### Comprehensive Geriatric Assessment for the Covid-19 positive patient - A Quick Guide

**CFS > 5 – complete CGA**

**Medical**
- Associated problems alongside Covid?
- Remember atypical presentations: falls, confusion, constipation, incontinence
- In depth physical examination
- Nutritional assessment. MUST score +/- dietetic referral. Oral thrush?
- Pro-active bowel management

**Psychological**
- Is there an established dementia diagnosis? If yes, what exactly is their baseline cognition?
- Are they different to their usual?
- 4AT assessment and complete delirium document
- Mental Capacity Assessment +/- DOLS for all patients
- PINCH ME assessment daily to reduce delirium risk factors
- Follow up to date NCA guidelines on managing delirium in Covid-19

**Medications**
- Medicine Reconciliation
- Are all medications still indicated/appropriate?
- Suspend non-essentials whilst unwell
- Liquids/suspensions may be better tolerated
- Consider IV if hypoactive delirium preventing administration.

**Mobility**
- What is the baseline: independent, stick, frame, hoist?
- Mobilise as soon as possible
- Not at baseline? Refer Physiotherapy
- Pressure area care – especially in hypoactive delirium.

**Function**
- Are they normally dependent/independent for personal care?
- If independent – encourage them to do as much as they are able in hospital
- Who does the cooking/cleaning/shopping?
- What level of formal care provision do they have?
- Below baseline? Refer OT +/- Social Worker.

**Socioeconomic**
- Who do they live with? Have co-inhabitants/close family been advised re: self isolation?
- If in 24 hr care, be specific – Residential vs Nursing. Have their needs changed?
- Are there any safeguarding concerns? If yes, refer to Safeguarding team
- Would they benefit from AgeUK input at discharge for food shopping?

**Spirituality/End of Life Care**
- If the patient lacks capacity, is there a Lasting Power of Attorney? Health + Welfare vs Finances
- Is there an Advance Care Plan in place? If no, consider one for all patients discharged to 24hr care facility
- What is the Preferred Place of Care/Preferred Place of Death? Would the person wish to return to hospital in event of further deterioration?
- If DNAR-CPR in place during admission, convert to uDNAR on discharge
- Consider early referral to Palliative Care team.

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**ALL patients > 65yrs should have a documented Clinical Frailty Score, Delirium and Ceiling of care/CPR status (separate documents on EPR)**

Refer to Ageing and Complex Medicine if concerned. Remote input can be provided where appropriate, followed by face-to-face assessment if required.