Comprehensive geriatric assessment of a mental health service user with safeguarding needs

In the final article of this series, Chris North discusses how gold standard assessment can improve nurses' understanding of the patient experience

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Abstract

This is the final article in a short series that presents case study examples of the use of comprehensive geriatric assessment (CGA) in different clinical settings. CGA is a holistic model that is used to determine frail older people's medical and mental health status, as well as any functional, social and environmental issues that might affect their care. When undertaken by nurses, it can enable individualised planning for health, safety and wellbeing.

This article explores the case of an older woman living in the community who was receiving support from a number of health and social care services and who had significant safeguarding needs. It highlights the complexity of caring for patients with physical and mental health conditions. CGA can link these conditions and needs together to allow a better understanding of their effects on the patient. The risks of significant transitions in care are also highlighted, along with recommendations for the provision of multidisciplinary care in community settings.

Keywords
community, comprehensive geriatric assessment, dementia, mental health, older people, safeguarding

COMPREHENSIVE GERIATRIC assessment (CGA) addresses the effects of multiple comorbidities in later life, incorporating medical, mental health, functional, social and environmental domains (Welsh *et al* 2014). When undertaken in hospital, CGA can significantly increase independence and reduce mortality (Ellis *et al* 2011).

The case study presented in this article focuses on the use of CGA as a model for identifying and addressing the needs of Emily (a pseudonym), a 77-year-old woman and long-standing user of specialist mental health services as a result of severe and enduring schizophrenia, who had recently been diagnosed with dementia. Around the time of assessment, Emily was accessing a range of services including social work, district nursing, home care and input from the community mental health team (CMHT).

A significant complexity in Emily's case was the combined effect of her chronic mental health condition and developing dementia, which left her without sufficient mental capacity to make decisions in her own best interests about her care and support. Evidence of Emily's mental capacity was supported by a review of her cognition using the most common cognitive screening tool, the Mini-Mental State Examination (MMSE) (Folstein *et al* 1975), which showed a significant decline of ten points over two years, suggesting increasing mental frailty and vulnerability.

This case study illustrates how CGA can be used to address the needs of a person who lacks capacity to make significant decisions about their day-to-day living and support arrangements, in particular when there is no appropriate family member available to act in the best interests of a vulnerable person. The issues raised by Emily's story should be explored and shared among a wider audience, if community-based practitioners are to develop better understanding of how to respond to the needs of people in similar circumstances. However, it must be acknowledged that, due to her lack of capacity, Emily was unable to give informed consent for her story to be shared. Consequently, it has been necessary to seek the agreement of the nominated

decision maker responsible for her care to publish this case study. Some of the details have been altered to ensure the privacy of all parties involved.

As team leader for the older people's CMHT, the author became involved in this case after serious safeguarding allegations were made following Emily's first care transition to older people's mental health services from working-age mental health services, resulting in a subsequent urgent care transition to a residential home. The potentially detrimental effects of care transitions for frail and/or cognitively impaired older people have been well documented (Coleman 2003) and include the risk of physical and mental decline as well as increased mortality. However, where serious safeguarding concerns highlight risks at home that cannot be effectively managed using community support, urgent placement in residential care is often the default option for older people with complex comorbidities who lack the mental capacity to determine their own care arrangements (Williams *et al* 2014).

Background

For many years Emily had been living alone with home care support provided twice daily by a private agency. Her long-standing schizophrenia was treated with ongoing fortnightly antipsychotic depot injections administered by her community psychiatric nurse (CPN).

She had been referred to older people's mental health services from working-age mental health services. The referral was made because of safeguarding and frailty concerns, including increasing cognitive impairment. Her score of 14/30 on the MMSE (Folstein *et al* 1975) highlighted that she had disorientation and poor short-term and long-term recall. The transition to specialist older people's services was intended to address the effect of cognitive decline on her physical wellbeing, as she had reportedly been forgetting to eat and take the cholesterol medication she needed, and was losing weight and eating out-of-date food.

Further concerns about her vulnerability arose because she often left her front door open, even at night or when she had left the house. There had been a noticeable deterioration in Emily's ability to self-care. Her son was spending more time with her to support her in her day-to-day activities, including bathing. There were also suggestions that she was being targeted by companies who had persuaded her to send them cash in the post.

Emily's initial assessment led to a diagnosis of and treatment for Alzheimer's disease. A CPN, community care officer, occupational therapist and mental health physiotherapist were allocated to address her care needs, cognitive and self-care decline, social isolation, falls risk, and balance and bathing difficulties.

Using the comprehensive geriatric assessment

In this case the CGA covered medical, mental health, functional, social and environmental domains using an interdisciplinary, multiagency approach, reflecting Emily's community-based setting. Her complex needs centred on long-standing mental health issues, against a backdrop of declining physical health related to falls, diabetes and chronic kidney disease. The relatively new diagnosis of dementia added to Emily's existing long-term conditions, and significantly increased her risk of experiencing delirium, falls or depression (Eccles *et al* 1996).

Medical domain As part of her transfer to older people's mental health services, Emily was assessed by her new consultant psychiatrist, who concluded that her progressively worsening cognition and her brain scan results suggested it was likely Emily also had Alzheimer's disease. Medication review was an important part of this process, since antipsychotics can be inappropriate for older people, increasing the risk of cerebrovascular events and mortality in patients diagnosed with dementia (American Geriatrics Society 2012 Beers Criteria Update Expert Panel 2012). Emily's depot medication was gradually reduced, without new emergence of psychosis. With input from specialist older people's mental health, Emily's situation and presentation stabilised within three to four months and remained stable for the next 12 months.

Unfortunately, a concurrent reduction in anticholinergic medication prescribed for the side effects of Emily's depot medication resulted in increased stiffness and muscle rigidity. Marked deficits in short-term recall were also noted, and she failed to attend outpatient clinics and appointments with district nurses for possible stress continence problems.

Mental health domain A CPN helped to co-ordinate care around Emily's ongoing social and emotional needs. An initial mental health nursing assessment based on her current and historical presentation used a five-dimensional framework. This focused on emotional, social, physical, intellectual and spiritual aspects to balance management of Emily's physical conditions with her long-standing mental health condition. The aim was to minimise the risk of re-emergence of psychosis, while also significantly reducing Emily's antipsychotic medication to improve

her physical, cognitive and social health. Her care plan involved gradual reduction in the frequency of depot medication to arrive at a minimal therapeutic dose and so reduce the risk of serious side effects and/or mortality associated with use of these medications in people who have dementia (Ballard *et al* 2008, 2009). Emily's CPN monitored the effect of this strategy on her mental health by visiting every three weeks.

Functional domain Emily presented as a socially withdrawn woman with impaired communication skills, who was nonetheless relatively independent, receiving twice-daily home care for meal preparation and medication. She would visit the bank and shops independently, but declined any opportunities for wider social engagement.

Social domain Emily lived alone, with support from a home care package. Her son was appointee for her financial affairs and reportedly visited three to four times weekly. She was estranged from her other children.

Frailty assessment To clarify Emily's degree of frailty, a tool was needed that would take into account her mental health and social vulnerability. A traditional phenotype model of frailty (Fried *et al* 2001) indicated that she was 'pre-frail' due to her reduced mobility, however it did not account for the disabling effect of her cognitive decline, long-term mental health condition and vulnerability. A broader assessment using the Rockwood Frailty Index (Jones *et al* 2004) considers frailty in terms of levels of dependence, drawn from assessments undertaken by various health and social care professionals, which reflects the CGA domains.

The Canadian Clinical Frailty Scale (Rockwood *et al* 2005) rated Emily as either mildly or moderately frail. The specific rating was dependent on the severity of her cognitive impairment and whether her physical limitations might be due to the poor motivation levels that often present in people with schizophrenia (Gard *et al* 2009). The difficulty in arriving at a clear frailty classification highlights a potential weakness in this frailty index, with the contribution of mental health issues limited to a simplistic dementia addendum, assuming a direct correlation between level of cognitive ability and functional performance. This is at odds with the National Dementia Strategy (Department of Health (DH) 2009), which promoted the concept of 'living well with dementia', that is, the ability to function well with the right level of support regardless of the degree of cognitive impairment. Nonetheless, from a nursing perspective, mild or moderate frailty was a better description of Emily's abilities and vulnerabilities, reflecting her reduced mental capacity and physical health status.

Safeguarding concerns In May 2014 Emily's son expressed concerns that the existing provider was not adequately meeting her personal hygiene and social care needs, which resulted in a change of home care provider. In September 2014, however, home care staff were concerned that Emily's son was continuing to attend to his mother's intimate care needs even when they had already provided care, and so they completed a safeguarding alert. In the first instance, Emily's social worker met with Emily's son to discuss the situation and highlight the inappropriateness of him bathing his mother, as this was being provided by home care services. A serious allegation of sexual assault a fortnight later resulted in health and social care agencies devising multiagency safeguarding measures. CGA provided the essential framework for in-depth consideration of the medical, mental health, functional and social domains of Emily's needs that needed to be safeguarded.

Emily had disclosed an incident involving her son to her home carers. Safeguarding procedures were followed and this was reported to the police. She was then moved to a residential home as a 'place of safety' while the allegation was investigated, and a restraining order was issued to her son.

It was initially unclear whether the allegations had any foundation or whether they had arisen because of a re-emergence of Emily's psychosis – or a combination of the two. Emily's cognitive impairment needed to be evaluated in the context of possible psychological trauma, enforced relocation to an unfamiliar place of safety and the possibility that sub-acute psychosis may have had a negative effect on her cognition (Ballard *et al* 2008). However, after assessment using the Mental Capacity Act 2005, it was established that Emily did not have the mental capacity to make informed decisions about the risks she faced if she continued to be cared for by her son. This led to the implementation of Deprivation of Liberty Safeguards (DoLS) (Ministry of Justice 2008), which provided a legal framework to ensure Emily's physical safety.

Emily stated her desire to maintain contact with her son, as he was her only meaningful family contact. Adopting a person-centred approach to Emily's care would have meant allowing a level of safe contact with her son while the situation was being investigated. However, as forensic evidence confirmed the allegations, the police concluded that her son should be considered a possible abuser and the restraining order remained in place.

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The situation presented an ethical dilemma for the nurses attempting to act in Emily's best interests, as she wanted to stay in contact with her son. Her lack of mental capacity provided the rationale for her health and social care professionals to make a best interests decision on Emily's behalf that she continue to reside in the care home, even though this decision was at odds with her stated wish to return home and resume contact with her son. The severity of the allegations meant that it was not possible to be sure of Emily's safety in her own home while her son was there.

Emily's emotional needs related to her coping with the distress of the situation with her son, while also losing her self-determination over where and with whom she lived. The role of her CPN in the CGA and care planning process was critical in providing meaningful emotional support through these periods of transition and acute distress. This is a crucial component of mental health nursing for older people and can help them to adapt to repeated losses experienced in later life (Lingard and Milne 2004).

Emily's social needs were closely linked to her emotional needs, as she relied on her son for regular company and advocacy. To compensate for the loss of this, a relatively unusual DoLS condition was set so that Emily continued to receive one-to-one support from her existing home care service and CMHT while living in the care home. This enabled her to continue to use community facilities such as shops and banks. In the context of the Mental Capacity Act 2005 and the Care Act 2014 (DH 2014), this fulfils an obligation that statutory health and social care services ensure that when people are deprived of their liberty it is with the least restrictive option in mind and with a view to helping them to maintain the habits and activities of their normal lifestyle (Boyle 2008). It highlights the importance of multiagency working in a CGA approach.

Emily's physical needs were actively managed and addressed through combined input from district nurses for diabetes, occupational therapists and a physiotherapist for falls risk, and a psychiatrist and CPN for polypharmacy issues attached to long-term antipsychotic treatment.

Outcomes and ongoing safeguarding plan Emily remained in residential care for six months. Her son was convicted of the alleged abuse, and Emily returned home with support from her CPN, social worker and occupational therapist. Her safeguarding plan now includes home care three times a day and day centre attendance three times a week. Social services is the new appointee for her finances. Emily remains frail and vulnerable due to the combination of impaired cognition and the side effects of long-term depot antipsychotic use, displaying a stooped posture and unsteady gait. However, her depot medication has now been discontinued and replaced with a much smaller dose of oral antipsychotic medication. She is reported to be more alert, animated and socially engaged, with notable improvements in her mood since returning home.

Conclusion

All care transitions have potential costs for older, frail and vulnerable people (Coleman 2003), including transitions between home care providers and from community settings to residential care. This is particularly the case where a combination of diminished mental capacity and safeguarding concerns limit self-determination and choice. It has been argued that DoLS are often implemented according to which resources are most readily or financially available, rather than what is in the person's best interests (Boyle 2008). The holistic approach that CGA offers is critical in appreciating and managing the risks. In the case study presented, the potential loss of Emily's self-care skills and independence, along with the need to prepare her for a potential return home at some point, was proactively identified and positively addressed through a multidisciplinary management plan.

A constructive multiagency approach with joint working between mental health nurses, social care practitioners, district nurses, police and DoLS assessors delivered a comprehensive response to Emily's needs under the local safeguarding framework. In such community scenarios, CGA acts as a holistic framework for multidisciplinary and multiagency working, placing community nurses in a unique position as care co-ordinators to lead when addressing the full range of physical, social, psychological, practical and spiritual needs and barriers that older people experience (Tucker *et al* 2009).

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Conflict of interest
None declared

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