

# G2C Case Studies

## Regional Geriatric Programs of Ontario GiiC Initiative for FHTs and CHCs

# think

**Geriatrics  
Interprofessional  
Interorganizational  
Collaborative Care**

### CAPACITY

Mrs. Clara Grey, aged 80, husband admitted to acute care 3 months ago and passed away 2 weeks later. Since her husband's death, she has been calling her daughter several times daily. Daughter is expressing concerns regarding her mother's ability to cope at home alone and frustration with the caregiver role.

**Past History & Medications:** Glaucoma—eye drops BID, Osteoporosis—Calcium and Vitamin D Note: did not tolerate Didrocal, Cataracts removed in summer 2005 and 2007, Dementia—Aricept 10 mg. o.d., Labs—normal 10 months ago. Note: Non-compliance with medication unless cued.

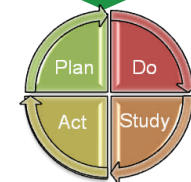
No physical complaints, independent ambulation, no witnessed falls, smoker—1 carton a week, long-standing limited appetite, with 20-25 lbs weight loss over past few years, suspect ETOH abuse, cognitive decline x 5 yrs—started on Aricept 2 yrs ago. Decreased short term memory, some disorientation to time (phoning at 1 am), decreased attention to personal care (not bathing, clothes soiled) . Dependent for IADL's—spouse had done shopping, meal prep, cueing for meds. Uses packaged foods, tea & toast—seldom uses microwave, does not cook. Still has valid driver's license. ? management of ADL's.

Retired secretary, son out of province, dtr. nearby but had not been involved in care due to “family conflict”. Mood swings & stubbornness reported by dtr.

Dtr., who is a patient at your primary care centre, has brought Mrs. Grey in for assessment.

**Collaborating for better  
patient outcomes . . .**

- ◆ Is the patient capable?
- ◆ What are the risks?



*Mrs. Grey demonstrates the complexities of care for older people who have chronic illnesses, frailty, and are living in the community. It is questionable if she was really managing with her husband's assistance. Now that this support is gone, her problems have become more apparent.*

### Assessment

**Physical:** has walker but does not use, unsteady gait noted, bruising on arms, legs, abrasion on side of face

**Cognitive:** socially appropriate to most questions. Showed anger when pressed for details, MMSE 21/30. Did not know medical history. Did not know 911.

**Mood:** decreased energy, sleeps through night, naps during day. Anger & frustration evident. Perceives daughter “trying to get me out of my house”. Displayed humour appropriate to situation, able to verbalize husband died but showed little emotion.

**Functional:** Dishevelled, dirty clothes, scratching head frequently, smelled of cigarette smoke, alcohol, body odour. Clara reports bills are being paid but dtr. found final notices from hydro & gas companies. Dtr. now doing shopping & laundry weekly. Clara “only” drives to local store for milk, bread, cigarettes.

**Environment:** Dtr. reports clutter throughout house, several days of unwashed dishes in sink, table & floors “sticky”, cigarette burns on carpet & favourite chair. Scatter mats throughout home, observed lighting cigarette from electric stove burner.

**Social:** High school education, married 60 yrs., No POAs delegated. Minimizes alcohol use. Denies need for assistance stating “I don't need your help or anyone else's”.

### How and why? Who and Where?

What are the issues/risks?

Are the risks actual or potential?

Are any of the risks tolerable?

Are there any risks that make capacity an issue?

How should the Primary Care IPC team approach this situation?

What is your role in a capacity assessment?

Who should be involved in her care? Why?

How will her choices and values be respected? Who will advocate?

How would you have a conversation with Clara and her daughter (what would you say)?

What parts of the conversation would you find difficult?

What are your recommendations?