Comprehensive Geriatric Assessment (CGA)

A structured, multidisciplinary approach to the care of older adults

This mini-module is designed as a structured educational resource for clinicians, students and educators. It synthesises peer-reviewed research and international clinical guidelines to provide a comprehensive overview of the Comprehensive Geriatric Assessment (CGA).

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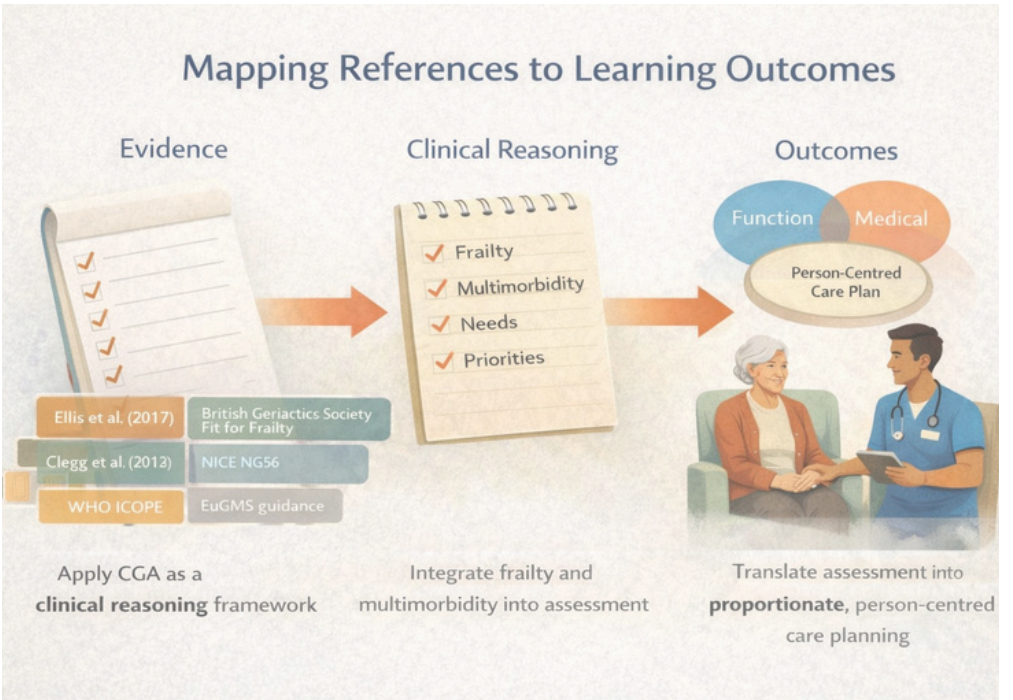
Module: Comprehensive Geriatric Assessment (CGA) in Practice



Learning Objectives

By the end of this module, you will be able to:

- ***Define and explain CGA*** *– articulate the purpose and principles of Comprehensive Geriatric Assessment as a multidisciplinary, person-centred approach to managing frailty and multimorbidity in older adults.*
- ***Describe the core domains*** *– identify the five domains (medical, functional, cognitive and psychological, social/environmental, and nutrition) and recognise the main evidence-based tools used to assess each.*
- ***Critically appraise CGA evidence*** *– evaluate the effectiveness and practical considerations of implementing CGA in acute, community, and care-home settings, including key outcomes and barriers to adoption.*
- ***Integrate frailty screening and care planning*** *– distinguish frailty screening from comprehensive assessment, and demonstrate how CGA findings inform diagnosis, prioritisation, and the development of personalised care plans.*

1. WHAT IS COMPREHENSIVE GERIATRIC ASSESSMENT (CGA)?

Adapted from Ellis et al., 2017; BGS "Fit for Frailty"; NICE NG56.

Key principle

CGA is a process, not an event. It synthesises multidimensional assessment into shared decision-making and dynamic care planning.

High-quality evidence demonstrates that CGA improves:

- functional outcomes
- likelihood of living at home
- care coordination
- appropriateness of interventions

Especially in people living with frailty and complexity.

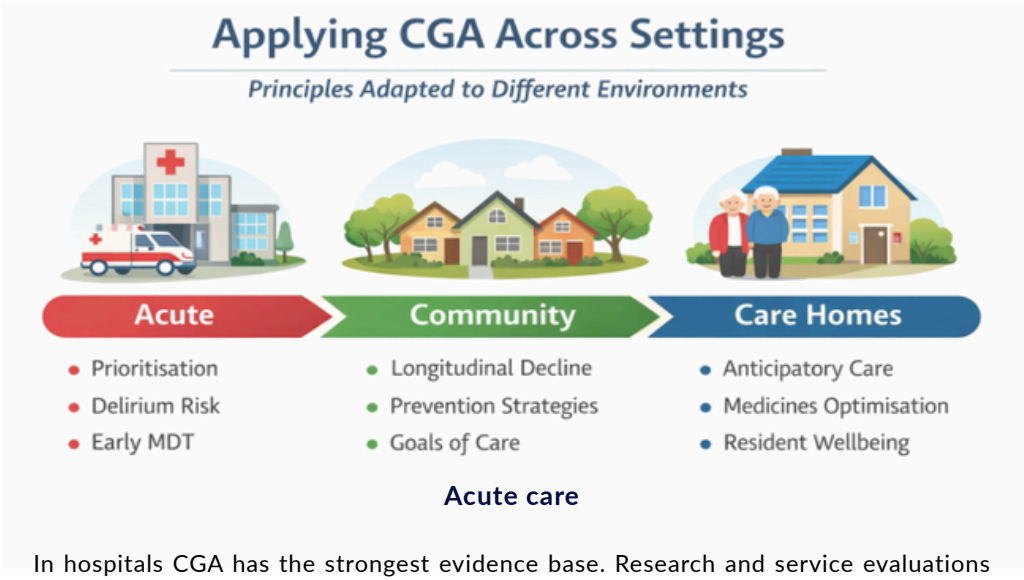
CGA is defined as a multidisciplinary diagnostic process designed to determine the medical, functional, psychological and social capabilities of a frail older person. Unlike a standard medical consultation, CGA is a systematic approach that shifts the focus from a single-disease model to a holistic view of the individual's health and well-being.

Core Principles

- **Multidimensional:** It explores several domains of health beyond simple pathology.
- **Multidisciplinary:** It involves a team of professionals, including geriatricians, frailty practitioners, nurses, physiotherapists, occupational therapists, pharmacists and social workers.
- **Interventional:** The assessment must lead to a coordinated and integrated plan for treatment and long-term follow-up.

2. APPLYING CGA ACROSS SETTINGS

Comprehensive Geriatric Assessment (CGA) is a clinical reasoning framework that maintains its principles across settings but adapts the emphasis to address context-specific needs. High-quality research and UK/European guidance show that effective CGA improves outcomes in primary care, community, acute and long-term care environments, as demonstrated in randomised trials, meta-analyses and professional guidance (Ellis et al., 2017; Stuck et al., 1993; BGS, 2014). In the following section the key adaptations across acute hospitals, community care and care homes are summarised, alongside evidence for their impact.



Acute care

In hospitals CGA has the strongest evidence base. Research and service evaluations show that CGA delivered in acute settings reduces falls, delirium and admissions to long-term care, and that embedding CGA into medical and surgical pathways leads to better recovery, lower mortality and shorter length of stay (Ellis et al., 2017; Stuck et al., 1993; BGS, 2014). The focus is on rapid prioritisation, identification of frailty syndromes, delirium risk assessment and early multidisciplinary team involvement so that care plans can be implemented during the admission.

Community care

Community CGA aims to maintain function and prevent avoidable admissions. Randomised trials and systematic reviews suggest that community-based CGA reduces physical frailty and unplanned hospital admissions without increasing nursing home placements or mortality (Ellis et al., 2017; BGS, 2014). UK research evidence from the NIHR shows that community CGA programmes improve medication appropriateness, daily functioning and quality of care (NIHR, 2023). Key elements include longitudinal monitoring of functional decline, collaborative goal setting, prevention strategies and linking people to voluntary and social support networks.

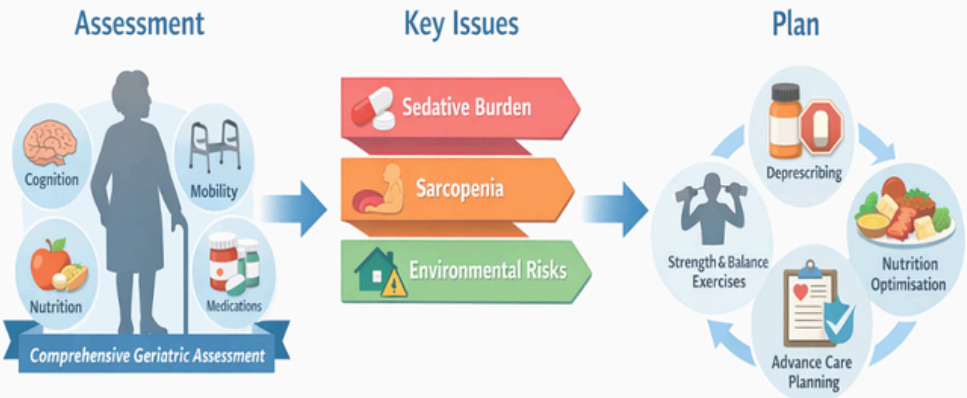
2. APPLYING CGA ACROSS SETTINGS

Care homes

CGA in care homes supports residents with complex needs and frailty. Guidance from the BGS and UK research emphasises anticipatory care planning, medicines optimisation and a person-centred approach (BGS, 2014; NIHR, 2023). Monitoring residents' functional trajectories, reviewing polypharmacy, assessing falls risk and nutrition, and engaging care home staff in multidisciplinary discussions can reduce adverse events and promote wellbeing. The focus on advance care planning ensures that residents' preferences and ceilings of treatment are documented and respected.

3. CASE-BASED CGA WALK-THROUGH & MAPPING EXERCISE

The following case illustrates how CGA is applied in practice. Using the framework helps clinicians identify the drivers of decline and develop proportionate care plans.



Case Study

Patient: 86-year-old woman living in a care home. She has recurrent falls, stage-3 chronic kidney disease, cognitive fluctuation and is taking ten medications, including sedatives. Over the past three months she has lost weight and her mobility has declined.

Step 1 – Assessment of CGA domains

- **Medical:** multimorbidity (CKD, hypertension), polypharmacy, fluctuating blood pressure.
- **Functional:** slow gait speed, difficulty rising from a chair, recent falls.
- **Cognitive & psychological:** intermittent confusion, low mood, risk of delirium.
- **Social & environmental:** lives in a care home, family involved in decisions.
- **Nutrition:** poor appetite, weight loss, possible sarcopenia.

Step 2 – Identify key drivers of decline

From the assessment the MDT identifies sedative burden, sarcopenia with poor nutritional intake, and environmental fall hazards as the main contributors to her deterioration. Evidence from hospital-based CGA trials shows that reducing sedative medications lowers falls and delirium (Ellis et al., 2017).

3. CASE-BASED CGA WALK-THROUGH & MAPPING EXERCISE

Step 3 – Create a care plan

- **Deprescribing:** review medications, taper sedatives, and optimise antihypertensives. Evidence from meta-analyses and guidance demonstrates that medication optimisation in CGA can reduce mortality and functional decline (Stuck et al., 1993; BGS, 2014).
- **Strength & balance:** initiate physiotherapy focusing on strength and balance training; evidence shows these interventions prevent functional decline and recurrent falls.
- **Nutrition optimisation:** refer to a dietitian for energy, and protein-dense meals and consider oral nutritional supplements; align with the Malnutrition Universal Screening Tool (MUST) and care home guidance.
- **Advance care planning:** discuss goals of care with the patient and family, document her preferences and ceilings of treatment to inform future decisions.

Assessment → Plan mapping table

CGA domain	Key finding	Clinical impact	Planned action
Functional	Falls, slow transfers	High fall and injury risk	Strength & balance programme
Cognitive & psychological	Fluctuating cognition	Delirium risk	Medication review, calm routine
Nutrition	Weight loss, poor intake	Sarcopenia, fatigue	Dietitian referral, supplements
Medications	Sedative burden	Falls, confusion	Deprescribing sedatives
Social & environmental	Care-home environment, limited space	Hazard exposure	Environmental risk assessment

This mapping ensures that each identified problem leads to specific, actionable interventions rather than generic advice.

4. IMPLICATIONS FOR PRACTICE & CPD

Implementing CGA across settings requires clinicians to move beyond checklists toward integrated care plans. National guidelines emphasise focusing on interactions between conditions, aligning care with patient goals, and rationalising treatments to reduce burdens (NICE, 2016). UK quality standards and professional guidance recommend timely CGA for all older adults at risk of frailty (BGS, 2014).

Using this module in practice

1. Learn – Review the evidence base, domains of CGA and case example to understand how CGA shapes clinical reasoning.
2. Reflect – Apply the reflective questions from Section 3 to a patient you have recently cared for. Consider how the CGA framework challenges your assumptions and alters management.
3. Apply – Integrate CGA principles into your setting: screen for frailty, complete multidimensional assessments, involve multidisciplinary teams early, and tailor interventions to the patient's goals.
4. Improve – Document outcomes, share learning with colleagues, and contribute to service development. UK research highlights that successful community CGA programmes involve continuity of care, personalised interventions and care coordination, but barriers include workload and system constraints (NIHR, 2023). Identifying and addressing local barriers is essential for sustainable improvement.

4. IMPLICATIONS FOR PRACTICE & CPD

CPD Cycle – Learn, Reflect, Apply, Improve

Key takeaways

- **Early identification and prioritisation:** Assess gait speed and frailty markers at first contact to trigger CGA (NICE, 2016).
- **Multidisciplinary collaboration:** Involve geriatricians, frailty practitioners, nurses, therapists, pharmacists and social care professionals. Research shows that early MDT involvement improves outcomes in acute and surgical settings (Ellis et al., 2017; BGS, 2014).
- **Medication optimisation:** Structured medication review and deprescribing reduce falls, delirium and mortality (Stuck et al., 1993; Ellis et al., 2017).
- **Function and nutrition focus:** Addressing mobility and nutritional deficits prevents decline and supports recovery.
- **Person-centred care:** Align all interventions with the older person's preferences and values; use advance care planning to document decisions.

MODULE: COMPREHENSIVE GERIATRIC ASSESSMENT (CGA) IN PRACTICE

References

1. Ellis, G., Gardner, M., Tsiachristas, A., Langhorne, P., Burke, O., Harwood, R., Conroy, S.P., Cowan, W. et al. (2017)Comprehensive geriatric assessment for older adults admitted to hospital'. Cochrane Database of Systematic Reviews, 2017(9), CD006211. Available at: https://doi.org/10.1002/14651858.CD006211.pub3 (Accessed 2 January 2026).
2. Stuck, A.E., Siu, A.L., Wieland, G.D., Adams, J. and Rubenstein, L.Z. (1993) Comprehensive geriatric assessment: a meta-analysis of controlled trials. The Lancet, 342(8878), pp. 1032–1036. Available at: 10.1016/0140-6736(93)92884-v (Accessed 2 January 2026).
3. Clegg, A., Young, J., Iliffe, S., Rikkert, M.O. and Rockwood, K. (2013) Frailty in elderly people. The Lancet, 381(9868), pp. 752–762. Available at: DOI: 10.1016/S0140-6736(12)62167-9 (Accessed 2 January 2026).
4. British Geriatrics Society (2014) Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings. London: British Geriatrics Society. Available at: https://www.bgs.org.uk/resources/resource-series/fit-for-frailty (Accessed 2 January 2026).
5. National Institute for Health and Care Excellence (NICE) (2016) Multimorbidity: Clinical assessment and management (NICE Guideline NG56). London: NICE. Available at: https://www.nice.org.uk/guidance/ng56 (Accessed 2 January 2026).
6. World Health Organization (WHO) (2017) Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity. Geneva: WHO. Available at: https://www.who.int/publications/i/item/9789241550109 (Accessed 2 January 2026).
7. European Geriatric Medicine Society (EuGMS) (2019) Frailty and comprehensive geriatric assessment: position paper. European Geriatric Medicine, 10(4), pp. 511–521. Available at: : https://www.eugms.org/groups-projects/comprehensive-geriatric-assessment (Accessed 2 January 2026).
8. National Institute for Health and Care Research (NIHR) (2024) Frailty: research shows how to improve care. NIHR Evidence Collection, 24 October. Available at: https://evidence.nihr.ac.uk/collection/frailty-research-shows-how-to-improve-care/ (Accessed 2 January 2026).

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About the Author

Silvia Tavares RN MSc is a registered nurse and trainee Advanced Clinical Practitioner specialising in frailty, multimorbidity and complex care. Over a career spanning more than twenty years she has worked primarily in acute settings and has developed strong links with community teams, combining bedside practice with research experience as a research nurse in disciplines outside frailty. Silvia is committed to translating evidence into practical, person-centred tools that support clinicians and improve outcomes for older adults. Her biography follows recommended guidance by highlighting her credentials, relevant experience and invitation to connect, without appearing self-aggrandising