

ClinicalEdu

Comprehensive Geriatric Assessment (CGA)

Learner Handbook - core reading for the ten-module ClinicalEdu course

Status

Production Pass 1B authoring baseline

Version

1.0 | Sources reviewed through 16 September 2026

Use

Independent, non-commercial professional education

About this handbook

This handbook supports the browser-based ClinicalEdu CGA course. It contains core reading and original diagrams but not every interactive case, formative question or assessment item. It can be read independently as a practical introduction to CGA.

How to use it

- Read the corresponding chapter before or after each web module.
- Use the practice points to prepare for module questions.
- Use the longitudinal case to practise integrating domains rather than treating them as separate checklists.
- Record questions and reflections in your ClinicalEdu CPD Diary.
- Check local policy and current national guidance for time-sensitive decisions.

Important CGA is not a substitute for acute clinical assessment, local escalation policy, capacity/consent law or specialist advice. The course teaches a framework for coordinated care, not patient-specific medical advice.

Course overview

Module 1: What CGA is - and is not

Define CGA as a multidimensional, multidisciplinary and iterative clinical process.

Module 2: Who needs CGA and when

Identify clinical patterns that should prompt consideration of CGA.

Module 3: Medical and physical domain

Build a problem list that integrates acute illness, chronic disease and geriatric syndromes.

Module 4: Medicines and treatment burden

Perform a structured medicines review within CGA.

Module 5: Cognition, delirium and psychological health

Differentiate delirium, dementia, depression and other cognitive/psychological problems.

Module 6: Function, mobility, falls and rehabilitation

Assess ADLs, IADLs, mobility, gait, balance and rehabilitation potential.

Module 7: Nutrition, continence, pain and sensory health

Identify undernutrition risk, swallowing issues, dehydration and oral-health contributors.

Module 8: Social, environmental and carer domains

Assess social support, carer capacity, isolation, finance and safeguarding concerns.

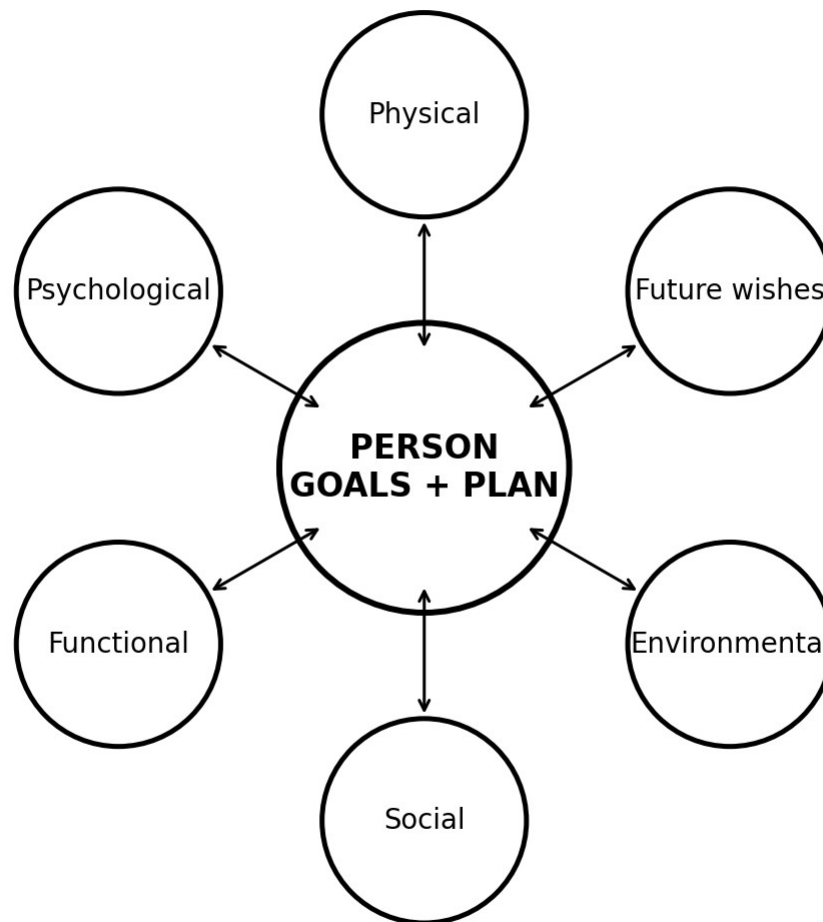
Module 9: Future wishes, goals and anticipatory care

Elicit what matters to the person and convert it into meaningful goals.

Module 10: From assessment to integrated care plan

Convert multidomain information into a prioritised problem list.

ClinicalEdu CGA six-domain integration model



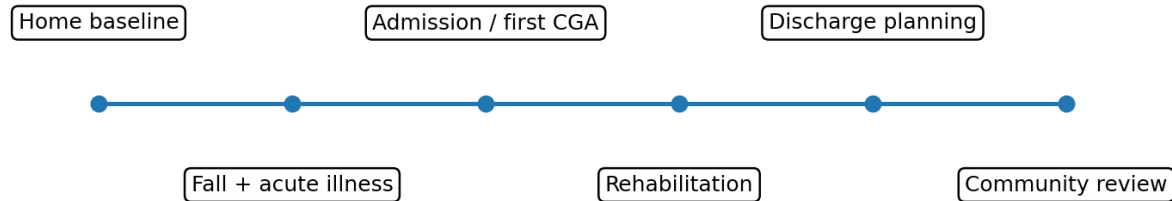
ClinicalEdu CGA six-domain integration model.

The longitudinal case

Mrs Evelyn Morgan is an 84-year-old widow who lives alone in a bungalow. She has heart failure with preserved ejection fraction, atrial fibrillation, stage 3b chronic kidney disease, osteoarthritis and hearing impairment. Her daughter visits twice weekly. Before the current episode she managed personal care independently, used a stick outdoors and had gradually stopped shopping

alone. She is admitted after a fall, fever and new confusion. The case is fictional and deliberately evolves across the course.

Longitudinal case: the CGA changes as new information emerges



The case evolves across acute care, rehabilitation and community follow-up.

1. What CGA is - and is not

Learning outcomes

- Define CGA as a multidimensional, multidisciplinary and iterative clinical process.
- Distinguish CGA from a clerking template, screening tool or one-off assessment.
- Explain why assessment must lead to a prioritised integrated care plan.
- Describe how person-centred goals and follow-up are built into CGA.

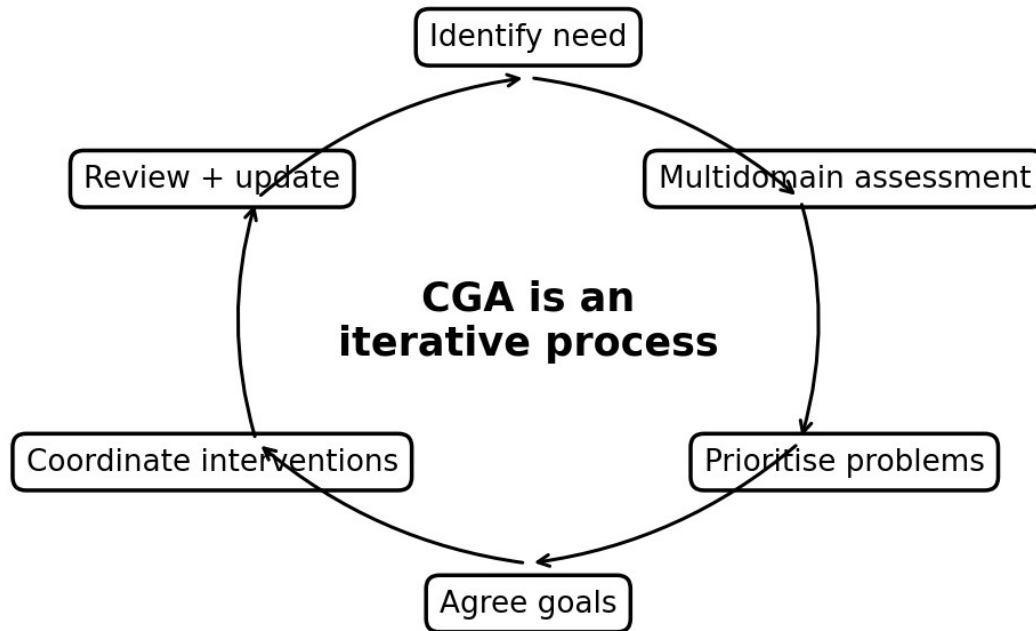
CGA is best understood as an intervention, not a form. It combines multidimensional assessment, multidisciplinary interpretation, prioritisation, action and review. The BGS current CGA Hub frames CGA around physical, psychological, functional, social, environmental and future-wishes domains, but the domains overlap and must be integrated rather than completed in silos.

A routine medical clerking can identify diagnoses without establishing how illness interacts with mobility, cognition, medicines, home circumstances, goals and recovery potential. CGA closes that gap by asking what matters, what is reversible, what threatens independence, what burden treatment creates and who will own each action.

The educational test is therefore not whether a learner can name six domains. It is whether they can turn information into an individualised, coordinated and reviewable plan.

Case continuation At first assessment Mrs Morgan has fever, confusion, postural symptoms and pain after a fall. The first CGA question is not “Which form do we complete?” but “What immediate risks and reversible problems are present, what was her baseline, and what matters to her?”

From assessment to coordinated, reviewable care



CGA should cycle through assessment, action and review.

Practice points

- Do not equate CGA with a form.
- Assessment without action and follow-up is incomplete.
- Person goals belong inside the process.

Quick self-check

1. Which statement best describes CGA?

- A. A standard geriatric clerking form
- B. A multidimensional, multidisciplinary process leading to an integrated care plan
- C. A frailty score
- D. A discharge checklist

Answer B. CGA is a process that links assessment to coordinated intervention and follow-up.

2. Who needs CGA and when

Learning outcomes

- Identify clinical patterns that should prompt consideration of CGA.
- Use frailty, multimorbidity, geriatric syndromes and functional change as triggers rather than rigid eligibility rules.
- Recognise proactive, reactive and transition points for CGA.
- Avoid using age or a single frailty score as an automatic inclusion/exclusion rule.

CGA is particularly useful when older people have frailty, multimorbidity, geriatric syndromes, functional decline, recurrent unplanned care, polypharmacy or complex transitions. Selection should remain clinical and service-dependent. Age alone is not an indication, and no single frailty score should function as a gatekeeper.

CGA can be reactive after a crisis, proactive in community or ambulatory care, or triggered by a transition such as discharge, care-home move, surgery or rehabilitation. A useful trigger is complexity plus risk of fragmentation: when several problems and services interact, a coordinated plan becomes more valuable.

NICE multimorbidity guidance supports person-centred care when treatment burden, multiple services, frailty, falls, polypharmacy or unplanned care make single-disease management inadequate.

Case continuation Mrs Morgan's fall is not an isolated event. She has acute illness, recent functional decline, polypharmacy and uncertainty about how safely she can return home. This combination makes CGA appropriate.

Practice points

- Use complexity and fragmentation as triggers.
- Age and frailty scores inform but should not become gatekeepers.
- CGA can be proactive, reactive or transition-focused.

Quick self-check

1. Which patient is most likely to benefit from CGA?

- A. An older adult with interacting frailty, falls, polypharmacy and functional decline
- B. Any adult solely because of age
- C. Only people in care homes
- D. Only people with dementia

Answer A. Complex interacting needs are a classic trigger.

3. Medical and physical domain

Learning outcomes

- Build a problem list that integrates acute illness, chronic disease and geriatric syndromes.
- Distinguish diagnosis from impact on function and goals.
- Identify reversible contributors and iatrogenic risk.
- Prioritise investigations and treatment according to likely benefit, burden and goals.

The physical domain begins with ordinary clinical medicine but extends beyond diagnosis. Acute illness must be recognised and treated while chronic conditions, geriatric syndromes and iatrogenic contributors are reviewed together.

A useful CGA problem list distinguishes active acute problems, chronic conditions requiring adjustment, symptoms, geriatric syndromes and risks. Investigations should answer clinically meaningful questions; more testing is not automatically more comprehensive.

Physical assessment should include pain, hydration, infection, cardiovascular status, respiratory disease, renal function, bowel/bladder issues, skin, oral health and any condition affecting function or treatment tolerance. The plan should state what is reversible, what needs monitoring and what can be simplified.

Case continuation Mrs Morgan's fever and confusion require an acute medical assessment. Orthostatic blood-pressure change, renal function, pain after the fall and heart-failure status influence both immediate treatment and rehabilitation.

Practice points

- Treat acute illness while looking for interacting chronic and geriatric problems.
- Prioritise clinically meaningful investigations.
- Document reversibility and monitoring.

Quick self-check

1. The physical domain should:

- A. List diagnoses only
- B. Integrate acute illness, chronic disease, syndromes and reversibility
- C. Exclude pain
- D. Avoid treatment burden

Answer B. CGA extends ordinary diagnosis into impact and action.

4. Medicines and treatment burden

Learning outcomes

- Perform a structured medicines review within CGA.
- Identify indication, benefit, harm, adherence, monitoring and treatment burden.
- Recognise prescribing cascades, interactions and medicines contributing to falls, delirium or hypotension.
- Plan safe deprescribing or optimisation with review.

Medicines review within CGA is a structured examination of indication, effectiveness, safety, adherence, monitoring and burden. The goal is not simply to reduce the number of medicines, but to improve the overall fit between treatment and the person's priorities and physiology.

NICE medicines-optimisation guidance supports structured medication review, particularly in older people and those taking multiple medicines. Multimorbidity guidance also asks clinicians to consider whether prognostic treatments still offer worthwhile benefit when frailty, limited life expectancy or treatment burden alter the balance.

Common CGA questions include: Is every medicine still indicated? Is there duplication? Could a medicine contribute to hypotension, falls, bleeding, constipation, delirium or renal injury? Is monitoring feasible? Is the regimen manageable? If treatment is changed, who reviews the effect and when?

Case continuation Mrs Morgan takes ten regular medicines. She reports dizziness on standing and occasionally misses evening doses. The team must review benefit and harm without assuming that “polypharmacy” means automatically stopping medicines.

Practice points

- Review indication, benefit, harm, adherence, monitoring and burden.
- Do not equate polypharmacy with inappropriate prescribing.
- Every medicine change needs a review plan.

Quick self-check

1. Medication review is best defined as:

- A. Counting medicines
- B. Structured examination of indication, benefit, harm, adherence and monitoring
- C. Stopping all preventive medicines
- D. Pharmacist-only work

Answer B. The aim is optimisation, not medicine-count reduction.

5. Cognition, delirium and psychological health

Learning outcomes

- Differentiate delirium, dementia, depression and other cognitive/psychological problems.
- Use baseline cognition and collateral history appropriately.
- Recognise delirium as an acute clinical syndrome requiring cause-finding and prevention measures.
- Keep cognitive impairment conceptually separate from decision-specific capacity.

Cognitive and psychological assessment should establish baseline cognition, look for acute change and consider mood, anxiety, distress and communication needs. Delirium and dementia can coexist; new inattention or fluctuating cognition should not be attributed to dementia without assessment for delirium and its causes.

NICE delirium guidance was updated in 2023 and supports active identification, prevention and assessment. Collateral history is often essential. Hearing and visual impairment can worsen apparent cognitive difficulty and should be addressed.

Cognition is not capacity. Capacity is decision-specific and time-specific and belongs to the dedicated legal framework. CGA should identify when capacity assessment may be needed, not infer incapacity from a cognitive score.

Case continuation Mrs Morgan's daughter says her mother was occasionally forgetful but managed bills and medication prompts. The current confusion fluctuates over hours. The learner must distinguish baseline cognitive vulnerability from probable acute delirium.

Practice points

- Establish baseline cognition and acute change.
- Think delirium when confusion fluctuates.
- Cognitive impairment does not automatically mean incapacity.

Quick self-check

1. New fluctuating confusion should prompt consideration of:

- A. Delirium
- B. Normal ageing
- C. Incapacity automatically
- D. Depression only

Answer A. Fluctuation and acute change are key delirium features.

6. Function, mobility, falls and rehabilitation

Learning outcomes

- Assess ADLs, IADLs, mobility, gait, balance and rehabilitation potential.
- Use current falls guidance to structure multifactorial assessment.
- Recognise deconditioning and the importance of early functional goals.
- Translate findings into multidisciplinary rehabilitation actions.

Function is central to CGA because it links disease to everyday life. Assessment should cover personal ADLs, instrumental ADLs, transfers, mobility, gait, falls history, fear of falling, equipment and rehabilitation potential. Baseline and current function must be separated.

NICE NG249 (2025) provides the current falls framework. In hospital and residential care, comprehensive falls assessment does not require additional eligibility criteria. Assessment should lead to modifiable actions rather than a generic “falls risk” label.

Rehabilitation goals should be meaningful and measurable. Early mobilisation, strength and balance work, appropriate aids, pain control and environmental modification should be coordinated with the person’s goals and medical stability.

Case continuation Before admission Mrs Morgan walked outdoors with a stick and wanted to keep tending her small garden. She now needs one-person assistance to transfer. The rehabilitation plan should aim toward meaningful baseline activities, not only an abstract mobility score.

Practice points

- Separate baseline from current function.
- Make rehabilitation goals meaningful and measurable.
- Use falls assessment to generate action, not labels.

Quick self-check

1. Functional assessment should compare:

- A. Current function only
- B. Baseline, current function and recovery goals
- C. Age groups only
- D. Diagnosis count

Answer B. Trajectory matters.

7. Nutrition, continence, pain and sensory health

Learning outcomes

- Identify undernutrition risk, swallowing issues, dehydration and oral-health contributors.
- Assess continence, pain, vision and hearing as functional determinants.
- Recognise how these domains interact with delirium, falls and rehabilitation.
- Create targeted actions rather than a list of abnormalities.

Nutrition, continence, pain and sensory health are often treated as secondary problems, yet each can determine recovery. Undernutrition reduces strength; dehydration worsens delirium and renal injury; pain limits mobilisation; urinary symptoms can contribute to falls; hearing loss can impair communication and cognition testing.

The purpose of assessment is not to create a long list. Each finding should connect to an intervention, owner and review point. Swallowing difficulty, weight loss or poor intake may require dietetic or speech-and-language input; continence issues may need medication and functional review as well as urological assessment.

Sensory aids should be available and working. Simple measures such as ensuring hearing aids are fitted can materially improve communication, orientation and participation in rehabilitation.

Case continuation Mrs Morgan has eaten poorly for several days, has lost weight over recent months, avoids drinking because of urgency, and her hearing-aid batteries are flat. These details materially change the CGA plan.

Practice points

- Small domains can determine recovery.
- Treat hearing/vision as clinical issues, not background detail.
- Connect findings to named interventions.

Quick self-check

1. Poor hearing can affect:

- A. Communication and cognitive assessment
- B. Only audiology
- C. Nothing relevant to CGA
- D. Only discharge paperwork

Answer A. Sensory function has cross-domain effects.

8. Social, environmental and carer domains

Learning outcomes

- Assess social support, carer capacity, isolation, finance and safeguarding concerns.
- Assess the home environment, accessibility, equipment and community services.
- Recognise carer strain and the limits of informal support.
- Integrate social/environmental feasibility into the clinical plan.

The social domain explores support, relationships, carer capacity, isolation, safeguarding, finances and what practical help is available. The environmental domain examines safety, access, stairs, heating, equipment, transport, technology and community services. These domains determine whether a clinical plan is actually deliverable.

Carers should be involved with consent and their own needs recognised. A daughter who visits twice weekly is not the same as 24-hour support. Care planning must avoid quietly transferring risk and workload to relatives without discussion.

Environmental assessment should connect with occupational therapy, social care and community teams where needed. The question is not merely “Is the home safe?” but “What needs to change for the person to function there at an acceptable level of risk?”

Case continuation Mrs Morgan’s daughter works full time and cannot provide daily care. The bungalow has two steps at the entrance and no grab rail in the shower. A discharge plan that assumes constant family support would be unrealistic.

Practice points

- Clarify what carers can actually provide.
- Test clinical plans against the home environment.
- Avoid transferring responsibility to relatives by assumption.

Quick self-check

1. Social assessment should include:

- A. Carer capacity and support network
- B. Only marital status
- C. Only benefits
- D. Only housing tenure

Answer A. CGA explores practical and relational support.

9. Future wishes, goals and anticipatory care

Learning outcomes

- Elicit what matters to the person and convert it into meaningful goals.
- Incorporate advance care planning, treatment preferences and future wishes appropriately.
- Recognise when capacity, consent or best-interests processes are required.
- Document uncertainty, escalation planning and review without reducing care to DNACPR status.

Future wishes are a core CGA domain. They include the person's priorities, fears, acceptable trade-offs, preferred place of care, advance planning and treatment preferences. These discussions should be proportionate to the clinical situation and should not be reduced to a resuscitation decision.

BGS explicitly includes future wishes within contemporary CGA. The information from other domains helps make these discussions realistic: functional trajectory, frailty, cognition, treatment burden and social circumstances all influence what choices mean in practice.

Where capacity is uncertain, the appropriate legal framework must be used. Where preferences are known, they should shape the care plan. Anticipatory plans should specify what to do if predictable deterioration occurs, who to contact and when the plan should be reviewed.

Case continuation Mrs Morgan says her priority is to remain at home if possible and to avoid repeated hospital stays, but she would accept treatment for reversible illness. This should shape escalation and follow-up planning without assuming she is “for comfort care only”.

Practice points

- Future wishes are broader than CPR decisions.
- Document nuanced preferences and review them.
- Use capacity/consent frameworks when required.

Quick self-check

1. Future wishes in CGA include:

- A. Goals and treatment preferences
- B. DNACPR only
- C. Family preference only
- D. No clinical information

Answer A. Future wishes are broader than CPR decisions.

10. From assessment to integrated care plan

Learning outcomes

- Convert multidomain information into a prioritised problem list.
- Assign actions, ownership, timescales and review points.
- Communicate the plan across settings and disciplines.
- Use iteration and follow-up so CGA remains a process rather than a static document.

The endpoint of CGA is not a completed assessment; it is a prioritised and coordinated plan. A useful plan states the problem, what matters to the person, agreed action, owner, timescale, monitoring and review. It also records uncertainty and what would trigger reassessment.

CGA is iterative. Some problems resolve, others emerge, and goals can change. Transitions are therefore high-risk points. Information must move with the person and responsibilities must be explicit across hospital, primary care, community, rehabilitation and social care.

The final quality check is whether another clinician or team can understand what matters, what has been decided, what remains unresolved, what they are expected to do and when the plan should be reviewed.

Case continuation Mrs Morgan improves after treatment and rehabilitation. The final CGA must integrate medicines changes, mobility goals, nutrition, hearing support, home modifications, daughter's availability, future wishes and named community follow-up.

Integrated care plan: information must become owned actions and review

Problem / need	What matters	Action	Owner	Review
Falls + mobility	Walk safely to garden	Physio + falls plan	PT / team	1 week
Medicines burden	Less dizziness	Review hypotensive	Prescriber + pharmacist	48 h
Nutrition	Maintain strength	Food-first + dietetic	Nurse / dietitian	1 week
Home safety	Remain at home	OT home assessment	OT + community team	Before discharge

Example structure for a reviewable integrated care plan.

Practice points

- Every priority needs an owner and review point.
- Transitions require explicit communication.
- CGA is complete only when information becomes coordinated action.

Quick self-check

1. The defining output of CGA is:

- A. A completed form
- B. An integrated, coordinated care plan
- C. A frailty score
- D. A list of diagnoses

Answer B. Assessment must lead to coordinated action.

A practical CGA worksheet

Use this as a thinking framework rather than a substitute for local documentation.

Domain	What to establish	Action / owner / review
Physical	Acute illness, long-term conditions, pain, frailty syndromes, tests/treatment, risks	
Psychological	Cognition, delirium, mood, distress, communication	
Functional	ADLs/IADLs, mobility, transfers, falls, rehabilitation potential	
Social	Support network, carer capacity, isolation, finances, safeguarding	
Environmental	Home access, hazards, equipment, transport, technology, community services	
Future wishes	Goals, treatment preferences, advance planning, escalation,	

review

From CGA to integrated care plan

A useful care plan is brief enough to use, detailed enough to coordinate care, and explicit about ownership. For each priority, record: problem/need; what matters to the person; agreed action; responsible person/team; timescale; monitoring; review trigger.

Integrated care plan: information must become owned actions and review

Problem / need	What matters	Action	Owner	Review
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Nutrition	Maintain strength	Food-first + dietetic	Nurse / dietitian	1 week
Home safety	Remain at home	OT home assessment	OT + community team	Before discharge

Example plan structure; use local documentation where required.

Course completion and reflection

Each module can be completed independently. Full-course completion requires all ten modules, the integrated final assessment and a 250-500 word reflection. The certificate records completion of ClinicalEdu learning and does not imply external CPD accreditation unless separately stated.

- What changed in your understanding of CGA?
- Which domain is most often missed in your setting?
- What specific change will you make to assessment or care planning?
- How will you review whether that change helped?

References and further reading

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9. CG103 Delirium: prevention, diagnosis and management. NICE.

<https://www.nice.org.uk/guidance/cg103>

10. NG249 Falls: assessment and prevention. NICE. <https://www.nice.org.uk/guidance/ng249>

Sources reviewed through 16 September 2026. Re-check current guidance and local policy for time-sensitive clinical decisions.