Belgian Minimum Geriatric Screening Tools

for Comprehensive Geriatric Assessment

T Pepersack for the College of Geriatrics

BELGISCHE
VERENIGING VOOR
GERONTOLOGIE EN
GERIATRIE

SOCIETE
BELGE DE
GERONTOLOGIE ET DE
GERIATRIE

www.geriatrie.be

Missions des collèges

missions	Faits
1. Consensus d'indicateurs de qualité	
2. Modèle d'enregistrement informatisé	
3. Visite	
4. Rapport annuel	
5. Fonction expert	
6. Rapport sur l'utilisation des moyens	
7. Programme de soins	

BGMS: *3 parts program*

1. 2003 questionnaire
2. 2004 consensus
3. 2005 registration feasibility

BGMS: *introduction*

- Enregistrement continu de variable de qualité est une obligation

- Le Ministère attend de nous cet enregistrement…

$\Rightarrow$ 2003: College & SBGG : *choose it ourselves* !

BGMS: *3 parts program*

1. ***2003 questionnaire***
2. 2004 consensus
3. 2005 registration feasibility

BMGS: *objectifs*

- Analyser les outils utilisés en routine par les équipes belges de gériatrie

- Demander *leurs* propositions pour un "Belgian *Minimum* Geriatric Screening Tools"
  - ~ “comprehensive geriatric assessment”
    feasible
    approuvé par les équipes

BMGS : *méthodologie*

- Questionnaire

  envoyé par e-mail; poste,
  téléchargeable (www.geriatrie.be)
- Echelles *utilisées* et *proposées* pour une évaluation gériatrique minimale
- domaines : AVJ; I-AVJ; chutes; cognition; dépression; social; nutrition; douleur; QoL

BGMS: *résultats*

- 59 questionnaires
- Lits G aigus et subaigus

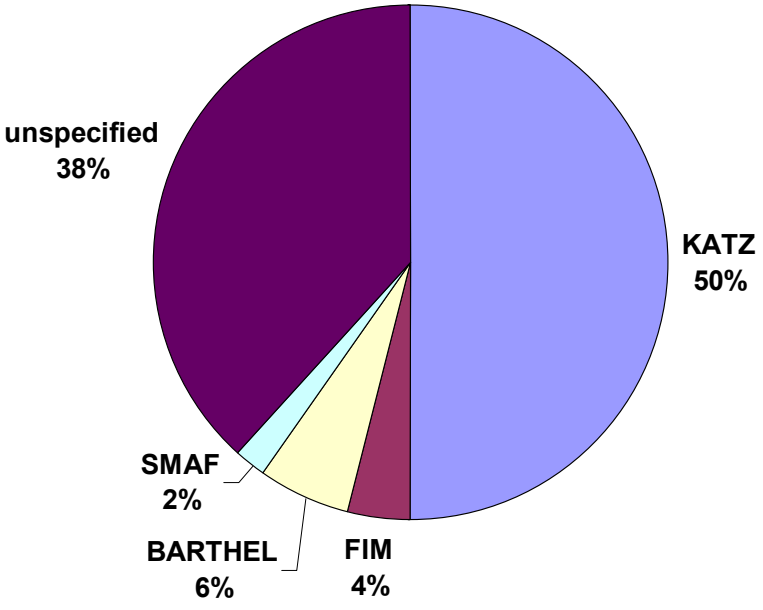
comprehensive geriatric assessment

- ADL
- IADL
- Risque de chute
- COGNITION
- DEPRESSION
- SOCIAL
- NUTRITION
- DOULEUR
- QOL

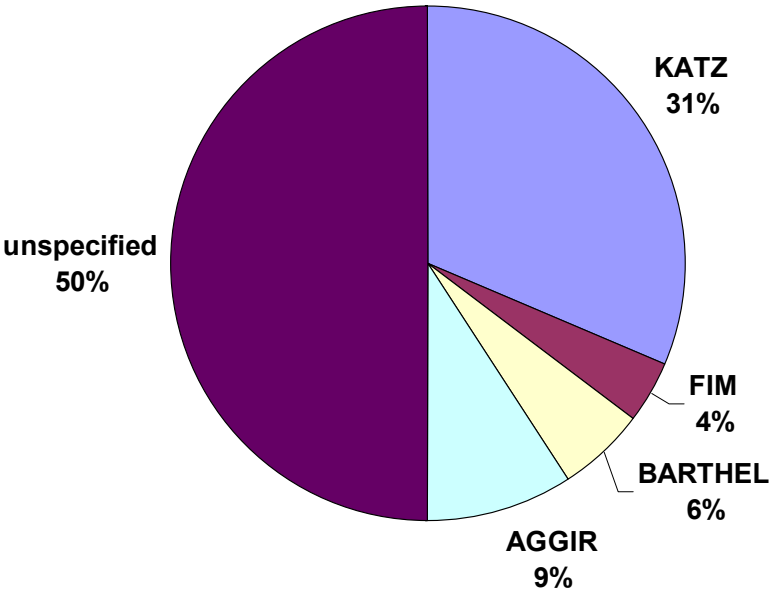
Actuellement utilisés; *proposés pour un BMGS*

ADL

utilisés 92%

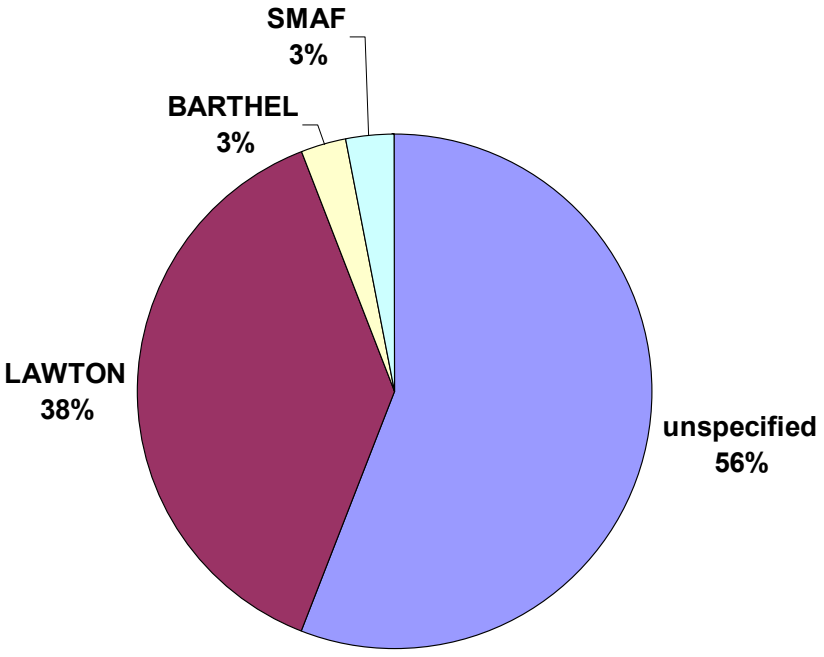


proposées 92%

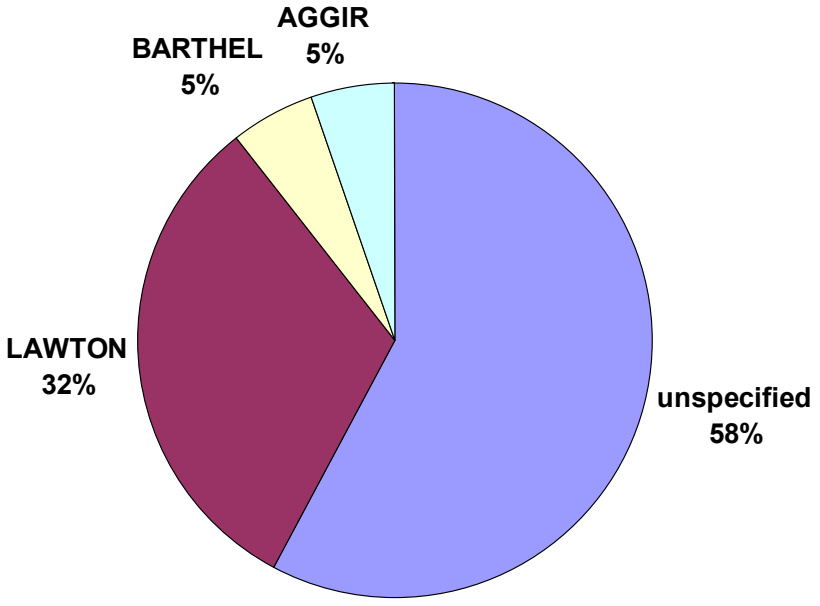


IADL

utilisées 56%

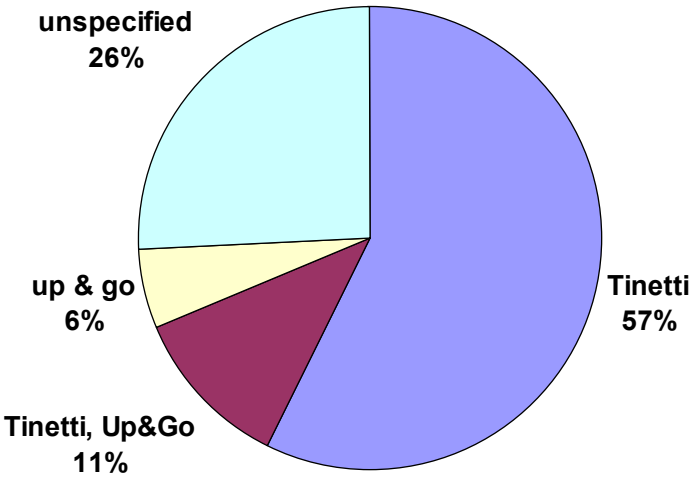


proposées 58%

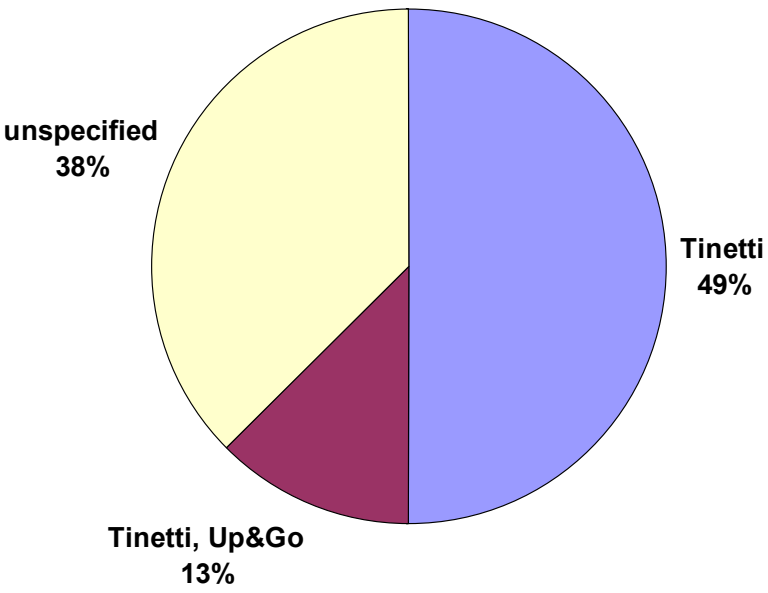


Risque de chute

utilisées 59%

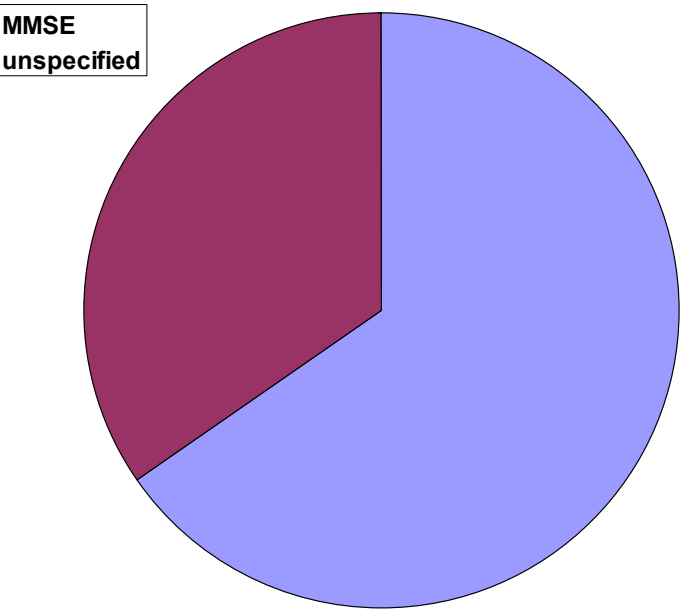


proposées 68%

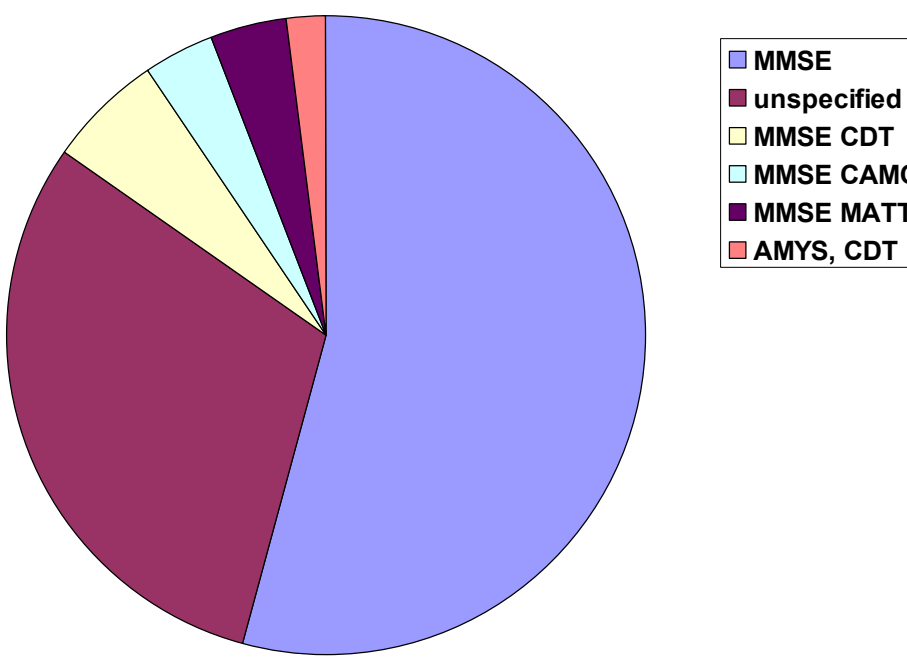


cognition

utilisées 52%

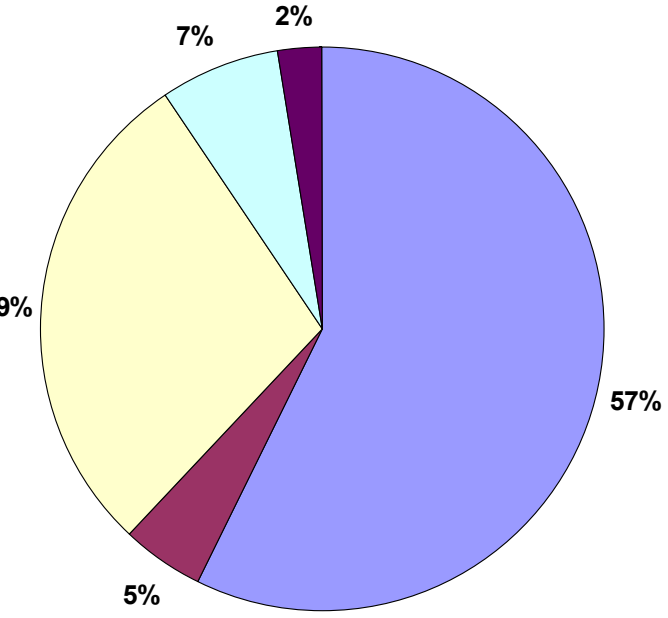


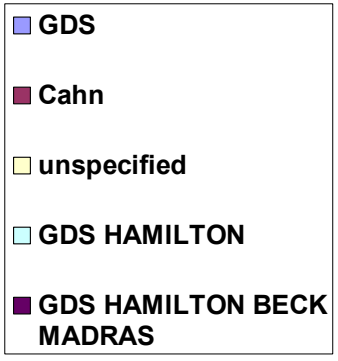
proposées 51%



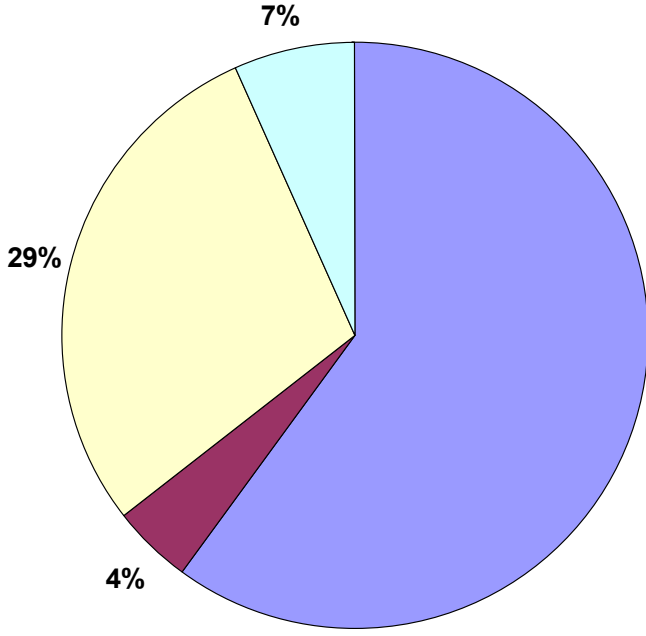
dépression

utilisées 39%



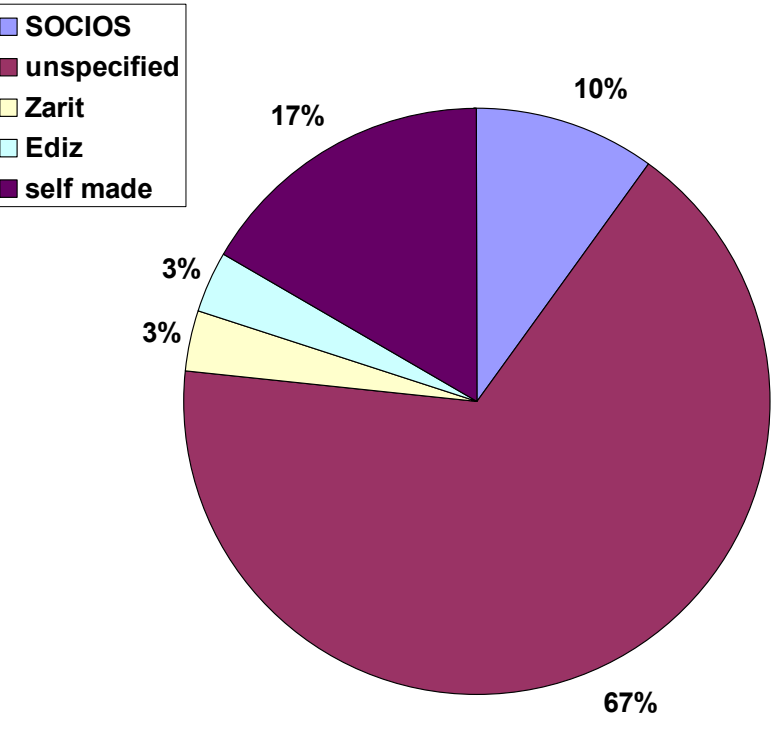


proposées 45%

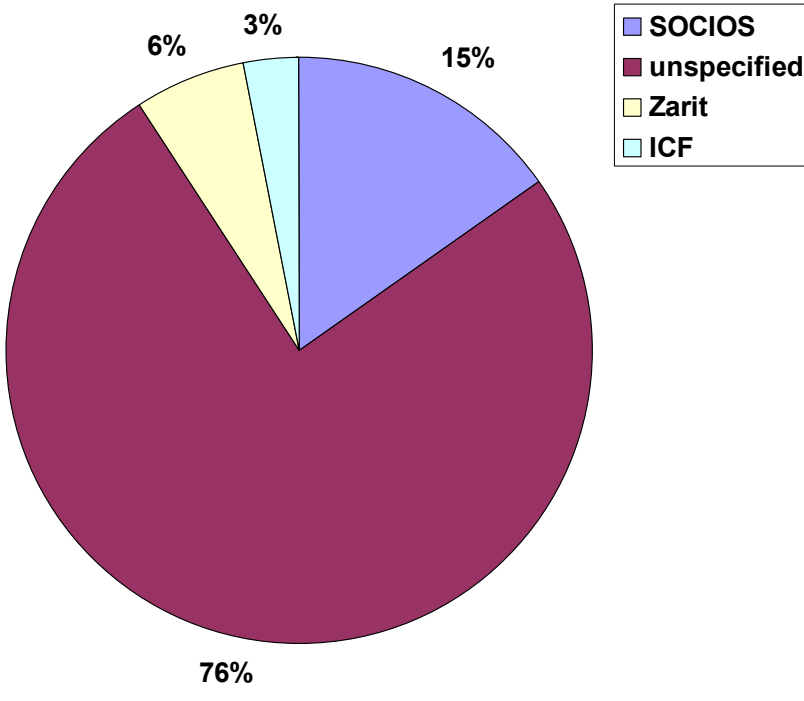


social

utilisées 51%

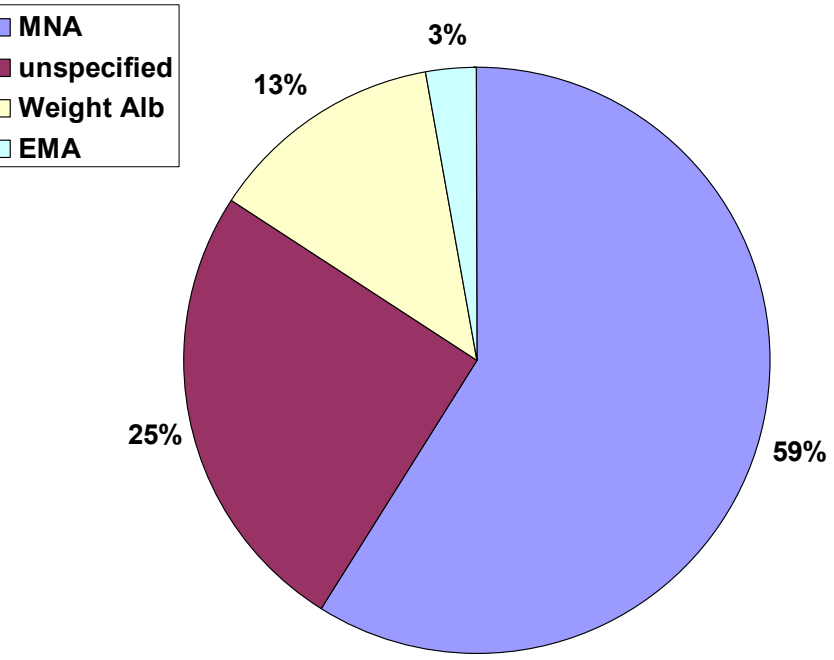


proposées 56%

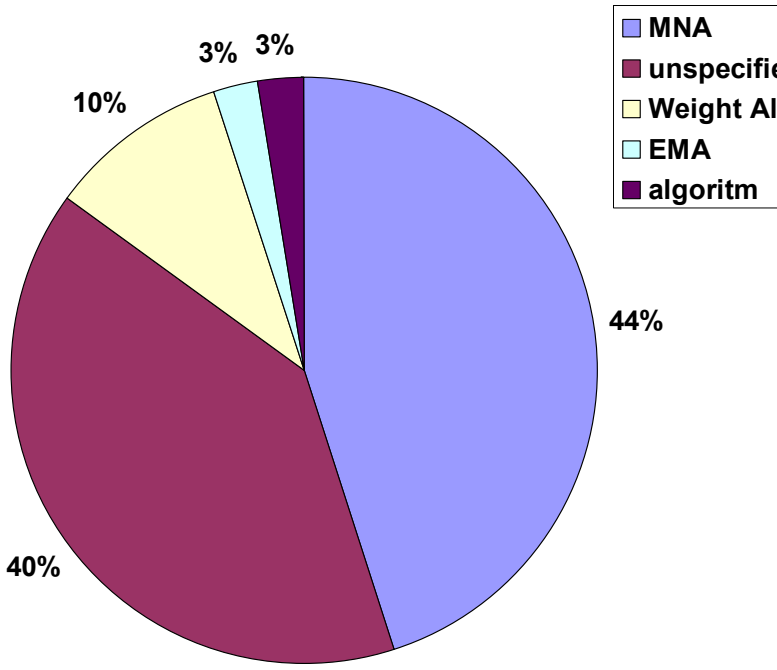


nutrition

utilisées 36%

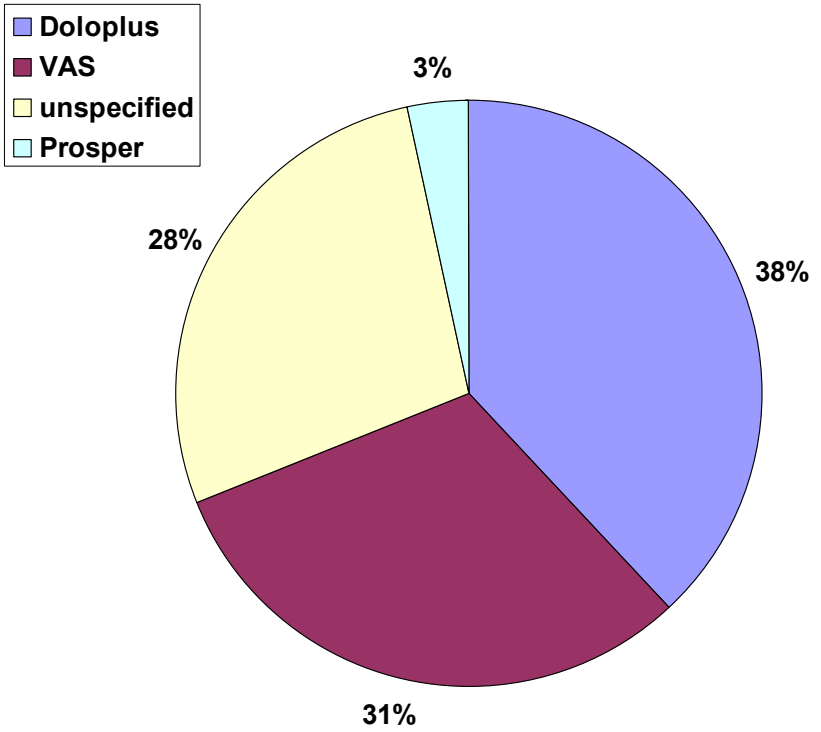


proposées 40%

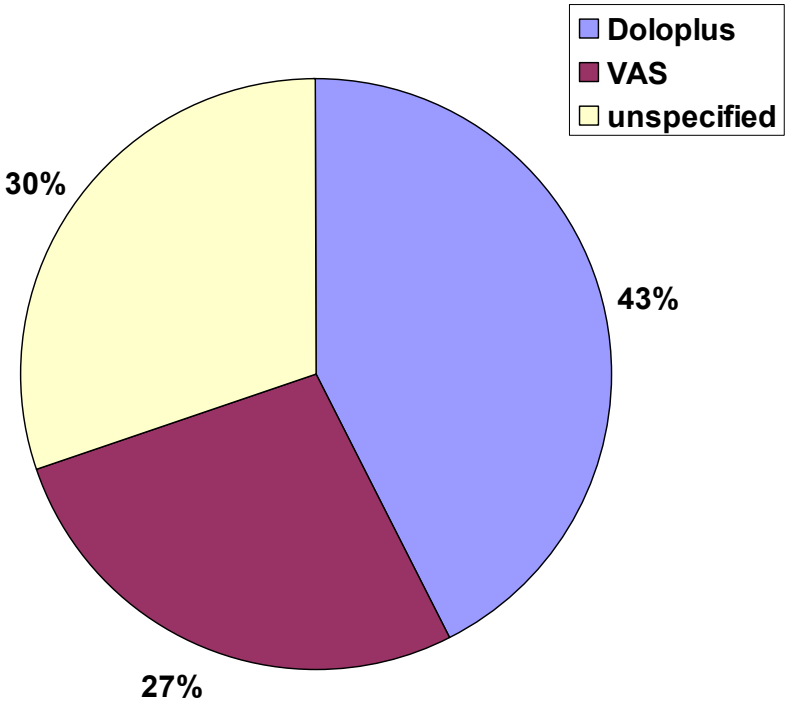


douleur

utilisées 49%

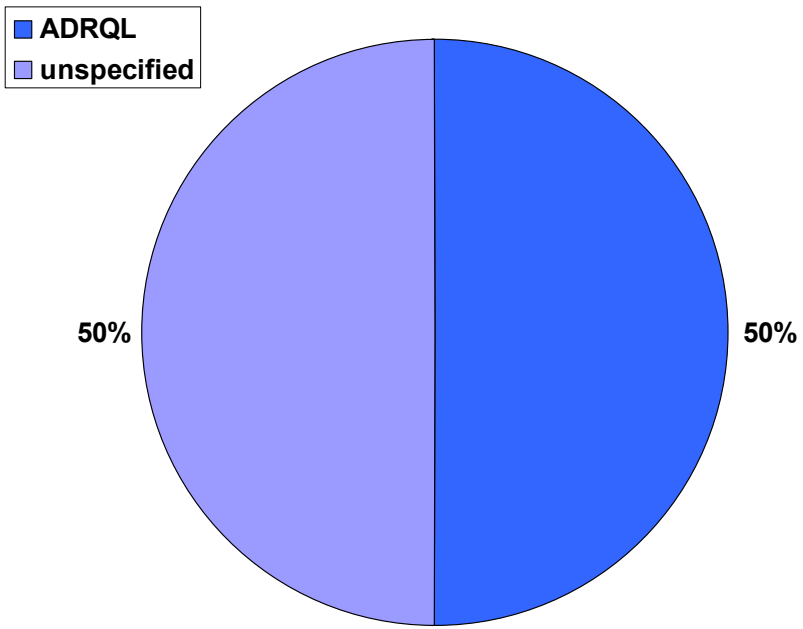


proposées 54%

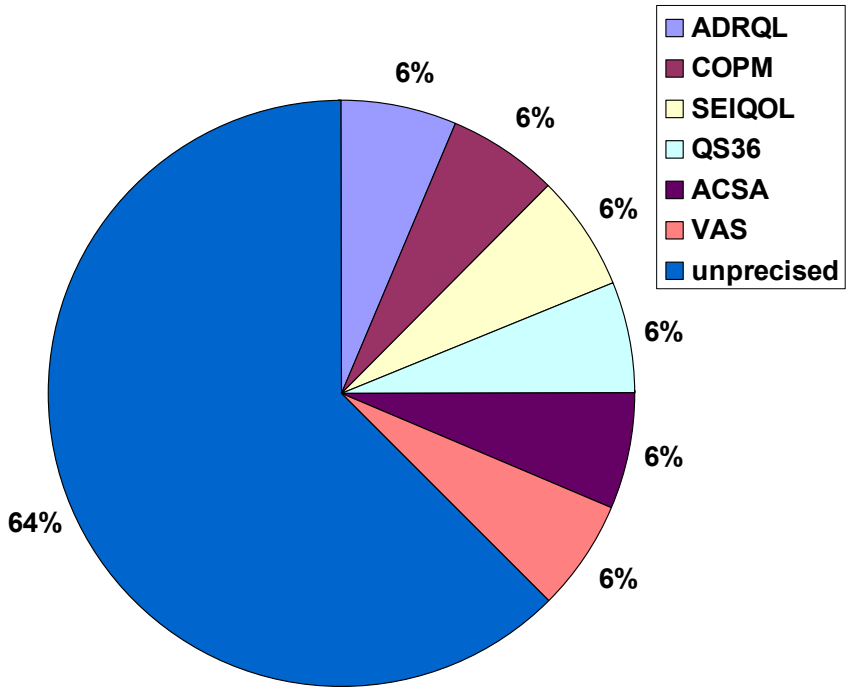


quality of life

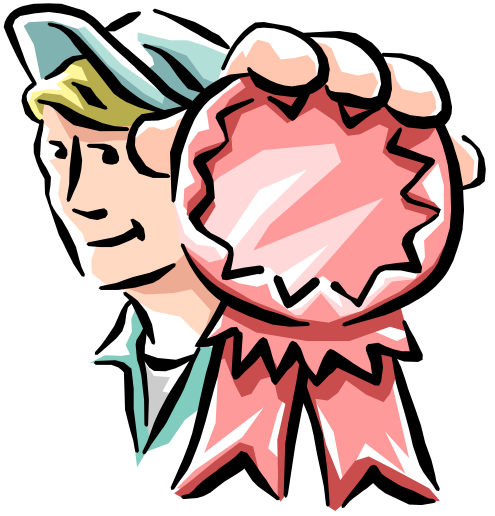
utilisée 2%



proposées 27%



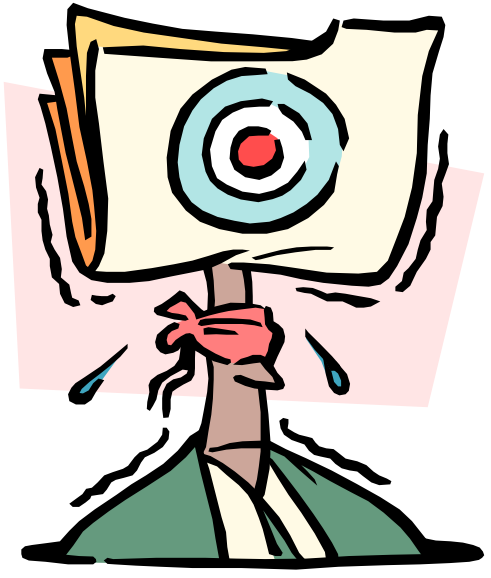
Conclusions 2003



Taux de réponse

Intérêt pour CGA

Transparence



Qualité du questionnaire

CGA non encore généralisée

Manque d'uniformité CGA

~ pas de consensus

BGMS: *3 parts program*

1. 2003 questionnaire
2. ***2004 consensus***
3. 2005 registration feasibility

Perspectives 2004

Groupes de travail pour proposer une CGA "minimale"

- Sur base de l'enquête 2003
- Spécifiques, sensibles, validés
- "feasible"
- Outils de dépistage 'screening tools'
- Base pour des algorithmes d'interventions gériatriques

Working groups

ADL-IADL

- P De Vriendt, G Dargent, C Swine

Mobility

- JP Baeyens , Ghesquière

Cognition

- M Lambert , E Gorus, C Sachem

Depression

- A Velghe, Th Pepersack

Social

- JP Baeyens , H Vandekerkhof

Nutrition

- T Pepersack, H Daniels, J Pétermans, C Gazzotti

Pain

- N Vandennoorgate, A Pepinster

Frailty

- C Swine, G Dargent, P De Vriendt

Consensus BGMST

Domaines **Echelles** **Items**

- ADL I-ADL
- Mobilité
- Cognition
- Dépression
- Social
- Nutrition
- Douleur
- Fragilité

ADL-IADL

P De Vriendt, G Dargent, C Swine

ADL: BADL and IADL

- **Literature search:**
  - Results: a lot of assessment - tools
  - 'What' they measure
    - Pure BADL: only a few tools
    - Pure IADL: only a few tools
    - Combined BADL and IADL or ADL and other (eg. cognition, behaviour): the most tools
  - Type of patient
    - All patients
    - Condition or disease specific
  - Assessed by
    - Direct observation
    - Self-report ▸ patient of proxy
    - Interview

ADL: BADL and IADL:

selection of tools according the criteria

- Pure BADL
  - Katz: original instrument or Belgian version
  - Barthel - index
- Pure IADL
  - Lawton – scale
- Combined
  - RAI
  - AGGIR
  - FIM
  - SMAF

» References and more information available on www.geriatrie.be

ADL: BADL and IADL: proposal (1)

- Question:
  - Choose an instrument already used or proposed be the respondents of the survey

    or

  - Choose an instrument that will be needed in ‘the future’ instead of the Katz? But it is uncertain what this will be.

ADL: BADL and IADL: proposal (2)

- BADL: Katz
- IADL: Lawton-scale

Motivation:

⇨ According the criteria (validated, …)

⇨ Pure tools: no overlap with others

⇨ Already used by the respondents (50% and 38%), Alzheimermedication, Elderly Home

⇨ Proposed by the respondents (31% and 32%)

⇨ Feasible:

➢ time needed: less than 5' each (Rubenstein et al., 1988)

Consensus BGMST

Domaines	Echelles	Items
• **ADL I-ADL**	• ***Katz, Lawton***	• 6, 8
• Mobilité		
• Cognition		
• Dépression		
• Social		
• Nutrition		
• Douleur		
• Fragilité		

Assessment of Mobility

J.P.Baeyens

B.Ghesquiere

Introduction

Assessment of MOBILITY

- GET-UP-AND-GO test
- TIMED UP AND GO TEST

Assessment of MUSCLE STRENGHT

- MRC-scale (0-5)
- HAND DYNAMOMETER of Jamar

Evaluation of FALL RISK

- STRATIFY score

GET-UP-AND-GO test

Version 1

- Get Up
- Standing
- Go
- Turning
- Sit down

Scores: 0=impossible
1=with help (manual or instrumental)
2=autonomous

GET-UP-AND-GO test

Version 2

- Get up, standing, go, turning and sit down

Score 1 till 5

-1 no instability

-2 very slowly execution

-3 hesitating, abnormal compensatory movements of body or arms

-4 patient is stumbling

-5 permanent risk of fall

S.Mathias, U.Nayak, B.Isaacs, 1985,
Arch.Phys.Med.Rehab. 67(6), 387-9

TIMED UP AND GO TEST

- Id, walk of 3 meters, but
- Timed in seconds

- < 20 sec. : independantly mobile
- > 30 sec. : dependent on help for basic transfers

D.Podsaldio, S.Richardson, 1991,
JAGS, 39(2), 142-8

STRATIFY score

(St.Thomas's Risk Assessment Tool In Falling elderly Inpatients)

YES or NO:

- Patient is admitted with falls, or presented falls since admission
- Is he agitated?
- Has he impaired vision?
- Has he frequently to go to the toilet
- Has he a transfer- and mobility- score of less than 3 or 4?

Oliver et al. 1997

STRATIFY score

(St.Thomas's Risk Assessment Tool In Falling elderly Inpatients)

Transfer score

- 0=impossible
- 1=help of 1 or 2 persons
- 2=help with words or other fysical support
- 3=autonomous

Mobility score

- 0=motionless
- 1=autonomous with help of wheelchair
- 2=march with physical or oral help of 1 person
- 3=autonomous

STRATIFY score

(St.Thomas's Risk Assessment Tool In Falling elderly Inpatients)

If result is 2 or more:

Risk of falling within the week.

Retesting by the nurse every week.

Consensus BGMST

Domaines	Echelles	Items
• ADL I-ADL	• Katz, Lawton	• 6, 8
• **Mobilité**	• ***Stratify***	• 5
• Cognition		
• Dépression		
• Social		
• Nutrition		
• Douleur		
• Fragilité		

Cognition

Lambert Greet

Ellen Gorus

Carine Sachem

literature

lots of different available tests

but… poorly studied or validated

unknown

not translated (Flemish & French)

time consuming

few international guidelines for *acute geriatric care*

pro's & contra's

- MMSE

pro : ± short (10 min.)

several cognitive functions

widely used

validated

geriatric population = high risk

con : cut off-score?

age; education

no validated Flemish version

French/German version ?

dialect? ; Walloon?

different versions :

orientation place

registration & recall: words

calculation &/or spelling; word choic

language : phrase

3 stage command

copy design

Folstein et al. J Psychiatric Res 1975; 12

Derouesné et al. La Presse Med 1999; 28

- Clock drawing test

pro : short (2 min.)

simple

validated

con : different versions

different scoring protocols

limited number cog. functions

often used in combination

Shulman et al. Int J Geriatr Psychiatry 1986; 1

Richardson & Glass. JAGS 2002; 50

- AMTS

pro : short & simple

recommended RCP & BGS

con : not widely used

no translation

Hodkinson. Age Ageing 1972; 1

Qureshi & Hodkinson. Age Ageing 1974; 3

conclusion and proposition

$$MMSE \quad \Leftrightarrow \quad CDT$$

Consensus BGMST

Domaines	**Echelles**	**Items**
• ADL I-ADL	• Katz, Lawton	• 6, 8
• Mobilité	• Stratify	• 5
• **Cognition**	• ***Clock DT***	• 1
• Dépression		
• Social		
• Nutrition		
• Douleur		
• Fragilité		

Depression

A Velghe, Th Pepersack

Screening questionnaires

- Beck Depression Inventory for Primary Care (BDI-PC)
  Behav Res Ther 1997;35:785-791
- Zung Self Rated Rating Scale
  Arch Gen Psychiatry 1965;12:63-70
- Center for Epidempiological Studies Depression Scaale (CES-D)
  Appl Psychol Measaure 1992;343-351
- Hamilton Rating Scale for Depression (HAM-D)
  J Neurol Neurosurg Psychiatry 1960;23:56-62
- Montgomery-Asberg Depression Rating Scale (MADRS)
- Cornell Scale for Depression in Dementia (CSDD)
- Geriatric Depression scale (GDS)
  Clin Gerontol 1982;1:37-43

Geriatric Depression Scale

- originally contained 100 items,
- condensed to 30 questions that indicate presence of depression.
- self-administered test
- "yes/no" question format, which may be more acceptable in the elderly population.
- initially validated among patients hospitalized for depression and among normal elderly living in the community without complaints of depression or history of psychiatric illness

Geriatric Depression Scale

- The GDS has been *well studied in various geriatric populations* unlike the other instruments discussed. It has been found to be a valid measure of depression in elderly medical inpatients.
- however, the GDS does not maintain its validity in populations that contain large numbers of cognitively impaired patients.
- In one study, the GDS maintained validity in cognitively impaired patients (MMSE score, 17.1)

Geriatric Depression Scale

- The GDS is available in several languages, and it has been found to maintain its reliability and validity when administered by telephone, which may be useful in a variety of epidemiological and clinical settings.
- A collateral source version of the GDS has been developed, although not extensively tested, which may prove useful as a screening instrument in those with aphasia, other communication deficits, or cognitive impairment.

Geriatric Depression Scale *Short Form* GDS-SF 15 items

- 5-7 min
- long-form and the short-form are highly correlated ($r = 0.84$, $P < .001$).
- short form has been validated in a geriatric affective disorder outpatient clinic (N = 116; average age 75.7 years).
- Using an optimal cutoff score of 5-6, the short-form GDS showed a sensitivity of 85% and specificity of 74%

Geriatric Depression Scale *Short Form* GDS-SF 10, 5 ,4 , 1 item(s)

- GDS 10-, 5-, 4-, and 1-item versions.
- GDS-4 had lower internal consistency than the GDS -15, but missed only 5 of 46 depressed patients in this sample.
- useful as a minimal screening procedure for detecting depression in elderly, primary care patients, especially among practitioners who feel that the 15-item GDS is too long.
- There has not been further validation of these shorter scales in other studies.

Depression Scales for Patients With Dementia

- Use outside informants (caregivers, nursing home staff) to provide history and reliable symptom reporting.
- A collateral source form of the GDS has been developed for use in the cognitively impaired, although it has not been validated in a demented population.

Depression Scales for Patients With Dementia

- The best validated scale for dementia patients is the Cornell Scale for Depression in Dementia (CSDD).
- The CSDD is an interviewer-administered scale that uses information both from the patient and an outside informant.
- The scale has correlated well with depression as classified by the Research Diagnostic Criteria

Depression Scales for Patients With Dementia

- Factor structure analysis reveals 4 to 5 factors that are assessed by the CSDD, including general depression, biologic rhythm disturbances, agitation/psychosis, and negative symptoms.
- However, even the CSDD has been better validated in patients with mild to moderate dementia, compared with patients with severe dementia.
- The CSDD has been used in aphasic patients and compared with Research Diagnostic Criteria.

Propositions

- Based on the research, it is clear the *GDS is the best validated* instrument in various geriatric populations (4 items).
- The *CSDD* may be better given its inclusion of information from caregivers, but further research in the *severely demented* elderly is needed

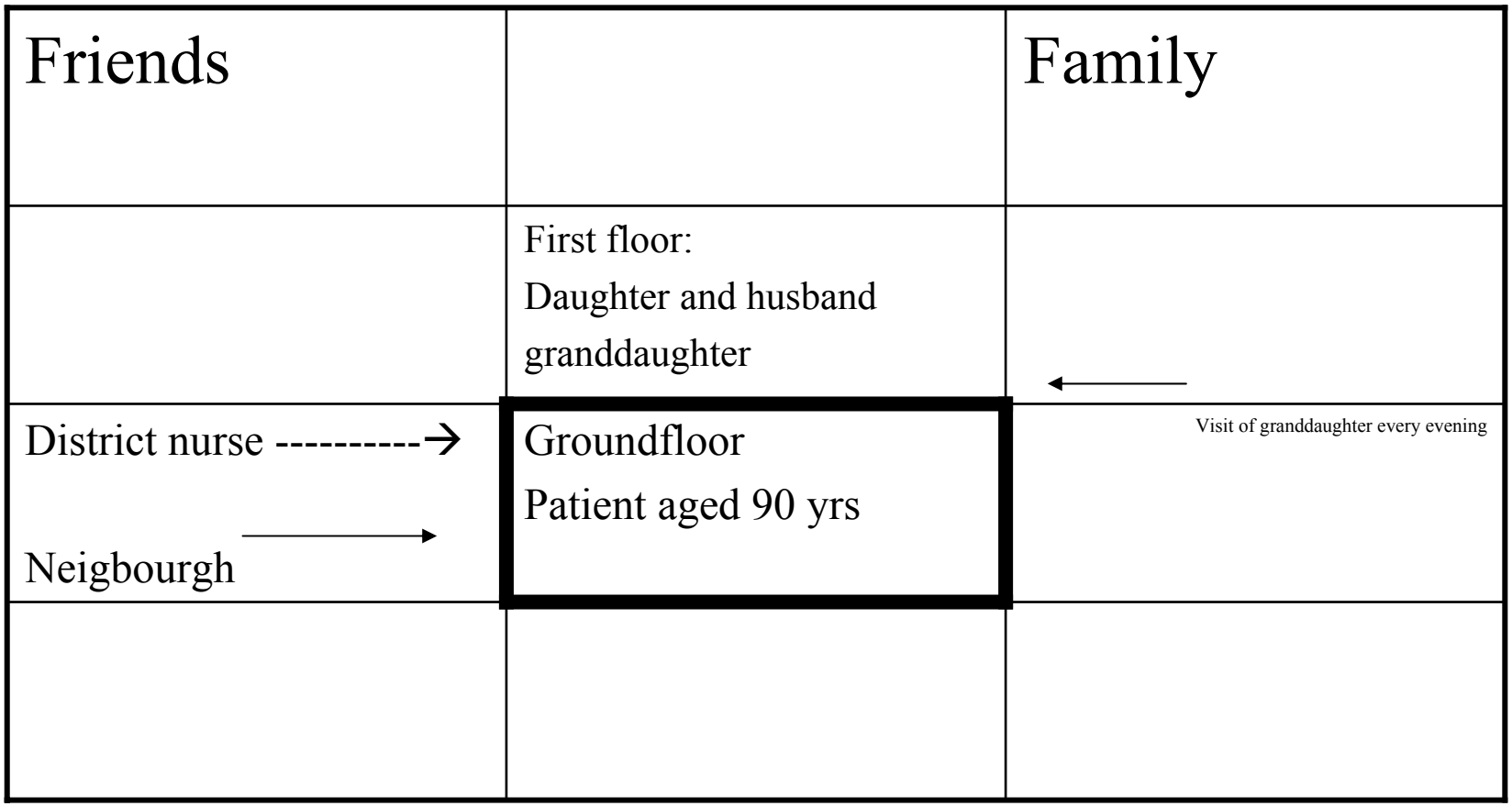
Consensus BGMST

Domaines	**Echelles**	**Items**
• ADL I-ADL	• Katz, Lawton	• 6, 8
• Mobilité	• Stratify	• 5
• Cognition	• Clock DT	• 1
• **Dépression**	• ***GDS, Cornell***	• 4 ou 5
• Social		
• Nutrition		
• Douleur		
• Fragilité		

Social indicators

J.P.Baeyens
H.Vandekerckhof

Social Network Diagram



R.Capildeo t al., B Med J, 1976, 1, 143-4

Socios

Future of patients

- S1 no changes expected (or not known)
- S2 only minor changes needed
- S3 change in living place
- S4 actions to be taken by expected death

Socios

Group context

- G1 only information is needed
- G2 patient and family needs guidelines
- G3 patient and family is not able to organise anything
- G4 conflict is present

Socios

Group context	Future of patients			
	S1	S2	S3	S4
G1	A	A	A	A
G2	A	B	B	B
G3	A	B	B	B
G4	B	C	C	C

Consensus BGMST

Domaines	**Echelles**	**Items**
• ADL I-ADL	• Katz, Lawton	• 6, 8
• Mobilité	• Stratify	• 5
• Cognition	• Clock DT	• 1
• Dépression	• GDS, Cornell	• 4 ou 5
• **Social**	• ***SOCIOS***	• 2
• Nutrition		
• Douleur		
• Fragilité		

Nutrition

T Pepersack, H Daniels, J Pétermans, C Gazzotti

Malnutrition screening

- Anthropometric measures
- Scale to assess the risk
  - *Nutritional Screening questionnaire*
  - *MNA,*
  - *MUST*

Malnutrition screening

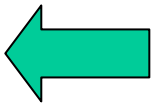
- Anthropometric measures
- Scale to assess the risk
  - *Nutritional Screening questionnaire*
  - *MNA,*
  - *MUST*

Anthropometric cut-off values that include body mass index for detecting underweight or undernutrition in adults

Anthropometric criteria	Recommended/type of study using criteria	Reference
BMI < 17.0	Elderly	Wilson, Morley 1988
BMI < 17.5	International classification for anorexia nervosa	WHO 1992
BMI < 18.0	Nursing home	Lowik et al 1992
BMI < 18.5	Community and hospital	Elia 2000, Kelly et al 2000
BMI < 19.0	Community and hospital	*Dietary Guidelines for Americans* 1995, Nightingale et al 1996
BMI < 20	Community and hospital	Jallut et al 1990, Vlaming et al 1999
BMI < 20	Hospital and community studies	McWhirter Pennington 1994, Edington 1996, 1999
BMI < 21	Elderly in hospital	Incalzi et al 1996
BMI < 22	Free-living elders (>70y)	Posner et al 1994
BMI < 23.5	Community and hospital	Potter 1998, 2001
BMI < 24 (and other criteria)	Community	Gray-Donald 1995
BMI < 24 (and other criteria)	Recipents of “meals on wheels”	Coulston et al 1996

Malnutrition risk screening

- Anthropometric measures
- Scale to assess the risk
  - *Nutritional Screening questionnaire*
  - *MNA,*
  - *Nursing Nutritional checklist*
  - *MUST*



NSI Checklist To Determine Your Nutritional Health

	YES
I have an illness or condition that made me change the kind or amount of food I eat.	2
I eat fewer than two meals/day.	3
I eat few fruits or vegetables, or milk products.	2
I have three or more drinks of beer, liquor or wine almost everyday.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take three or more different prescribed or OTC drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook, or feed myself.	2
Total nutritional score	_____

-2 indicates good nutrition
3-5 indicates moderate risk
6 or more indicates high nutritional risk

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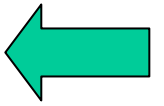
Malnutrition risk screening

- Anthropometric measures
- Scale to assess the risk
  - *Nutritional Screening questionnaire*
  - *MNA,*
  - *Nursing Nutritional checklist*
  - *MUST*



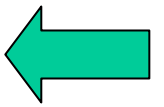
MNA screening tool

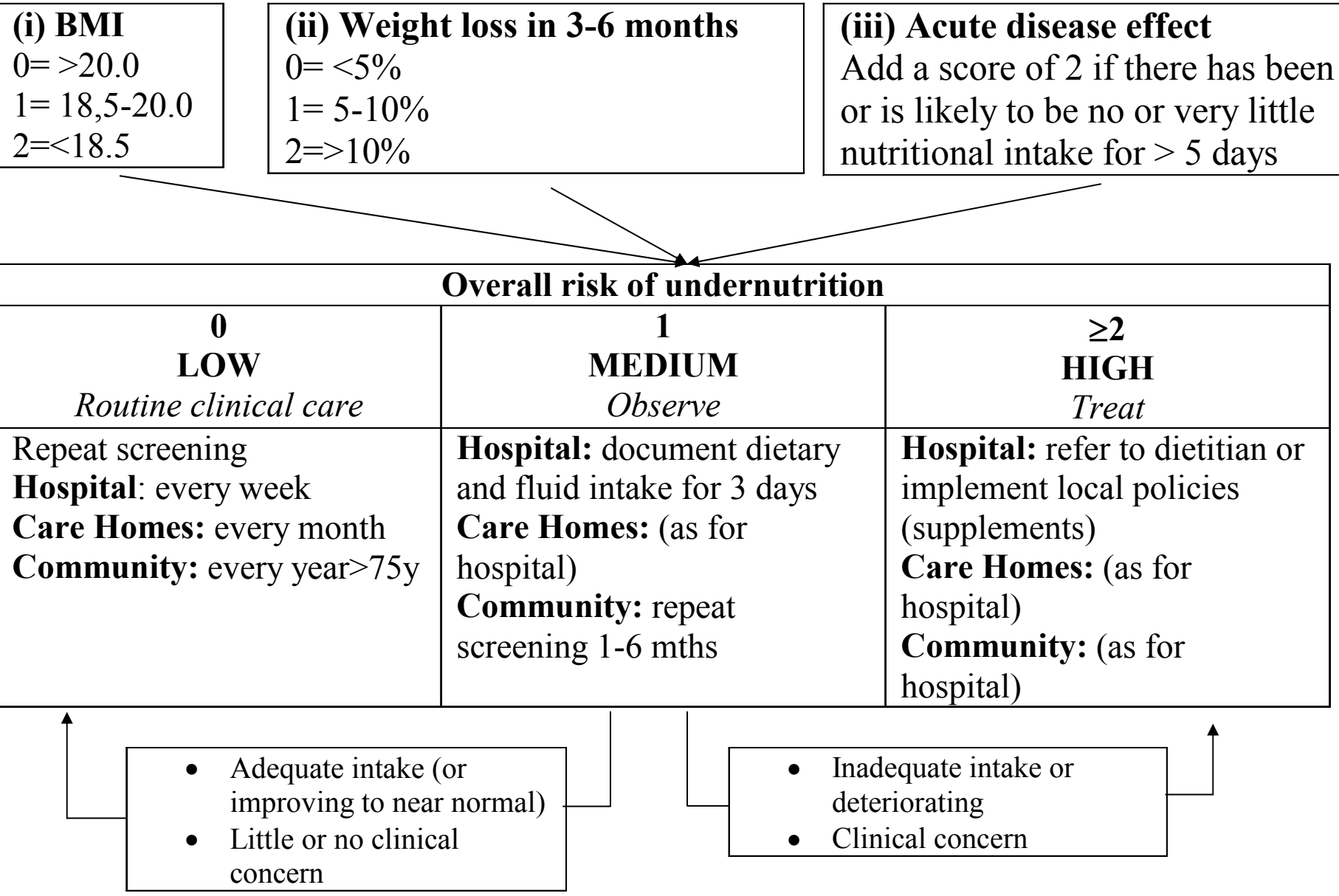
- Complete the Screening section by filling in the boxes with the numbers. Add the numbers in the boxes, for the screen.

http://www.mna-elderly.com/clinical-practice.htm

Malnutrition risk screening

- Anthropometric measures
- Scale to assess the risk
  - *Nutritional Screening questionnaire*
  - *MNA,*
  - *MUST*





The Malnutrition Universal Screening Tool (MUST) (BAPEN)

http://www.bapen.org.uk/screening.htm

proposition

Must ?

Consensus BGMST

Domaines	**Echelles**	**Items**
• ADL I-ADL	• Katz, Lawton	• 6, 8
• Mobilité	• Stratify	• 5
• Cognition	• Clock DT	• 1
• Dépression	• GDS, Cornell	• 4 ou 5
• Social	• SOCIOS	• 2
• **Nutrition**	• ***MUST***	• 3
• Douleur		
• Fragilité		

Screening for pain in the older person

Anne Pepinster, Nele Van Den Noortgate

Pain assessment

- Cognitively intact elderly or those with mild to moderate dementia (group I)

- Non communicative elderly or the elderly with moderate to severe dementia (group II)

Pain assessment: group I

- Proposition (college geriatricians)
  - Directly querying the patient
    - Presence of pain
    - Synonymous with pain (Burning, Discomfort, Aching, Soreness, Heaviness, Tightness)

OR

  - Using a pain scale:
    - vertical presentation of the VDS like the pain thermometer

More information and references on www.geriatrie.be

Pain assessment: group I

Pain assessment: group II

- Proposition: use of pain scale
  - Checklist of non-verbal Pain indicators
    - 6 questions with a score =0 if absent and score=1 if present; score between 0 and 6 correspond with the intensity of pain
  - ECPA (échelle comportementale de la douleur pour personnes âgées non communicantes)
    - 4 observation 5 min before the care (5 intensity ratings(0-4))
    - 4 observation during the care (5 intensity ratings (0-4))
  - Doloplus II scale

More information and references on www.geriatrie.be

Pain assessment: group II

- Proposition (college geriatricians)
  - Checklist of non-verbal Pain indicators
    - 6 questions with a score =0 if absent and score=1 if present; score between 0 and 6 correspond with the intensity of pain
      - Verbal complaints
      - Facial grimacing
      - Bracing
      - rubbing
      - Restlessness/agitation
      - Vocalisation

Feldt et al. Pain Manage Nurs 2000; 1:13

Consensus BGMST

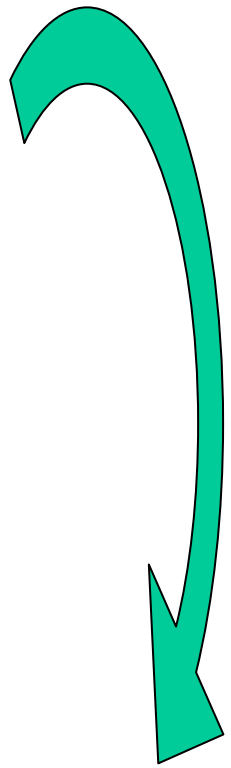
Domaines	Echelles	Items
• ADL I-ADL	• Katz, Lawton	• 6, 8
• Mobilité	• Stratify	• 5
• Cognition	• Clock DT	• 1
• Dépression	• GDS, Cornell	• 4 ou 5
• Social	• SOCIOS	• 2
• Nutrition	• MUST	• 3
• **Douleur**	• ***VAS, Checklist***	• 1 ou 6
• Fragilité		

Frailty

C Swine, G Dargent, P Devriendt

Frailty: definition and framework

- Homeostasis ↘ (physiological)
- Vulnerability ↗ (preclinical)
- **Frailty** **(impairments)**
- Functional decline (disability)

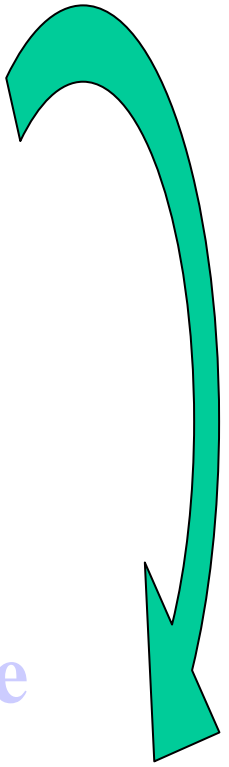


Outcomes of frailty

- Functional decline (disability, dependance)
- Geriatric syndromes
- **Health services use**
- **Institutionalisation**
- **Failure to thrive**
- **Death**

Frailty: definition and framework

- Homeostasis ↘ (physiological)
- Vulnerability ↗ (preclinical)
- Frailty (impairments)
- **Functional decline (disability)**



Risk for functional decline frailty screening

- Early screening needed (admission)
- Feasible in the admission unit (emergency)
- Help for triage and further assessment
- Potential tool for liaison geriatrics

Existing tools

- HARP Hospital Admission Risk Profile
  Sager et al. J Am Geriatr Soc 1996
- ISAR Identification of Seniors At Risk
  Mc Cusker J. et al : JAGS 1999; 47: 1229-1237
- SIGNET Case finding in the ED
  Mion L.C. et al. JAGS 2001; 49: 1379-1386
- SHERPA **Score hospitalier d'évaluation du risque de perte d'autonomie** *P. Cornette, et al. Revue Médicale de Bruxelles 2002 ;23-suppl1 :A181.*
- SEGA Short emergency geriatric assessment
  Schoevaerdts et al. La revue de gériatrie 2004 in press

HARP *Sager et al. J Am Geriatr Soc 1996*

AGE

75 y	0
75- 84 y	1
85 y	2

MMSa

15-21	0
0- 14	1

IADL 2w before admission

6- 7	0
0- 5	1
	TOTAL

0 - 1 low risk

2 - 3 intermediate risk

4 - 5 high risk

ISAR

Identification of Seniors At Risk

Identification Systématique des Aînés à Risque

Mc Cusker J. et al : Detection of older people at increased risk of adverse health outcomes after an emergency visit: the ISAR screening tool. JAGS 1999; 47: 1229-1237

- Self administred questionaire

- **Previous hosp. admission (6 m.) Yes/ No**
- **Vision problems Yes/ No**
- **Memory problems Yes/ No**
- **Premorbid help need Yes/ No**
- **Current help need Yes/ No**
- **More than 3 medications Yes/ No**

ISAR

Identification of Seniors At Risk

Identification Systématique des Aînés à Risque

Mc Cusker J. et al : Detection of older people at increased risk of adverse health outcomes after an emergency visit: the ISAR screening tool. JAGS 1999; 47: 1229-1237

Score	prevalence	%AR***	likelihood* (**)	
• 2 or more yes	51%	72%	2,0	(1,7)
• 3 or more yes	27%	44%	3,0	(2,2)
• 4 or more yes	12%	23%	4,7	(2,8)

- **likelihood of adverse outcome or current disability*
- *** likelihood of adverse outcome (death, institutionalization, functional decline)*
- **** % of patients at risk detected*

SIGNET: triage risk screening tool

Establishing a case-finding and referral system for at risk older individuals in an emergency department setting: the SIGNET model.
Mion L.C. et al. JAGS 2001; 49: 1379-1386

1 Presence of cognitive impairment

2 Lives alone or no caregiver available

3 Difficulty walking, transfers or recent fall

4 Recent ED visit or hospitalization

5 Five or more medications

6 Need further follow-up at home
(Abuse, neglect, compliance, iADL)

If yes at question 1 or at 2 other questions: further assessmen

Factors predicting FD 3 months after hospital discharge in 600 older patients, a screening tool (SHERPA)

P. Cornette, W. D'Hoore, C. Swine IDENTIFICATION DES PATIENTS AGES HOSPITALISES A RISQUE DE DECLIN FONCTIONNEL ***Revue Médicale de Bruxelles 2002 ;23-suppl1 :abst.O.397, p A181.***

• **AGE**	**< 75**	**0**			
	75-84	**1.5**			
	>85	**3**			
MMS (21)	**> 15**	**0**	**Falls (1y)**	**no**	**0**
	<14	**2**		**Yes**	**2**
iADL	**6-7**	**0**			
	5	**1**	**B s.p. H**	**no**	**0**
	3-4	**2**		**Yes**	**1.5**
	0-2	**3**			

Category	%	%FD	OR
Low (0-3)	36	13	1
Mild (3.5-4.5)	23	23	2
Mod.(5-6)	18	39	4
High (>6)	23	62	10

Existing tools

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• Nutrition	• MUST	• 3
• Douleur	• VAS, Checklist	• 1 ou 6
• **Fragilité**	• ***ISAR***	• 6

Consensus BGMST

Domaines	Echelles	Items
• ADL I-ADL	• Katz, Lawton	• 6, 8
• Mobilité	• Stratify	• 5
• Cognition	• Clock DT	• 1
• Dépression	• GDS, Cornell	• 4 ou 5
• Social	• SOCIOS	• 2
• Nutrition	• MUST	• 3
• Douleur	• VAS, Checklist	• 1 ou 6
• Fragilité	• ISAR	• 6

N= 28 à 36

Consensus BGMST

Domaines	Echelles	Alertes/Procédures
ADL I-ADL	• Katz, Lawton	• Fonction (continence)
Mobilité	• Stratify	• Chutes
Cognition	• Clock DT	• Démence, delirium
Dépression	• GDS, Cornell	• Dépression
Social	• SOCIOS	• Complexité
Nutrition	• MUST	• Dénutrition
Douleur	• VAS, Checklist	• Douleur
Fragilité	• ISAR	• Durée hospitalisation

BGMS: *3 parts program*

1. 2003 questionnaire
2. 2004 consensus
3. ***2005 registration feasibility***

BGMS 2005: *objectifs*

1. Évaluer la faisabilité du BMGST au sein des unités belges de gériatrie
2. Evaluer l'efficacité du BMGST sur le taux de détection des problèmes gériatriques
3. Analyser des variables de qualité dans les données collectées

BGMS 2005: *méthodologie*

- Study design: prospective observational survey followed by bench marking (feed back).
- Chaque unité de gériatrie enregistrera un BMGST chez 10 patients admis consécutivement entre mars et mai 2005.

BGMS 2005: *méthodologie*

1. Endéans les 48h après l'admission l'équipe définit *le motif d'admission* et les *problèmes gériatriques actifs* suspectés pour lesquels une intervention gériatrique est programmée.
2. Puis, dans un second temps et endéans la semaine, le BMGST est complété.

BGMS 2005: *méthodologie*

- Les données seront collectées sur papier ou dans un logiciel (Access Microsoft®) téléchargeable sur le site de la SBGG (www.geriatrie.be) .

	Date	Check
Protocol	June 2004	✓
Scales translation Engl to Fr & Nl	July 2004	✓
Financial report	Oct. 2004	✓
Software	Dec. 2004	
Software translation Fr & Nl	January 2005	
Announcements	Journées d'automne 2004, G News Dec 2004, Winter Meeting BVGG, March 2005	
Preliminary trial (College)	Feb 2005	
General Registration	March-May 2005	
Data management	July 2005	
Statistical analysis	Aug. 2005	
Final report	Sept. 2005	
Benchmarking	Oct. 2005	
Diffusion	Oct. 2005:Journées d'automne Feb. 2006: Winter Meeting	

BGMS: *3 parts program*

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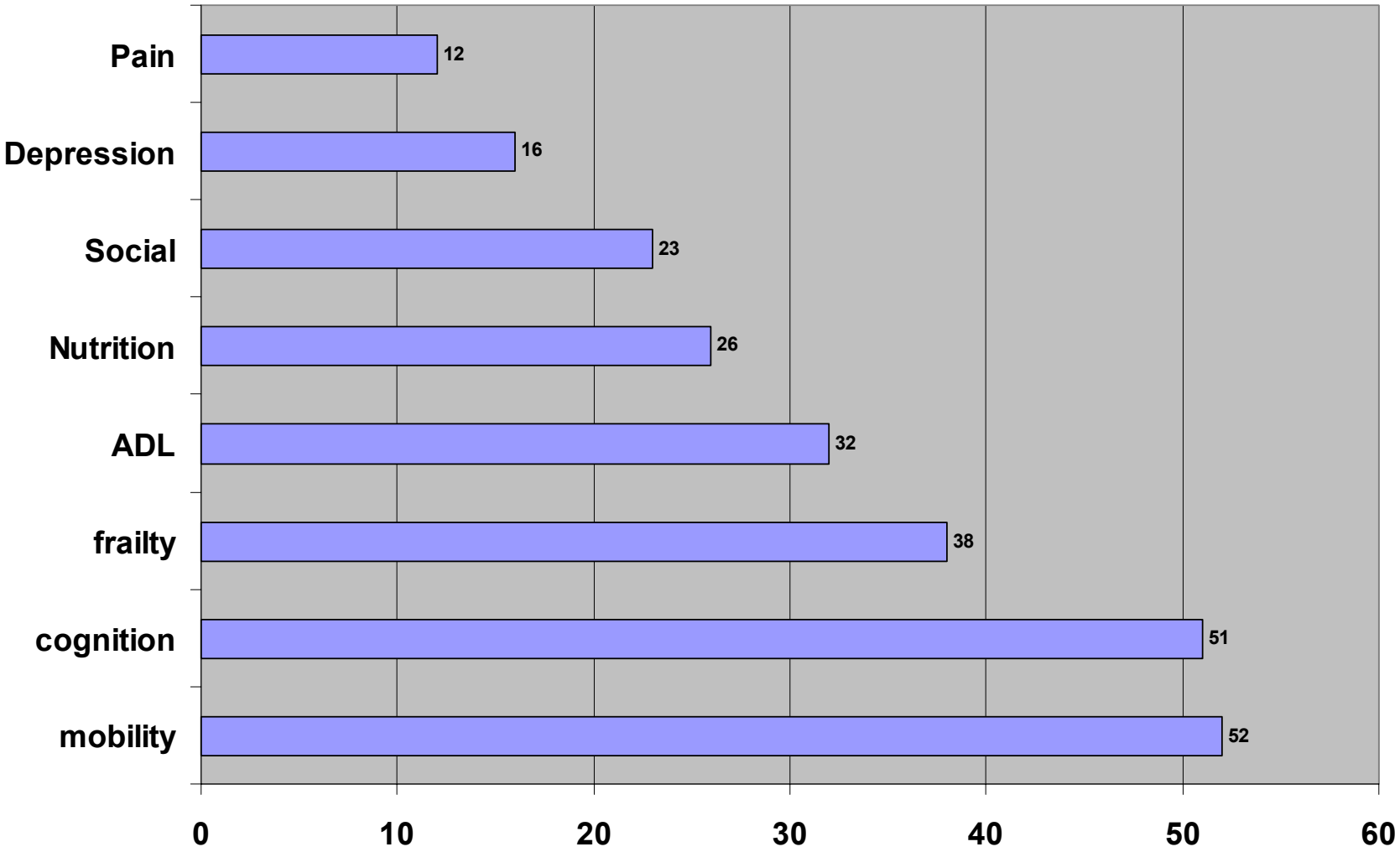
2. 2004 consensus
3. 2005 registration feasibility
4. ***2006 quality variable registration***

BGMS 2006: *choice of the thema*



Missions des collèges

missions	Faits
1. Consensus d'indicateurs de qualité	Étude nutritionnelle Étude continence Eude SEGA BGMST
2. Modèle d'enregistrement informatisé	Idem
3. Visite	« visitation 2000»
4. Rapport annuel	Oui
5. Fonction expert	Oui
6. Rapport sur l'utilisation des moyens	Non
7. Programme de soins	Oui

acknowledgements

- College:

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- G Dargent, P Hellinckx , Ministery Social Affairs
- external experts & participants : P De Vriendt, C Sachem, A Velghe

and YOU

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SOCIETE BELGE DE GERONTOLOGIE ET DE GERIATRIE