

G2C Case Studies

Regional Geriatric Programs of Ontario
GiiC Initiative for FHTs and CHCs

think

Geriatrics
Interprofessional
Interorganizational
Collaborative Care

CAPACITY

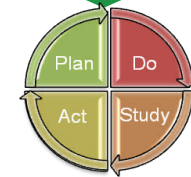
Mr. Cecil Fields, aged 90, farmer, neighbour reports safety concerns: property “a mess”, observed burning brush near house but left it unattended, wandering outside in Feb. without coat, driving slowly and “swerving”. CCAC previously contacted by neighbour & out to assess but Cecil “suspicious” and hesitant to let them in house. Did not provide any personal information during this visit. Lives with son Angus, aged 60, query if developmentally delayed. Son has never worked outside of farm, thinks he has Grade 6 education. No POAs. Two men have been “loners” & fairly isolated, seen in town for groceries & banking.

Medical history unknown. Cecil smells of urine.

Neighbour recently able to get inside home. Reports home has no running water, well on property, washtub half-full of “black” water, house ++ cluttered, smells musty & stale, open cans of food on counter, outdated food in frig. Both men wearing “worn” clothes. Three cats in house—litter box ‘full’. Roof of house needs repair, front steps have sagged and pulled away from the house. Neighbour has brought Mr. Fields to your primary care centre, after he showed the neighbour a “gash” on his lower leg.

Collaborating for better
patient outcomes . . .

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



Mr. Fields demonstrates the complexities of care for older people who are frail , living in the community with minimal or no support and without ongoing medical care/supervision. Although he has “managed” on his own , is there potential to improve his quality of life?

Assessment

Physical: 6’1”, thin, estimate wt. at 140 lbs, clothes hanging on thin frame, gnarled hands, stooped posture, slow, shuffling gait, balance poor. BP 142/78 sitting, 138/77 standing, visual impairment, ? Cataracts, reports pain in neck, shoulders, back, hips, knees & hands. Takes Tylenol (only med).

Laceration on right lower leg, 4 cm in length, dried blood on surrounding skin.

Cognitive: Grade 8 education, has always lived & worked on family farm.

Presents as ‘simple’, enjoys watching TV with his son. MMSE 22/27, unable to complete pentagons, sentence and “Close your eyes” due to vision. Did not know 911 address. MoCA 19/30. Unable to complete trail making test or copy cube. Clock draw: drew circle but unable to place numbers within it.

Mood: Presented as “guarded”, was cooperative with testing, but frequently questioned the need. Scored 6/15 on Geriatric Depression Scale.

Functional: Reports that he cooks the meals and Angus helps. Favourite dish is pork & beans and toast.

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 his care? Why?

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

How would you have a conversation with Cecil (what would you say)?

What parts of the conversation would you find difficult?

What are your recommendations?

What concerns, if any, do you have for his son?