitive impairment. She has lived on her own since the death of her husband. She has attentive friends, but no formal support. She is brought to your general practice surgery by a concerned neighbour who feels Mrs Ash is “struggling to cope.”

In the case for table 6 – you are given some solutions but need to work out how practical this would be in general practice.

Assessment
You recognise the need for basic functional assessment. Initially Mrs Ash denies any problems. Using the questions in box 3 you ask specifically about basic activities of daily living, falls, continence, memory, and mood. Using these direct but non-threatening questions she admits to problems with dressing and climbing stairs. Her neighbour confirms these problems and adds that Mrs Ash’s eyesight seems to be a problem, that she doesn’t go out as much, and sometimes needs help with the shopping. You have already noticed that Mrs Ash used a table to steady herself when walking from the waiting area to your consulting room—“furniture walking.” Focused physical examination shows general muscle wasting and no focal neurological deficits. You note that she struggles to read large print in a magazine.

You arrange for a longer home visit at the next opportunity. In the home environment you ask Mrs Ash to demonstrate her mobility on stairs, her ability to dress herself, and transfers on and off a chair. You note her antalgic gait, particularly on the stairs; that she uses the arms of the chair to help her get up from it, so she would need a handrail to get up from the toilet (at a similar height); and that her visual problems complicate dressing. You mention that her arthritis must make it difficult to do the shopping and cleaning, and she admits that “sometimes she relies on friends to help but that it would be nice to be able to go out more often.”

Outcome
You create a problem list with important items of: visual impairment affecting reading and dressing; general deconditioning and pain from osteoarthritis impairing chair and toilet transfers and ability to go out on own, shop, and clean; lack of mobility causing some social isolation.

With Mrs Ash’s agreement, arrangements are made for ophthalmic review; analgesia is prescribed; help with shopping, cleaning, and laundry is arranged through social services; and an occupational therapy assessment for toileting aids is requested. You recognise that a more comprehensive assessment of mobility and care needs is required and refer Mrs Ash for multidisciplinary assessment through the local care of the elderly team.

Patients may omit important symptoms, rationalising them as an inevitable consequence of ageing or fearing that admitting to problems may lead to placement in a care home. While exploring activities of daily living, make the distinction between what the patient wants to do, what they can do, and what they actually do—with the last descriptor being the most important.

With the patient's consent, proactively seek a history from as many perspectives as possible (family, carers, care home staff) to give a more objective description of current and previous function. Use health records, particularly to confirm extent or rate of decline. This process is easiest if information is available in a structured format such as the ADL questionnaires discussed below.

Summary points

In older adults functional decline is a common presentation of many disease states.

Causes and consequences are diverse, so functional assessment is not suited to a traditional medical model of system based history and examination

Consider functional assessment "screening": where illness has caused change in function; before considering long term care; and when planning major elective procedures in older adults

Validated scales for assessing basic and extended activities of daily living can help inform and focus history taking

Key elements of the physical examination include subjective "end of the bed" assessment; upper and lower limbs; vision; hearing; and the patient's environment. Functional decline is rarely related to a single problem, a problem list can guide intervention. When functional change is evident, referral for multidisciplinary, comprehensive geriatric assessment is often needed

Older people often present to healthcare services with acute and chronic problems that act together to adversely affect function. A common pathway comprises functional decline, followed by loss of independence and need for institutional care. However, this process is not necessarily inevitable or irreversible. Timely recognition of functional difficulties can lead to interventions that may prevent or arrest the decline.

Activities of daily living (ADL): These are "everyday tasks," ranging from aspects of self care that are needed daily (such as toileting and eating—often described as basic or personal ADLs) through to more complex tasks (such as shopping, using a telephone—often described as instrumental or extended ADLs). When a person has difficulty with one or more basic activities, daily support (from family or carer) is needed for the person to remain safe

Comprehensive geriatric assessment: The simultaneous multilevel assessment of various domains by a multidisciplinary team to ensure that problems are identified, quantified, and managed appropriately. This includes assessment of medical, psychiatric, functional, and social domains, followed by a management plan that often includes rehabilitation[1]

Disability: A construct described in the World Health Organization's *International Classification of Functioning, Disability and Health* (ICF).[2] Disability (now termed activity limitation) refers to restrictions in performing usual tasks. ICF terminology recognises two other levels of function: physical impairment and handicap; all these levels of functioning are interconnected.[2] Quality of life measures seek to describe outcomes beyond participation in society and are outside the scope of WHO-ICF

Frailty: A popular conceptual definition of frailty is "the propensity to deteriorate in the face of a stressor."[3] Frailty constructs range from simple measures of physical function, such as grip strength, through defined physical phenotypes, to complex multidimensional indices that are useful in research but difficult to apply in clinical practice

Functional ability: Primarily refers to performance of basic and extended ADL to maintain safety. Thus functional ability is a global term and not synonymous with the more focused label "physical function." Although the focus of this review is physical function, comprehensive functional assessment should also include cognition, mood, and carer related matters

What is an assessment of functional status and why does it matter?

Decline in function itself may be a presentation of otherwise occult pathologies[4] so, not surprisingly, it is associated with increased mortality.[5] Relatively minor insults (such as changes to drugs and constipation) may precipitate substantial deterioration in function.[4] Systematic reviews have shown that intervention based on comprehensive geriatric assessment can improve physical function and reduce admission to care homes and hospital in older people.[1 6 7] The first step in this process is the recognition and description of functional problems—this task should be routine for all health professionals and not the sole preserve of the geriatrician.

It is unusual for patients themselves to identify functional decline,[8] and assessment precipitated by "crisis" remains common.[9] Because functional screening of unselected older populations has not consistently improved clinical outcomes,[10 11] opportunistic assessment is preferred and should form part of consultations for management of chronic diseases. We suggest a process of functional evaluation based on structured history and examination, which may be supplemented with standardised assessment instruments.

- **Feeding:** Are you able to feed yourself? Can you cut up food without help?
- **Bathing:** Are you able to take a bath or shower without help? Are you confident to take a bath or shower with no one in the room or house?
- **Grooming:** Do you need help with brushing hair, shaving, or applying make-up?
- **Dressing:** Can you get dressed without help? Can you manage buttons and laces?
- **Continence:** Do you ever wet yourself if you are not able to get to the toilet in time? Do you ever soil or mess yourself with bowel motions?
- **Toileting:** Do you need help to use the toilet?
- **Transfers:** Are you able to get out of bed and on to a chair with no help?
- **Mobility:** Are you able to walk 50 yards on the flat with no help? Do you use any walking aids such as a stick or frame? Have you fallen or stumbled in the past year?
- **Stairs:** Are you able to climb a flight of stairs without help?
- **Extended or instrumental ADL (based on the Nottingham extended ADL scale)**[17]
- **Mobility:** Are you able to walk outside on uneven surfaces? Are you able to travel on your own to local destinations? Do you feel confident to use public transport?
- **Leisure:** Are you able to continue your previous hobbies? Are you able to stay in contact with friends and family?
- **Domestic:** Are you confident in managing your finances? Are you able to go shopping for essentials? Can you manage your laundry?
- **Kitchen:** Are you able to make a hot drink or snack? Are you able to walk with a hot drink without spilling it?
- *This structured history includes screening questions for continence, mobility, and falls

Standardised assessment tools

Many such tools are available for use in different settings or disease states, but no consensus exists on the optimal measure,[22 23 24] and detailed knowledge of scales is not essential for the general clinician.

However, awareness of some of the more prevalent instruments may help in communicating with other professionals and in interpreting older age research (box 6). Moreover, functional assessment need not involve detailed and time consuming scales. For example, the get up and go test (box 5) is as useful for predicting falls as many more complex tools.[19] If time allows, use of a longer validated assessment instrument can have added value—for example, instrumental ADL tools such as the Nottingham scale[17](box 3) or Lawton scale (box 6)[25] give standardised quantifiable data that may avoid the ceiling effects associated with common assessments of basic activities of daily living.

What are the challenges?

We recognise that functional assessment is not always straightforward. However, with the guidance offered we hope that basic assessment should be feasible in a busy practice. The assessments require some initial investment of time, but the combination of early recognition of functional decline and appropriate referral is ultimately more efficient than the multiple consultations that may result if functional problems are left to progress.

Although history taking is the cornerstone of assessment, it poses particular challenges in many older people. Barriers to communication will be more prevalent and can include cognitive impairment (delirium or dementia, or both), deafness, depression, dysphasia, and distraction caused by pain or emotional distress. General rules include the importance of speaking clearly and not too quickly while facing the patient and giving adequate time to respond. The importance of collateral history has already been emphasised.

Many older people have a complex array of medical comorbidities, functional problems, and difficult social circumstances. In these situations it is easy to feel overwhelmed, but we must avoid therapeutic nihilism. For those who perform poorly on the most basic functional assessment tasks there may still be the opportunity for meaningful improvements. A return to complete independence may not be possible for all, but small gains can greatly improve functioning and quality of life. For example, regaining the ability to move from bed to toilet independently with appropriate equipment may mean the difference between staying at home and requiring institutional care.

Busy general clinicians may feel that functional assessment is not part of their remit. With an ageing population, all clinicians are likely to encounter functional problems in their patients. Although not all clinicians have the training and infrastructural resources to offer a comprehensive assessment or rehabilitation interventions, all clinicians should screen for functional problems in older patients so that referral can be appropriately directed (box 4).[27]