Delirium

Depression

Dementia

3D's: Assessment Tools
At Your Fingertips

Developed by:
Toronto Best Practice in LTC Initiative
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Acknowledgments

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PURPOSE OF THE POCKET CARDS

These pocket cards were developed to provide healthcare providers with a quick reference guide on selected screening tools to assess for delirium, depression, and/or dementia.

These pocket cards should be used in conjunction with the 3D's Delirium, Depression, Dementia Resource Guide (2007), and the poster on Recognizing for Delirium, Depression and Dementia (2007).

PLEASE NOTE:
The screening tools should only be used in combination with a full head-to-toe assessment.

DEFINITIONS

DELIRIUM

Delirium is a medical emergency which is characterized by an acute and fluctuating onset of confusion, disturbances in attention, disorganized thinking and/or decline in level of consciousness.

Delirium cannot be accounted for by a preexisting dementia; however, can co-exist with dementia.

DEPRESSION

Depression is a term used when a cluster of depressive symptoms (as identified on the SIG E CAPS depression criteria) is present on most days, for most of the time, for at least 2 weeks and when the symptoms are of such intensity that they are out of the ordinary for that individual.

Depression is a biologically based illness that affects a person's thoughts, feelings, behaviour, and even physical health.

DEMENTIA

Dementia is a gradual and progressive decline in mental processing ability that affects short-term memory, communication, language, judgment, reasoning, and abstract thinking.

Dementia eventually affects long-term memory and the ability to perform familiar tasks. Sometimes there are changes in mood and behaviour.

ASSESSMENT TOOL REFERENCE GUIDE

DELIRIUM

Confusion Assessment Method (CAM) Instrument

- Helps in identifying individuals who may be suffering from delirium or an acute confusional state
- Useful for differentiating delirium and dementia

I WATCH DEATH

- Acronym for finding the cause of delirium

DEPRESSION

Geriatric Depression Scale and Geriatric Depression Scale (GDS –4 Short Form)

- May assist in supporting a diagnosis of depression (an adjunct to clinical assessment)
- Provides quantitative rating of depression

Cornell Scale for Depression

- Used to assess for depression in dementia
- Should have assessment information that suggests depression before using

SIG E CAPS

- If there are nervous problems or a depressed mood use the acronym SIG E CAPS (Sleep disturbance, loss of Interest, feelings of Guilt, low Energy, Concentration and cognitive difficulties, Appetite disturbance, Psychomotor changes, Suicidal ideation) to describe

Suicide Risk in the Older Adult

- Helps identify suicidal risk in individuals with a depressed mood

ASSESSMENT TOOL REFERENCE GUIDE

DEMENTIA

Folstein MMSE & Clock Drawing Test (CDT)

- Tend to be used together; screen for cognitive impairment which may suggest dementia or delirium
- These screening tests do not provide diagnoses but rather should be viewed as part of the whole assessment picture
- Assesses areas of cognitive function that assists to differentiate if an organic brain disorder may be present and to what degree
- Clock: tests abstraction, attention, concentration and visuospatial constructional skills

Mini-Cog Dementia Screen

- 3-minute cognitive screen developed in a purposively ethnolinguistically diverse sample
- Detects clinically significant cognitive impairment as well as or better than the MMSE in multiethnic elderly individuals
- Easier to administer to non-English speakers, and less biased by low education and literacy

Cohen Mansfield Agitation Inventory (CMAI)

- Used to assess the frequency of manifestations of agitated behaviour; specific forms of this scale offer the opportunity for care teams to rate the degree of disruptiveness the behaviours create

TIPS ON SUCCESSFUL BEST PRACTICE IMPLEMENTATION

Below are suggested implementation tips to assist long-term care homes that are considering implementing best practices on delirium, depression and dementia.

- Liaise with the Best Practice Regional Coordinator to get started with implementation plan.
- Select a dedicated person (e.g., clinical resource nurse, PIECES trained nurse, best practice champion nurse) who will provide leadership and support to the implementation of the guidelines.
- Identify the key resource people in your LTC Home, e.g., PIECES trained nurses, U-First trained staff.
- Establish a working group comprised of key stakeholders and members who are committed in leading the implementation initiative.
- Keep a work plan to track activities, responsibilities and timelines.
- Collaborate with your local PRC to provide education sessions and ongoing support for implementation.
- Foster culture of learning through team work, collaborative assessment and treatment planning.
- Access additional resources/services available in your community such as Psychogeriatric Resource Consultant, Crisis team, Geriatric Mental Health Outreach team, Alzheimer Society, etc.
- Link with other LTCH in your area that are implementing the 3D BPG.
- Monitor and evaluate the progress of implementation.
- Celebrate your successes.

CONFUSION ASSESSMENT METHOD (CAM): A Rating Scale for Delirium

CRITERIA 1

Acute onset and fluctuating course
Is there evidence of an acute change in mental status from baseline?
Did the abnormal behaviour fluctuate or increase and decrease in severity?

CRITERIA 2

Inattention
Did the resident have difficulty focusing attention or keeping track of what was being said?

CRITERIA 3

Disorganized thinking
Was the resident's thinking disorganized or incoherent, such as rambling conversation, illogical flow of ideas, or unpredictable switching from subject to subject?

CRITERIA 4

Altered level of consciousness
How would you rate the level of consciousness? (alert, vigilant, lethargic, stupor or coma)?

CONSIDER DELIRIUM IF: 1 AND 2, AND EITHER 3 OR 4, ARE PRESENT

Adapted from Inouye, S.K., Van Dyck, C. H., Alessi, C. A., Balkin, S., Siegal, A. P., & Horwitz, R. I. (1990). Clarifying confusion: The Confusion Assessment Method: A New Method for Detection of Delirium. *Annals of Internal Medicine*.

GERIATRIC DEPRESSION SCALE - GDS-4: Short Form

Ask the following 4 questions:

1. Are you basically satisfied with your life?	□ Yes	□ **NO**
2. Do you feel that your life is empty?	□ **YES**	□ No
3. Are you afraid that something bad is going to happen to you?	□ **YES**	□ No
4. Do you feel happy most of the time?	□ Yes	□ **NO**

Answers in capitals score 1. For GDS-4 score of 1 or more indicates possible depression.

SIG E CAPS

Depressive Symptoms:
At least 5 of the following symptoms* have been present nearly every day, for most of the day, during the same 2-week period and represent a change from previous functioning.

S - Sleep is disturbed.
I - Interest is decreased.
G - Guilt (feelings of guilt are common, having regrets, etc.).
E - Energy is lower than usual.
C - Concentration is poor and memory problems may be exacerbated.
A - Appetite is disturbed, usually a loss of appetite accompanied (or not) by weight loss.
P - Psychomotor retardation or agitation (agitation may by misconstrued as a result of anxiety only).
S - Suicidal ideation, at least a passive wish to die, is frequently present.

Additional symptoms: At least 1 of the symptoms is either
(1) Depressed Mood
(2) Loss of interest in pleasure

*Symptoms cause significant distress or impairment in daily activities, social life, or other important areas of functioning.
*Symptoms are not due to the direct effects of a substance (e.g., drugs of abuse or medication) or a general medical condition.

SUICIDE RISK IN THE OLDER ADULT

Assess for:

Suicidal Intent

- Verbalizes suicidal thoughts
- Can outline a concrete realistic plan
- Physical ability to carry out threat
- Describes suicidal intent
- Methods are available

Suicidal Behaviour

- Gives guarded answers to questions
- Increasing withdrawal
- Resolving depression
- Gives away possessions
- Drug/Alcohol abuse
- Diverts interviewer off topic
- Depressed affect
- Sudden interest/disinterest in religion
- Puts affairs in order

Risk Factors

- Male
- Low self-esteem
- Supports systems: decreased or non-existent
- Decline in cognitive status
- History of suicide attempts or violence
- Substance abuse
- White
- Family history of suicide
- Decline in physical status
- Impulsivity
- Recent loss or change in life

FOLSTEIN MMSE

Questions:

Orientation:
What is the *(year) (season) (month) (date) (day)* - 5 points
Where are we? (*country) (province) (city) (floor in building, room number)* or *(name of building, address)* - 5 points

Registration:
Name 3 objects: One second to say each. Then ask the Resident to repeat all 3 after you have said them. One point for each correct. Then repeat them until he/she learns them. Count trials and record. - 3 points

Attention & Calculation:
Ask serial 7's. One point for each correct answer. Stop at 5 answers. Or spell "WORLD" backwards. - 5 points

Recall:
Ask for objects above. One point for each correct. - 3 points

Language Tests:
Name: pencil, watch - 2 points
Repeat: no ifs, ands, or buts - 1 point
Follow a 3-stage command: *"Take the paper in our right hand, fold it in half, and put it on the floor."* - 3 points
Read and obey the following*: Close your eyes*. (Show command on separate sheet of paper. Three repetitions allowed; score only if the resident actually closes his/her eyes in response to the command.) - 1 point
Write a sentence spontaneously. The sentence should have a noun and verb and make sense. Ignore spelling mistakes. (Provide separate sheet of paper.) - 1 point

Design:
Copy the design. (Show design on separate sheet of paper and ask Resident to copy. Allow multiple tries). - 1 point

Scoring:
25/30 = normal cognitive functioning; **20-24 =** mild cognitive impairment; **10-20 =** moderate cognitive impairment; **<10 =** severe cognitive impairment