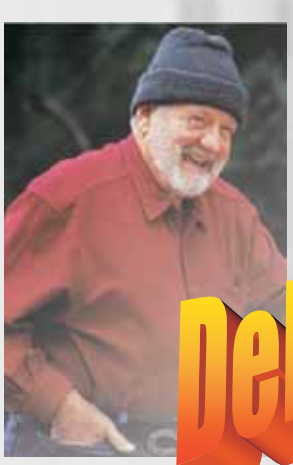
3D's



Delirium

Depression

Dementia

RESOURCE GUIDE

Developed by:
Toronto Best Practice in LTC Initiative
January 2007

Acknowledgments

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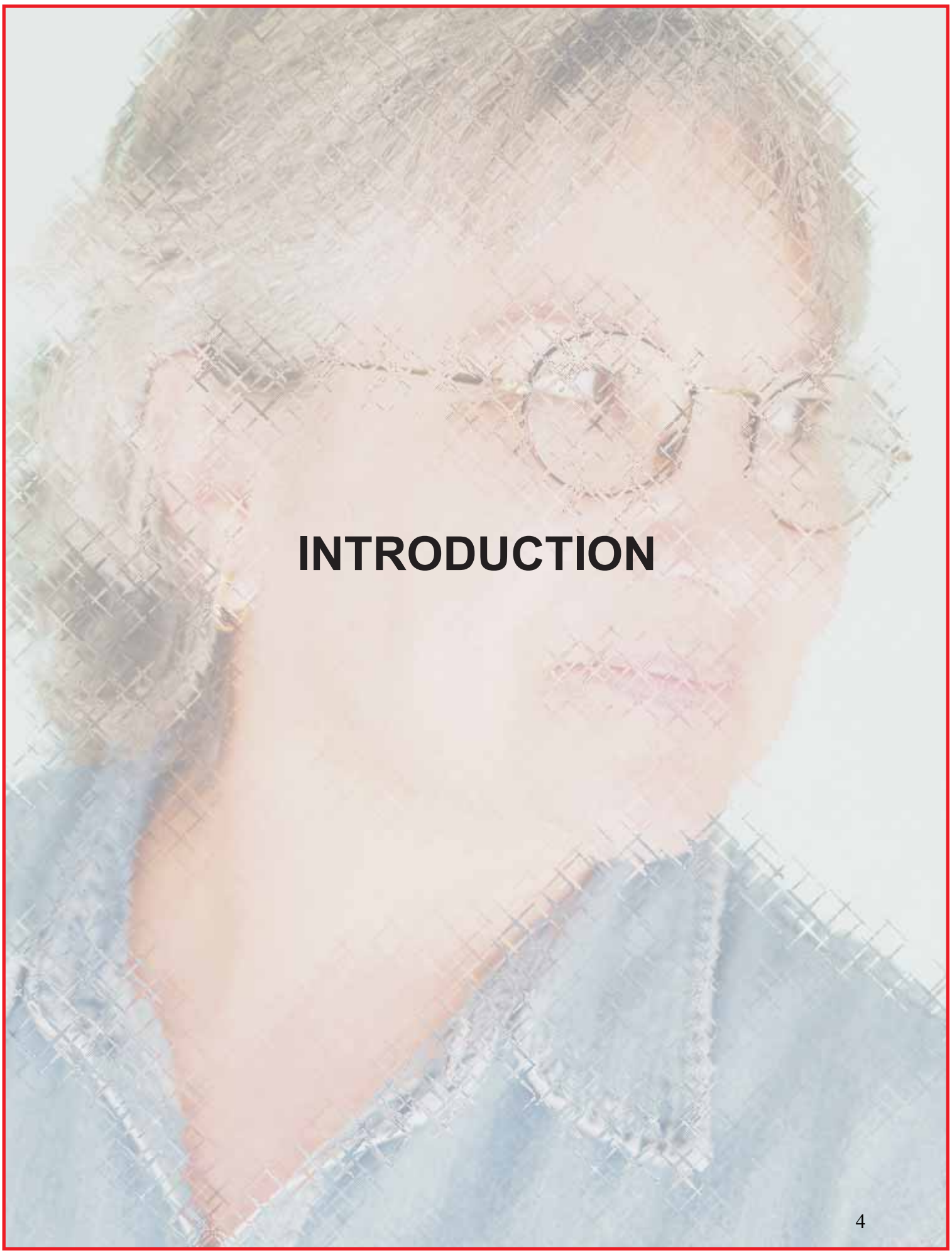


INTRODUCTION

Background

Demographic research shows that the proportion of Canadians who are seniors are expected to increase dramatically. According to the 1999 Health Canada statistics, adults 65 years and over will account for almost 18% of our country's population by 2021. The majority of older adults will continue to live productively in the community with or without support.

Currently in Ontario, about 70,000 of the elderly population with average age of 83 years, resides in long-term care homes (Smith, 2004). It has also been reported that 80% - 90% of long-term care home residents live with some form of mental illness and/or cognitive impairment (Canadian Coalition for Senior's Mental Health (CCSMH), 2006; Rovner et al., 1990; Drance, 2005).

Delirium, depression and dementia (3D's) are often under recognized in the geriatric population. Lack of recognition impacts on the quality of life, morbidity and mortality of the older adult. To enhance the health, quality of life and safety of older adults, it is important to further develop the knowledge and skills of the healthcare team. This resource guide will assist the healthcare professional to consistently assess, implement and evaluate treatment.

The Toronto Best Practice Implementation Steering Committee was developed to review best practices and develop processes for implementation in long term care homes. Based on the 2004 Ontario Classification results, the committee identified **delirium, depression and dementia** as one of the Best Practice topics to be implemented.

Goal

The goal of this resource guide is to provide resources for health professionals. There are many best practices available; however, the committee focused on the recommendations from the following guidelines:

- Registered Nurses' Association of Ontario (2004). *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression.* Toronto, Canada: Registered Nurses' Association of Ontario.

- Registered Nurses' Association of Ontario (2003). *Screening for Delirium, Dementia and Depression in the Older Adults.* Toronto, Canada: Registered Nurses' Association of Ontario.

Educational programs, services and other sources were reviewed by the committee and some have been included in the resource guide.

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

Best Practice Recommendations Addressed in the Resource Guide

The following recommendations from the RNAO Best Practice Guidelines on Screening for 3D's in Older Adults will be addressed in this resource guide:

- Nurses should maintain a high index of suspicion for delirium, depression and dementia in the older adult.
- Nurses should be aware of the differences in the clinical features of 3D's and use a structured assessment method to facilitate this process.
- Nurses should objectively assess for cognitive changes by using one or more standardized tools in order to substantiate clinical observations.
- When the nurse determines the resident is exhibiting features of 3D's, a referral for a medical diagnosis should be made to specialized geriatric services, specialized geriatric psychiatry services, neurologists, and/or members of the multidisciplinary team, as indicated by screening findings.

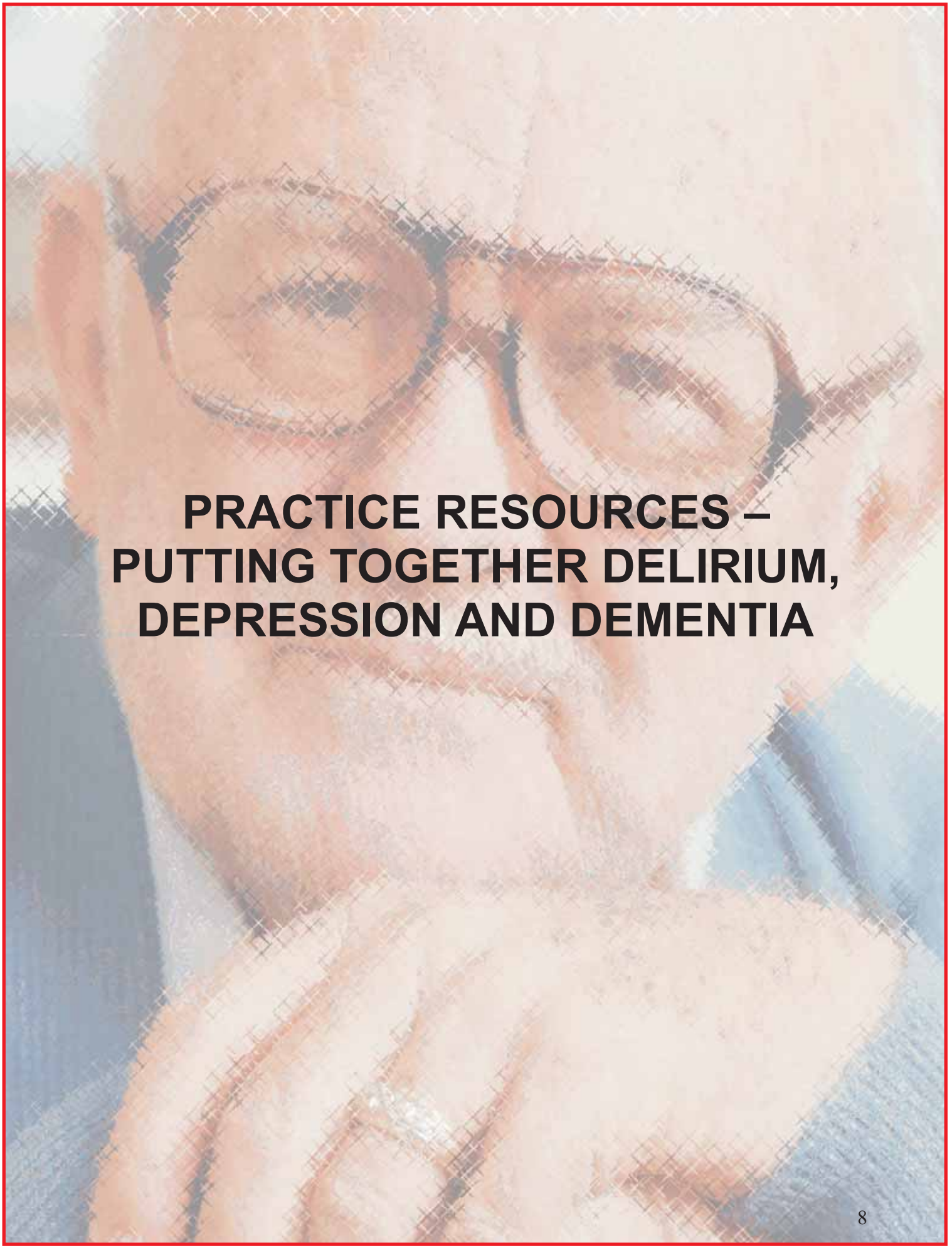
From the RNAO Best Practice Guidelines on Caregiving Strategies for Older Adults with 3D's, the following recommendations will be addressed:

- In order to target the individual root causes of delirium, nurses working with other disciplines must select and record multi-component care strategies and implement them simultaneously.
- Nurses must be aware of multi-component care strategies for depression: non-pharmacological interventions and pharmacological caregiving strategies.
- Nurses should have knowledge of the most common presenting symptoms of: Alzheimer Disease, Vascular Dementia, Frontotemporal Lobe Dementia, Lewy Body Dementia and be aware that there are mixed dementias.
- Nurses should know their clients, recognize their retained abilities, understand the impact of the environment, and relate effectively when tailoring and implementing their caregiving strategies.
- Nurses caring for clients with dementia should be knowledgeable about non-pharmacological interventions for managing behaviour to promote physical and psychological well-being.
- Nurses caring for clients with dementia should be knowledgeable about pharmacological interventions and should advocate for medications that have fewer side effects.

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 Psychogeriatric Resource Consultant (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's BPG.
- Monitor and evaluate the progress of implementation.
- Celebrate your successes.



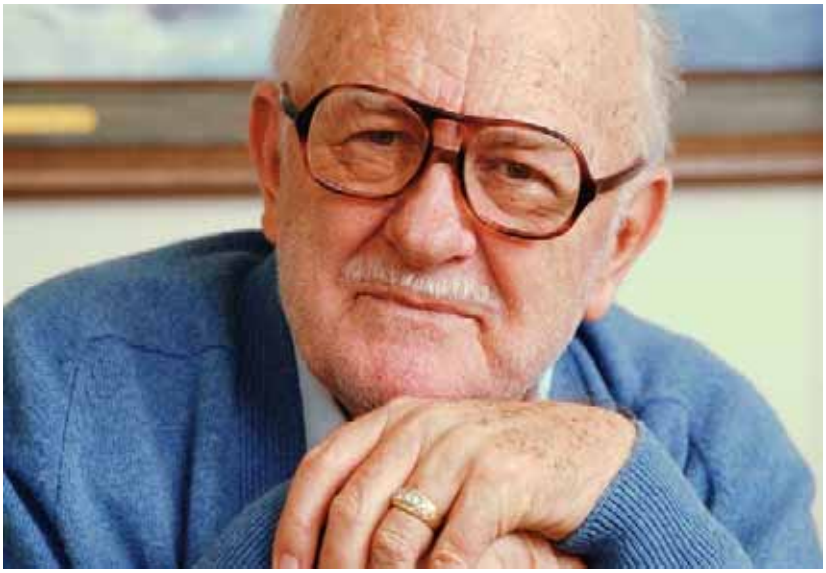
PRACTICE RESOURCES – PUTTING TOGETHER DELIRIUM, DEPRESSION AND DEMENTIA

Best Practice Recommendations addressed in this section

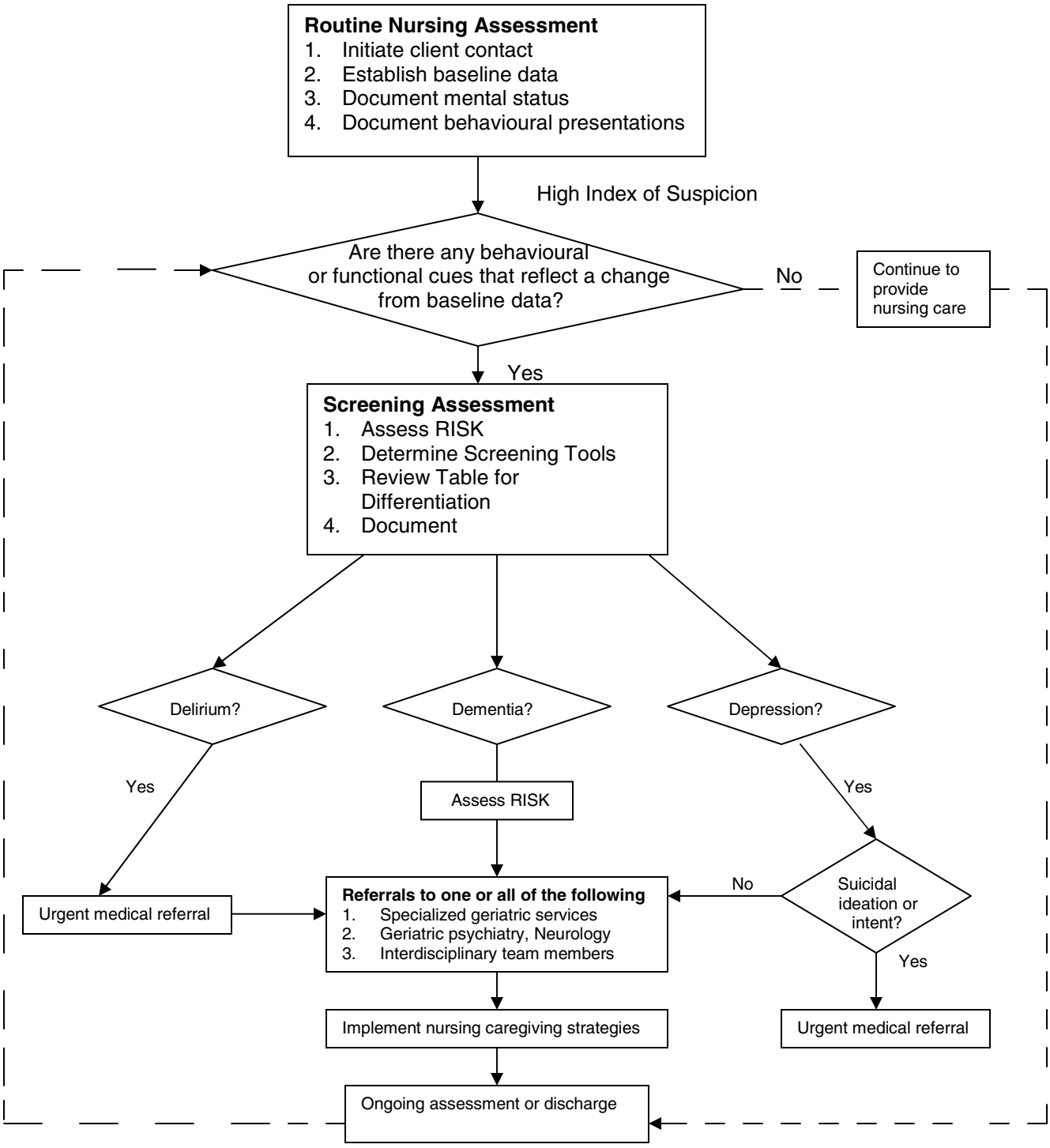
- Nurses should maintain a high index of suspicion for delirium, dementia and depression in the older adult.
- Nurses should be aware of the differences in the clinical features of 3D's and use a structured assessment method to facilitate this process.
- Nurses should objectively assess for cognitive changes by using one or more standardized tools in order to substantiate clinical observations.
- When the nurse determines the resident is exhibiting features of 3D's, a referral for a medical diagnosis should be made to specialized geriatric services, specialized geriatric psychiatry services, neurologists, and/or members of the multidisciplinary team, as indicated by screening findings.

What you will find in this section

- Screening Assessment Flow Diagram for Delirium, Depression and Dementia
- Recognizing Delirium, Depression and Dementia
- Assessment Tool Reference Guide



Screening Assessment Flow Diagram for Delirium, Depression and Dementia



Adapted from: Registered Nurses' Association of Ontario (2003). *Screening for Delirium, Dementia and Depression in the Older Adults.* Toronto, Canada: Registered Nurses' Association of Ontario.

Recognizing Delirium, Depression and Dementia (3D's)

Residents may have more than 1D present at the same time and symptoms may overlap.

	Delirium	Depression	Dementia
Definition	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 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 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.
Onset	• Sudden Onset: Hours to days	• Recent unexplained changes in mood that persist for at least 2 weeks.	• Gradual deterioration over months to years
Course	• Often reversible with treatment • Often fluctuates over 24 hour period and often worse at night	• Usually reversible with treatment • Often worse in the morning	• Slow, chronic progression, and irreversible
Thinking	• Fluctuations in alertness, cognition, perceptions, thinking	• Reduced memory, concentration and thinking, low self-esteem	• Cognitive decline with problems in memory plus one or more of the following: aphasia, apraxia, agnosia, and/or executive functioning.
Psychotic Feature	• Misperceptions and illusions	• Delusions of poverty, guilt, somatic symptoms	• Signs may include delusions of theft/persecution and/or hallucinations depending on type of dementia.
Sleep	• Disturbed but with no set pattern. Differs night to night	• Disturbed • Early morning awakening or hypersomnia	• May be disturbed with an individual pattern occurring most nights
Mood	• Fluctuations in emotions – outbursts, anger, crying, fearful	• Depressed mood • Diminished interest or pleasure • Changes in appetite (over or under eating) • Possible suicidal ideation/plan; hopelessness	• Depressed mood especially in early dementia • Prevalence of depression may increase in dementia; however, apathy is a more common symptom and may be confused with depression.
Psychomotor Activities	• Hyperactive delirium: agitation, restlessness, hallucinations • Hypoactive delirium: unarousable, very sleepy • Mixed delirium: combination of hyperactive and hypoactive manifestations	• Hyperactive: agitated depression • Hypoactive: withdrawn, decreased motivation/interest	• Wandering/exit seeking *or* • Agitated *or* • Withdrawn (may be related to co-existing depression).

	Delirium	Depression	Dementia
Screening Tools	• **Confusion Assessment Method (CAM) – An algorithm used to screen for delirium:** Screen for delirium is positive if the person has features 1 & 2 plus either 3 or 4 as listed below. (1) Presence of acute onset and fluctuating course AND (2) Inattention AND EITHER (3) Disorganized thinking OR (4) Altered level of consciousness Assess for causes: • **I WATCH DEATH** [**I**nfections, **W**ithdrawal, **A**cute metabolic, **T**oxins, drugs, **C**NS pathology, **H**ypoxia, **D**eficiencies, **E**ndocrine, **A**cute vascular, **T**rauma, **H**eavy metals]	• **Geriatric Depression Scale (GDS)** Interpretation of the 15 Question GDS Screen: ≤ 4 = Indicates absence of significant depression 5-7 = Indicates borderline depression > 7 = Indicates probable depression • **Cornell Scale for Depression** Interpretation of Score: 1.4 = No psychiatric diagnosis 4.8 = Non-depressive psychiatric disorders 12.3 = Probable major depressive disorder 24.8 = Major depressive disorder • **SIG E CAPS (DSM-IV Criteria)** Interpretation of Score: ≥ 5 = Indicates probable depression • **Assessment of Suicide Risk in the Older Adult** (critical if depression is present and/or history of depression)	• **Mini Mental Status Exam (Folstein) measures cognitive functioning** Interpretation of Score: 25-30 = normal 20-24 = mild 10-20 = moderate < 10 = severe cognitive impairment • **Clock Drawing Test (CDT)** • **Mini-Cog Dementia Screen** Interpretation of Score: 0 to 2 = high likelihood of cognitive impairment 3 to 5 = low likelihood of cognitive impairment. • **If behavioural issues, consider using Cohen-Mansfield Agitation Inventory (CMAI)**
Laboratory Tests	Delirium workup includes the following tests: • Hgb, WBC, Na, K, Ca, O_2 sats, Blood gases, Urea, Creatinine, Liver function tests, Chest X-ray, Urinalysis and Culture, Alcohol/drug/toxicology screen	Depression workup includes the following tests: • TSH, B12, folate, Ca, Albumin, FBS, Ferritin, Iron, Hgb, K, ESR	Dementia workup includes the following tests: • CBC, TSH, Blood glucose, Electrolytes, including Ca
DSM-IV Criteria	Diagnostic Criteria: A. Disturbance of consciousness (i.e, reduced clarity of awareness of the environment) with reduced ability to focus, sustain or shift attention. B. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting,	Diagnostic Criteria: Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. 1. depressed mood most of the day, nearly every day 2. marked diminished interest or pleasure in normal	Diagnostic Criteria: A. The development of multiple cognitive deficits manifested by both 1. memory impairment (impaired ability to learn new information or to recall previously learned information). 2. one (or more) of the following cognitive disturbances: a) aphasia (language disturbance) b) apraxia (impaired ability

	Delirium	Depression	Dementia
DSM-IV Criteria	established or evolving dementia. C The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day. D. There is evidence from the history, physical examination or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.	activities 3. significant weight loss or gain 4. insomnia or hypersomnia nearly every day 5. psychomotor agitation or retardation nearly every day 6. fatigue or loss of energy nearly every day 7. feelings of worthlessness or excessive guilt 8. diminished ability to think or concentrate, or indecisiveness 9. recurrent thought of death or suicidal thoughts/actions	to carry out motor activities despite intact motor function) c) agnosia (failure to recognize or identify objects despite intact sensory function) d) disturbance in executive functioning (e.g., planning, organizing, sequencing, abstracting) B. The cognitive deficits in the above criteria (Criteria A1 and A2) each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.
Next Steps	Notify: • Attending Physician ASAP (consider delirium as a medical emergency and may require transfer to an Emergency Department) Involve: • Internal team members including Psychogeriatric Resource Person (PRP) [PIECES trained staff] • Family members	Refer to: • Attending Physician and if suicidal risk consider transfer to Emergency Department • Geriatric Mental Health Outreach Team • Psychogeriatric Resource Consultant (PRC) Involve: • Internal team members including Psychogeriatric Resource Person (PRP) [PIECES trained staff] • Family members	Refer to: • Attending Physician • Geriatric Mental Health Outreach Team • Psychogeriatric Resource Consultant (PRC) Involve: • Internal team members including Psychogeriatric Resource Person (PRP) [PIECES trained staff] • Family members
Note	For issues of violence or abuse, follow LTCH protocols.		

Glossary of Terms

Delusions	• False belief not shared by one's culture • Incorrect beliefs not based on reality
Hallucinations	• A sensory experience without any real world stimulus, may be visual, auditory, tactile, gustatory or olfactory
Illusions	• Misperception of real stimuli
Psychomotor Agitation	• Pacing and physical restlessness, hyperactive behaviour
Psychomotor Retardation	• Physical slowing of speech, movement and thinking, hypoactive behaviour

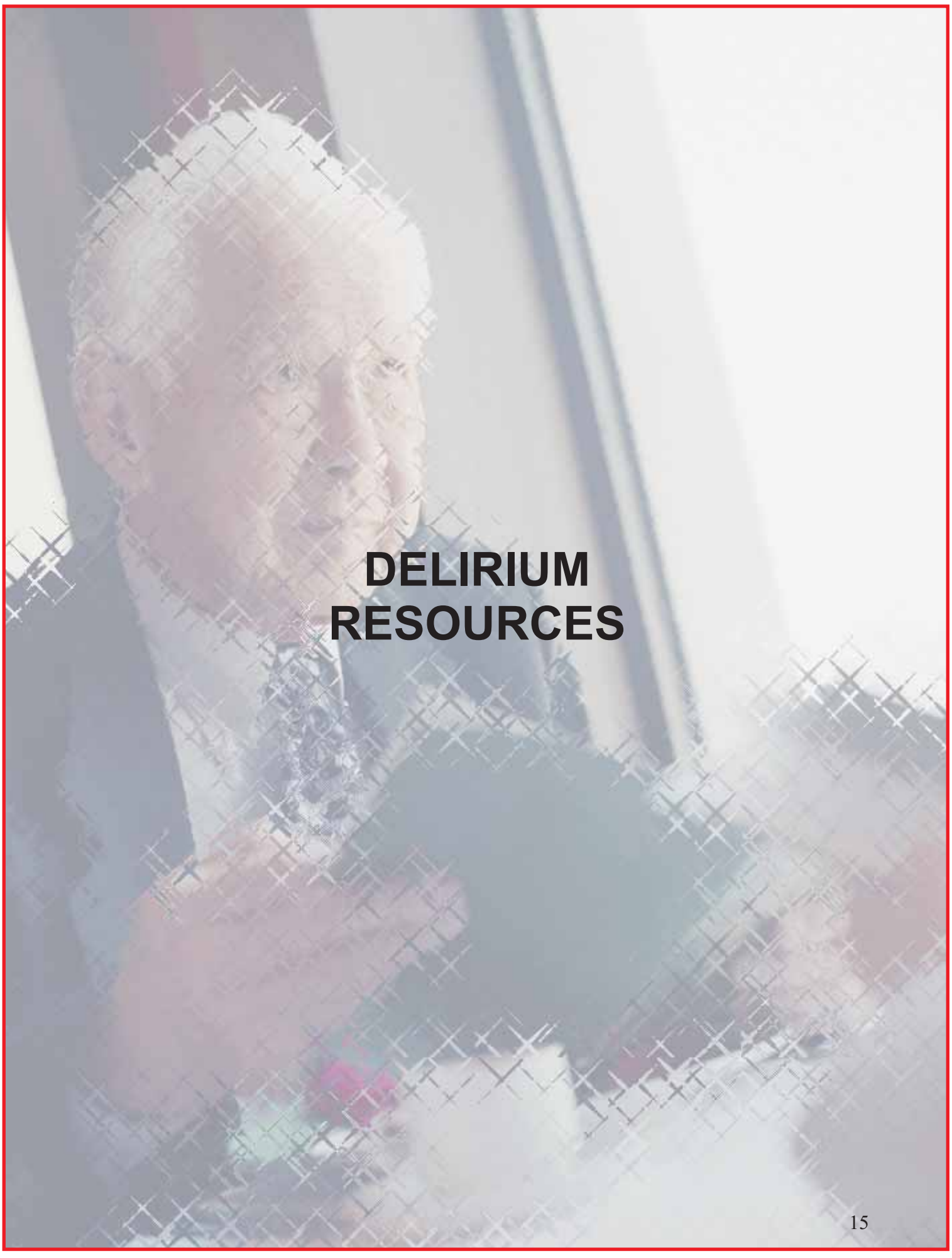
References:
■American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.
■PIECES Consultation Team (2005-2006). Putting the PIECES Together. Fifth Edition.
■Registered Nurses' Association of Ontario (2003). *Screening for Delirium, Dementia and Depression in Older Adults.* Toronto, Canada: Registered Nurses' Association of Ontario.
■Vancouver Island Health Authority (2006). The 3Ds. Comparison of Depression, Delirium, and Dementia

Adapted from:
Ontario Psychogeriatric Association (OPGA) (2005). Basics of the 3Ds.

Developed by:
Toronto Region Best Practice in LTC Initiative
January 2007

Assessment Tool Reference Guide

	Tool	Description of Tool	Refer to…
Delirium	Confusion Assessment Method (CAM) Instrument	• To help identify individuals who may be suffering from delirium or an acute confusional state • Useful for differentiating delirium and dementia	Page 19 & 21
	I WATCH DEATH	• Acronym for finding the cause of delirium	Page 23
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	Page 32 & 34
	Cornell Scale for Depression	• Used to assess for depression in dementia • Should have assessment information that suggests depression before using	Page 37
	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	Page 39
	Suicide Risk in the Older Adult	• Helps identify suicidal risk in individuals with a depressed mood	Page 41
Dementia	Folstein Mini-Mental Status Exam (MMSE) and the 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	Page 49 & 57
	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	Page 59
	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	Page 62



DELIRIUM RESOURCES

Delirium Definition

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.

Predisposing Factors May Include:

- Infection
- Dehydration/Malnutrition
- Medication side-effects
- Alcohol/drug withdrawal
- Alcohol/drug intoxication
- Recent surgery/anesthetic
- Worsening of a chronic illness
- Hypo or hyperglycemia
- Constipation or diarrhea
- Pain
- Recent injury (recent fall)
- Recently moved
- Recent hospitalization
- Recent loss (family member, friend, pet)
- Ill-fitting hearing aides or glasses

Best Practice Recommendations addressed in this section

- Nurses should maintain a high index of suspicion for 3D's in the older adult.

- Nurses should be aware of the differences in the clinical features of 3D's and use a structured assessment method to facilitate this process.

- Nurses should objectively assess for cognitive changes by using one or more standardized tools in order to substantiate clinical observations.

- In order to target the individual root causes of delirium, nurses working with other disciplines must select and record multi-component care strategies and implement them simultaneously.

What you will find in this section

- **Delirium Assessment Tool**

  The assessment tools listed below are not inclusive but have been selected by the Toronto Best Practice Implementation Steering Committee to screen for delirium. The evidence does not support a specific tool and one tool is not considered superior to another. It is stressed that screening tools can augment, but not replace a comprehensive "head to toe" nursing assessment. Thus, it is recommended that LTC Homes should use the screening tools in combination with the "head to toe" nursing assessment on admission.

  - **Confusion Assessment Method (CAM) Instrument**
  - **I WATCH DEATH**

- **Decision Tree: Strategies for Delirium**

- **Interventions/Safety Considerations for Delirium**

Confusion Assessment Method (CAM) Instrument

This screening tool assists with the identification of individuals who may be suffering from delirium or an acute confusional state. It is useful for differentiating delirium and dementia. It is important to note that CAM is not meant to be a diagnostic tool. The diagnosis of delirium requires: a comprehensive review of an individual's cognitive status and medical history, a physical examination, laboratory investigations, and a medication review.

How to Administer the CAM?

Information is gathered from an interview with the person and from discussions with carers and family members, a review of the person's chart, as well as observations made by the interviewer; all of which is used to make a determination about each feature in the delirium algorithm.

Please take note: it is not likely that the members of the care team will administer and score the CAM but rather use it as a framework for assessing the person. If in using the framework the care team identifies a number of indications of delirium (particularly the 4 listed in the algorithm below) they should maintain a high index of suspicion and raise the possibility of a delirium to the care team.

Features of the CAM:

The CAM has two parts, a nine-item questionnaire and a diagnostic algorithm for delirium. (An algorithm is a step-by-step procedure for solving a problem.)

1. Nine-item Questionnaire:
    - The questions focus on features of delirium, all of which are part of the DSM-IV-R diagnostic criteria for delirium.
    - It can be used as a rating scale, but also includes open-ended questions if the person administering the scale would like to collect more detailed clinical information.

2. Diagnostic Algorithm for Suspecting Delirium

Diagnostic Algorithm for Suspecting Delirium

The algorithm includes 4 key features of delirium:

1. Acute onset and fluctuating course
2. Inattention
3. Disorganized thinking
4. Altered level of consciousness (LOC)
    - Alert (normal)
    - Vigilant (hyperalert, overly sensitive to environmental stimuli, startled very easily)
    - Lethargic (drowsy, easily aroused)
    - Stupor (difficult to arouse)
    - Coma (unarousable)
    - Uncertain

Delirium should be suspected if features (1) and (2) and either (3) or (4) are present. In such cases, further investigation is warranted to confirm a diagnosis of delirium.

Remember: Delirium can be a life-threatening event.

Addressograph with Resident's Name:

Confusion Assessment Method (CAM) Instrument
Original Version

Directions for the CAM: Answer the following questions.
Score 1 for answers in **bold letters.**

Questions	**Initial Assessment Date:**	**Re-Assessment Date:**
Acute Onset 1. Is there evidence of an acute change in mental status from the person's baseline?	□ **Yes** □ No	□ **Yes** □ No
Inattention The questions listed under this topic are repeated for each topic where applicable. 2. a) Did the person have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?	□ Not present at any time during interview □ **Present at some time during interview, but in mild form** □ **Present at some time during interview, in marked form** □ **Uncertain**	□ Not present at any time during interview □ **Present at some time during interview, but in mild form** □ **Present at some time during interview, in marked form** □ **Uncertain**
2. b) (If present or abnormal) Did this behaviour fluctuate during the interview, that is, tend to come and go or increase and decrease in severity?	□ **Yes** □ No □ Uncertain □ Not applicable	□ **Yes** □ No □ Uncertain □ Not applicable
2. c) (If present or abnormal) Please describe this behaviour	Description of behaviour:	Description of behaviour:
Disorganized Thinking 3. Was the person's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?	□ **Yes** □ No	□ **Yes** □ No
Altered Level of Consciousness 4. Overall, how would you rate this person's level of consciousness?	□ Alert (normal) □ **Vigilant (hyperalert, overly sensitive to environmental stimuli, startled very easily)** □ **Lethargic (drowsy, easily aroused)** □ **Stupor (difficult to arouse)** □ **Coma (unarousable)** □ **Uncertain**	□ Alert (normal) □ **Vigilant (hyperalert, overly sensitive to environmental stimuli, startled very easily)** □ **Lethargic (drowsy, easily aroused)** □ **Stupor (difficult to arouse)** □ **Coma (unarousable)** □ **Uncertain**

Questions	Initial Assessment Date:	Re-Assessment Date:
Disorientation 5. Was the person disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?	□ **Yes** □ No	□ **Yes** □ No
Memory Impairment 6. Did the person demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?	□ **Yes** □ No	□ **Yes** □ No
Perceptual Disturbances 7. Did the person have any evidence of perceptual disturbances, for example, hallucinations, illusions, or misinterpretations (such as thinking something was moving when it was not)?	□ **Yes** □ No	□ **Yes** □ No
Psychomotor Agitation 8. Part 1 At any time during the interview, did the person have an unusually increased level of motor activity, such as restlessness, picking at bedclothes, tapping fingers, or making frequent sudden changes of position?	□ **Yes** □ No	□ **Yes** □ No
Psychomotor Retardation 8. Part 2 At any time during the interview, did the person have an unusually decreased level of motor activity, such as sluggishness, staring into space, staying in one position for a long time, or moving very slowly?	□ **Yes** □ No	□ **Yes** □ No
Altered Sleep-Wake Cycle 9. Did the person have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?	□ **Yes** □ No	□ **Yes** □ No
Score		
Assessor		

Scoring

To have a positive CAM result, the person must have: (1) Presence of acute onset and fluctuating course AND (2) Inattention AND EITHER (3) Disorganized thinking OR (4) Altered level of consciousness

Addressograph with Resident's Name:

Confusion Assessment Method (CAM) Instrument Shortened Version Worksheet

Assessor: _____
Date Administered (d/m/y): _____

Box 1

ACUTE ONSET AND FLUCTUATING COURSE

a) Is there evidence of an acute change in mental status from the person's baseline? No_____ Yes ___

b) Did the (abnormal) behaviour fluctuate during the day, that is, tend to come and go or increase and decrease in severity? No_____ Yes ___

INATTENTION

Did the person have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? No_____ Yes ___

Box 2

DISORGANIZED THINKING

Was the person's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? No_____ Yes_____

ALTERED LEVEL OF CONSCIOUSNESS

Overall, how would you rate the person's level of consciousness?

___Alert (normal)

___Vigilant (hyper-alert)
___Lethargic (drowsy, easily aroused)
___Stupor (difficult to arouse)
___Coma (can't arouse)

Do any checks appear in this box? No____ Yes____

If all items in Box 1 are checked and at least one item in Box 2 is checked, a diagnosis of delirium is suggested.

Adapted from: Inouye, SK, et al., (1990). Clarifying Confusion: The Confusion Assessment Method. A new method for detection of delirium. Annals of Internal Medicine, 113, 941-948.

I WATCH DEATH

Mnemonics may assist healthcare providers in systematically remembering common causes associated with the potential for delirium in older adults. **I WATCH DEATH** is an acronym for finding the causes for delirium. It is not meant to be a diagnostic tool.

How to Administer I WATCH DEATH?

Assess for each of the presenting symptoms by checking “yes” or “no”. If answer is “yes” to any of the presenting symptoms, further investigation is warranted to confirm a diagnosis of delirium.

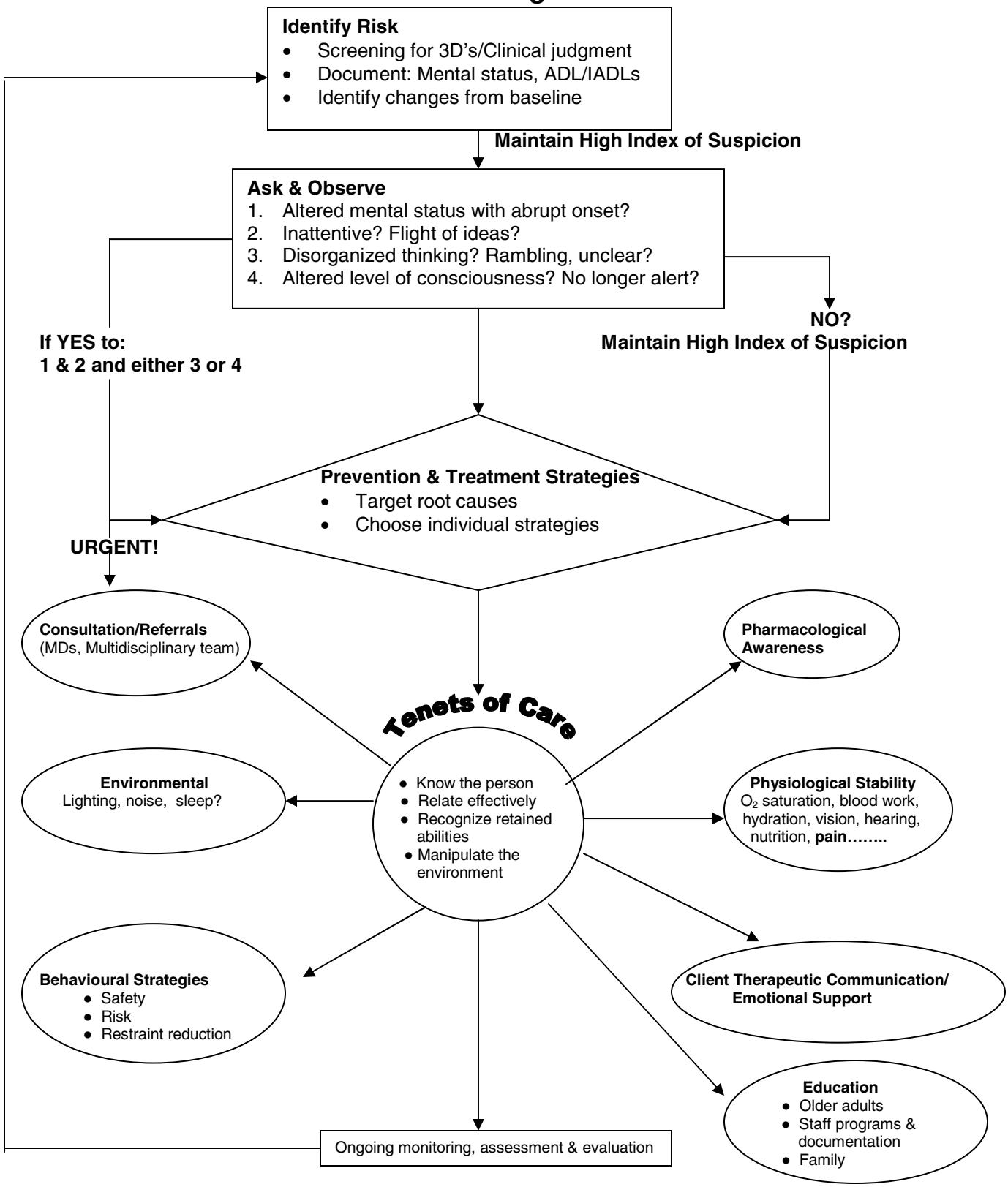
Addressograph with Resident's Name:

Assess for Causes of Delirium

Assessor: _____
Date Administered (d/m/y): _____

Mnemonic: I WATCH DEATH		Presenting Symptoms	Yes	No
I	**I**nfections	Urinary tract infection (UTI)		
		Pneumonia		
		Encephalitis		
		Other Infections: Specify:		
W	**W**ithdrawal	Alcohol		
		Benzodiazepines		
		Sedatives-hypnotics		
A	**A**cute metabolic	Electrolyte disturbance		
		Dehydration		
		Acidosis/Alkalosis		
		Hepatic/Renal failure		
T	**T**oxins, drugs	Opiates		
		Salycilates		
		Indomethacin		
		Lidocaine		
		Dilantin		
		Steroids		
		Other drugs:		
		Digoxin		
		Cardiac medications		
		Anticholinergics		
		Psychotropics		
C	**C**NS pathology	Stroke		
		Tumor		
		Seizures		
		Hemorrhage		
		Infection		
H	**H**ypoxia	Anemia		
		Pulmonary/Cardiac failure		
		Hypotension		
D	**D**eficiencies	Thiamine (with alcohol abuse)		
		B12		
E	**E**ndocrine	Thyroid		
		Hypo/Hyperglycemia		
		Adrenal insufficiency		
		Hyperparathyroid		
A	**A**cute vascular	Shock		
		Hypertensive encephalophathy		
T	**T**rauma	Head injury		
		Post-operative		
		Falls		
H	**H**eavy Metals	Lead		
		Mercury		
		Magnesium poisoning		

Decision Tree: Strategies for Delirium



Adapted from: Registered Nurses' Association of Ontario (2004). *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression.* Toronto, Canada: Registered Nurses' Association of Ontario.

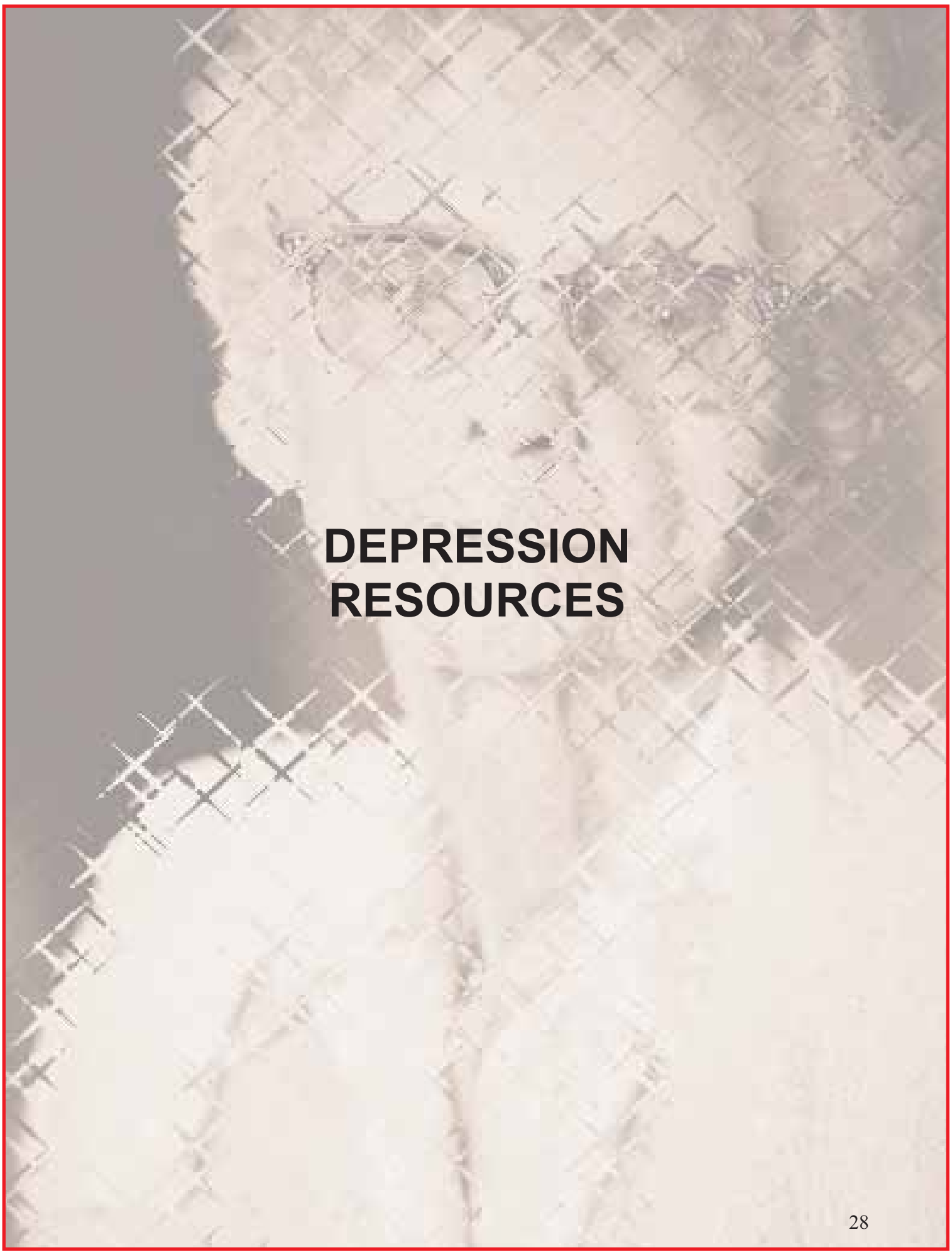
Interventions/Safety Considerations for Delirium

Category of Support	Interventions
Physiological Support	• Establish/maintain normal fluid and electrolyte balance. • Establish/maintain normal nutrition. • Establish/maintain normal body temperature. • Establish/maintain normal sleep/wake patterns (treat with bright light for two hours in the early evening). • Establish/maintain normal elimination patterns. • Establish/maintain normal oxygenation (if residents experience low oxygen saturation treat with supplemental oxygen). • Establish/maintain normal blood glucose levels. • Establish/maintain normal blood pressure. • Minimize fatigue by planning care that allows for separate rest and activity periods. • Increase activity and limit immobility. • Provide exercise to combat the effects of immobility and to "burn off" excess energy. • Decrease caffeine intake to help reduce agitation and restlessness. • Manage resident's discomfort/pain. • Promptly identify and treat infections.
Communication	• Use short, simple sentences. • Speak slowly and clearly, pitching voice low to increase likelihood of being heard; do not act rushed, do not shout. • Identify self by name at each contact; call resident by his/her preferred name. • Repeat questions if needed, allowing adequate time for response. • Point to objects or demonstrate desired actions. • Tell residents what you want done – not what not to do. • Listen to what the resident says, observe behaviours and try to identify the message, emotion, or need that is being communicated. • Validation therapy: technique tries to find the reason behind the expressed feeling. • Resolution therapy: attempts to understand and acknowledge the confused resident's feelings. • Use non-verbal communication alone or in combination with verbal messages. • Educate the resident (when not confused) and family.
Environment	• Reality orientation: offer orienting information as a normal part of daily care and activities. • Repeat information as necessary for the confused person. • Provide orienting information and explain the situation, unfamiliar equipment (e.g., monitors, intravenous lines, oxygen delivery devices), the rules/regulations, plan for care, and the need for safety measures. • Remove unfamiliar equipment/devices as soon as possible. • Provide call bell and be sure it is within reach. The resident should understand its purpose and be able to use it. • Use calendar and clocks to help orient resident. • Limit possible misinterpretations or altered perceptions which may occur due to pictures, alarms, decorations, costumed figures, television, radio and call system. Work with resident to correctly interpret his/her environment. • Establish a consistent routine, use primary nursing and consistency in caregivers.

Category of Support	Interventions
Environment	• Bring in items from the resident's home, allow the resident to wear his/her own clothes. • Avoid room changes, especially at night. Put delirious, disruptive residents in a private room if at all possible. • Create an environment that is as "hazard free" as possible. • Provide adequate supervision of acutely confused/delirious residents. • Avoid physical restraint whenever possible, use a sitter or have a family member stay with the resident if safety is a concern. If restraints must be used, use the least restrictive of these. • Consider moving the resident closer to the nurses' station. • Environmental manipulations may be appropriate if many residents wander: wandering alarms, exit door alarms, or painting lines on floor in front of exits or rooms you do not want the resident to enter. Wandering can also be managed through "collusion", walking with resident, then you or other staff, "invite" him/her to return to ward/facility. • Have a plan to deal with disruptive behaviour; keep your hands in sight; avoid "threatening" gestures or movement; remove potentially harmful objects from resident, room, and the caregiver's person. Bear in mind that these episodes may not be remembered by residents. If they are remembered, often they are the cause of embarrassment.
Sound and Light	• Keep the environment calm and quiet with adequate, but soft, indirect light and limit noise levels. • Provide glasses and hearing aides to maximize sensory perception. • Consider the use of night lights to combat nighttime confusion. • Use music which has an individual significance to the confused and agitated resident to prevent the increase in or decrease agitated behaviours.
Psychosocial	• Encourage residents to be involved in, and to control, as much of their care as possible. • Be sure to allow them to set their own limits, and do not force residents to do things they do not want to, as this is likely to cause disruptive behaviours. Reminiscing can also help increase self-esteem.
Social Interaction	• Encourage family and friends to visit, but visits work best when scheduled, and numbers of visitors and lengths of visits should be limited so as not to overwhelm the resident. • Consider involving the resident in programming so as to decrease his/her social isolation (physiotherapy and occupational therapy may be potential options).
Behavioural Management Interventions	• Changing staffing patterns or altering care routine (including amount/type of touching). • One to one supervision. • Pay attention to residents. • Talk with/counsel residents; give verbal reprimands. • Ignore. • Removal of resident from the situation; time out; seclusion/isolation. • Reposition. • Positive reinforcement of desired behaviours; removal of reinforcer of undesired behaviour. • Restrict activities. • Physical or chemical restraint as a last resort.

Category of Support	Interventions
Cognitive and Attentional Limitation Interventions	• Diversion can be used to distract the resident from the disruptive behaviours that she/he is currently engaging in. • Divide activities into small steps in order to simplify them and decrease likelihood of causing disruptive behaviours. • Determine what triggered or caused the disruptive behaviour, and try to prevent its occurrence.
Pharmaceutical Interventions	• In general, limit use of medications (to the extent possible) in residents with acute confusion and disruptive behaviours. • Regularly evaluate each medication used and consider discontinuing. If this is not possible, use the minimal number of medications in the lowest effective doses. • Monitor for intended and adverse effects of medications. • Treat pain in the delirious resident; however, be alert for narcotic induced confusion and disruptive behaviours. • Avoid medicating residents to control wandering, as medications are likely to make them drowsy and light-headed, increasing the risk for falls. • Be sure to monitor for side, untoward or paradoxical effects.
Other Interventions	• Consult with a Nurse Specialist/Geriatrics or Psychiatry for severe disruptive behaviours, psychosis, or if symptoms do not resolve in 48 hours. • Provide reassurance to residents both during and after acute confusion/delirious episodes. • Acknowledge resident's feelings/fears. • Allow residents to engage in activities that limit anxiety. • Avoid demanding abstract thinking for delirious residents, keep tasks concrete. • Limit choices, and offer decision-making only when residents are capable of making these judgments.

Adapted from:
Rapp, C. G., & The Iowa Veterans Affairs Nursing Research Consortium (1998). Research-Based Protocol: Acute confusion/delirium. In M. G. Titler (Series Ed.). *Series on Evidence-Based Practice for Older Adults* (pp. 10-13). Iowa City, IA: The University of Iowa College of Nursing Gerontology Nursing Interventions Research Center, Research Dissemination Core.



DEPRESSION RESOURCES

Depression Definition

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.

Predisposing Factors May Include:

- Biological
  - Family history
  - Prior episode

- Physical
  - Chronic or other medical conditions especially those that result in pain or loss of function, e.g., arthritis, CVA, CHF, etc.
  - Exposure to drugs, e.g., hypnotics, analgesics and antihypertensives.
  - Sensory deprivation.

- Psychological
  - Unresolved conflicts, e.g., anger or guilt.
  - Memory loss or dementia.
  - Personality disorders.

- Social
  - Losses of family and friends (bereavement).
  - Isolation.
  - Loss of job/income.

Best Practice Recommendations addressed in this section

- Nurses should maintain a high index of suspicion for 3D's in the older adult.

- Nurses should be aware of the differences in the clinical features of 3D's and use a structured assessment method to facilitate this process.

- Nurses should objectively assess for cognitive changes by using one or more standardized tools in order to substantiate clinical observations.

- Nurses must be aware of multi-component care strategies for depression: non-pharmacological interventions and pharmacological caregiving strategies.

What you will find in this section

- **Depression Assessment Tools**
  The assessment tools listed below are not inclusive but have been selected by the Toronto Best Practice Implementation Steering Committee to screen for depression. The evidence does not support a specific tool and one tool is not considered superior to another. It is stressed that screening tools can augment, but not replace a comprehensive "head to toe" nursing assessment. Thus, it is recommended that LTC Homes should use the screening tools in combination with the "head to toe" nursing assessment on admission.

  - **Geriatric Depression Scale (GDS)**
  - **Geriatric Depression Scale – GDS-4: Short Form**
  - **Cornell Scale for Depression**
  - **SIG E CAPS**
  - **Suicide Risk in the Older Adult**

- **Decision Tree: Strategies for Depression**

Geriatric Depression Scale (GDS)

This screening tool may assist in supporting a diagnosis of depression. It should be used as an adjunct to clinical assessment. It provides quantitative rating of depression. The GDS is used for cognitively intact individuals and is not validated in dementia. The scale is designed as screening tool and is not diagnostic.

How to Administer the GDS?

Place a check mark for every "yes" answer to the questions and then add the check mark to obtain a total number. Below is a glossary of the GDS Scorecard.

Score	Interpretation
≤ 4	Absence of significant depression
5 – 7	Borderline depression
≥ 7	Probable depression

A score of ≥ 5 requires further investigation to confirm diagnosis of depression.

Is Depression Present?

Answer	Interpretation	Next Steps
No	• Low GDS and no clinical signs	None
Possible	• High GDS, no clinical signs • Low GDS, with clinical signs • Intermediate GDS score with or without clinical signs • Other subjective or objective indicators of depression	Further investigation required
Probable	• High GDS with clinical signs	Further investigation required
Definite Yes	• Previous history of depression with current clinical signs present • Recent medical diagnosis of depression	Further investigation required

Addressograph with Resident's Name:

Geriatric Depression Scale (GDS)

Assessor: _____
Date Administered (d/m/y): _____

Ask the following questions:

	(✓) if answer is "yes"
1. Do you feel pretty worthless the way you are now?	
2. Do you often get bored?	
3. Do you often feel helpless?	
4. Are you basically satisfied with your life?	
5. Do you prefer to stay at home rather than doing new things?	
6. Are you in good spirits most of the time?	
7. Are you afraid that something bad is going to happen to you?	
8. Do you feel that your life is empty?	
9. Do you feel happy most of the time?	
10. Do you feel full of energy?	
11. Do you think it is wonderful to be alive now?	
12. Do you feel that your situation is hopeless?	
13. Have you dropped many of your activities and interests?	
14. Do you think that most people are better off than you are ?	
15. Do you feel that you have more problems with your memory than most?	
Total Number of (✓)	

Glossary: Geriatric Depression Scale Scorecard

4 or less: Indicates absence of significant depression	5-7: Indicates borderline depression	More than 7: Indicates probable depression

Is Depression Present?

No:	Low GDS and no clinical signs
Possible:	High GDS, no clinical signs
	Low GDS, with clinical signs
	Intermediate GDS score with or without clinical signs
	Other subjective or objective indicators of depression
Probable:	High GDS with clinical signs
Definite Yes:	Previous history of depression with current clinical signs present
	Recent medical diagnosis of depression
Clinical Signs:	Adapted from DSM IV Diagnostic Criteria for Major Depressive Disorder

Additional Comments: Overall impression or other related comments:

_____
_____
_____
_____
_____
_____

Geriatric Depression Scale – GDS-4: Short Form

This screening tool may assist in supporting a diagnosis of depression. It should be used as an adjunct to clinical assessment. It provides quantitative rating of depression. The GDS is used for cognitively intact individuals and is not validated in dementia. This short form GDS can be used as a quick screening tool and is not meant to be used for diagnostic purposes.

How to Administer the GDS-4: Short Form?

Answer the 4 questions with either “yes” or “no”. Score 1 for every answer in capitals. A score of 1 or more indicates a possible depression and further investigation is required to confirm the diagnosis of depression.

Addressograph with Resident's Name:

Geriatric Depression Scale – GDS-4: Short Form

Assessor: _____
Date Administered (d/m/y): _____

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**
Total Score	

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

Cornell Scale for Depression

This screening tool provides a quantitative rating of depression in individuals with or without dementia. The scale was designed to utilize information obtained from carers/family, as well as an interview with the person. Frequent coexistence of depression and dementia in older people suggested the need for a depression-rating instrument designed specifically for use in this group. The Cornell is found to be reliable, sensitive and valid in rating depression in a population of demented subjects with various degrees of depression. The scale is designed as screening tool and is not diagnostic.

How to Administer the Cornell Scale for Depression?

Administration requires 2 separate interviews. The clinician/healthcare provider first interviews the person's carer and family:

- During the carer and family interview, the clinician inquires about the signs and symptoms of depression as they appear on the scale.
- Additional descriptions can be used to clarify the carer/family the meaning of an item.
- The clinician assigns preliminary scores to each item of the scale on the basis of the carer's/family's report.

Next, the clinician briefly examines the person using the Cornell scale items as a guide.

- If there is disagreement between the clinician's impression and the carer's/family's report, the carer/family is interviewed again in order to clarify the source of discrepancy.
- Finally, the clinician scores the Cornell scale based on his/her judgment formed during this process.

Please note: Two items, "loss of interest" and "lack of energy" require both a disturbance occurring during the week prior to the interview and relatively acute changes in these areas occurring over less than one month.

The Scale:

- 19 questions distributed within 5 major headings (mood-related signs, behavioural disturbance, physical signs, cyclic functions and ideational disturbance).
- Each question is scored on a three-point scale:
  0 = absent
  1 = mild or intermittent
  2 = severe
  n/a = unable to evaluate

  The item "suicide" is rated with a score of "1" if the person has passive suicidal ideation, e.g., feels like life is not worth living.
- A score of "2" is given to subjects who have active suicidal wishes, or have made recent suicide attempt.
- History of a suicide attempt in a subject with no passive or active suicidal ideation does not in itself justify a score.
- The clinician is to mark an "n/a" when an item cannot be evaluated.

Older persons often have disabilities or medical illnesses with symptoms and signs similar to those of depression. Scoring of the Cornell scale on such items as "multiple physical complaints", "appetite loss", "weight loss", "lack of energy" and possibly others may be confounded by disability or physical disorder.
To minimize assignment of falsely high Cornell scale scores in disabled or medically ill individuals, raters are instructed to assign a score of "0" for symptoms and signs associated with these conditions. In many

cases the relationship between symptomatology and physical disability or illness is obvious. In some individuals, however, the determination cannot be made reliably.

There is a maximum score of 38. The ratings are based on behaviours observed or reported the previous week.

The five categories (mood-related signs, behavioural disturbance, physical signs, cyclic functions, and ideational disturbance) provide a format to assist the interviewer in organizing his/her assessment interviews and observation. The total time for administration and rating of the Cornell Scale is approximately 30 minutes.

How to interpret the results?

Caution must be used when interpreting the score. It is important for the clinician to note the exact responses. This will allow a more consistent interpretation of the scores in each area of the tool.

	Average Cornell Ratings
No psychiatric diagnosis	1.4
Non-depressive psychiatric disorders	4.8
Minor or probable major depressive disorder	12.3
Definite major depressive disorder	24.8

Decimal points found in ranges are due to mathematical act of averaging. Clinicians are <u>not</u> encouraged to assign partial scores during assessment.

Addressograph with Resident's Name:

Cornell Scale for Depression

Assessor: _____
Date Administered (d/m/y): _____

Mood-related Signs

1. Anxiety……_____
   anxious expression, ruminations, worrying

2. Sadness……_____
   sad expression, sad voice, tearfulness

3. Lack of reactivity to pleasant events…____

4. Irritability……_____
   easily annoyed, short tempered

Behavioural Disturbance

5. Agitation……_____
   restlessness, handwringing, hairpulling

6. Retardation……..._____
   slow movements, slow speech, slow reactions

7. Multiple physical complaints
   (score 0 if GI symptoms only)……_____

8. Loss of interest
   less involved in usual activities
   (score only if change occurred acutely,
   e.g., less than 1 month)……_____

Physical Signs

9. Appetite loss
   eating less than usual……_____

10. Weight loss
    (score 2 if greater than 5 lbs. in 1 month)
    ……_____

11. Lack of energy
    fatigues easily, unable to sustain activities(score only if change occurred acutely, e.g., in less than 1 month)……_____

Cyclic Functions

12. Diurnal variation of mood symptoms,
    worse in the morning……_____

13. Difficulty falling asleep
    later than usual for resident……_____

14. Multiple awakenings during sleep…….._____

15. Early morning awakening
    earlier than usual for this resident……_____

Ideational Disturbance

16. Suicide
    feels life is not worth living, has suicidal wishes, or makes suicide attempt…..._____

17. Poor self-esteem
    self-blame, self-depreciation, feelings of failure……_____

18. Pessimism
    anticipation of the worst……_____

19. Mood-congruent delusions
    delusions of poverty, illness, or loss…_____

Scoring System

Ratings should be based on symptoms and signs occurring during the week prior to interview. No score should be given if symptoms result from physical disability or illness.

0 = absent
1 = mild or intermittent
2 = severe
N/A = unable to evaluate

SIG E CAPS

The acronym SIG E CAPS or a “prescription for energy capsules” can be used to screen for nervous problems or possible depressed mood. The scale is designed as screening tool and is not diagnostic.

How to Administer the SIG E CAPS?

Assess for each of the presenting symptoms by checking “yes” or “no”. Add the number of “yes” answers to obtain a total number.

Interpretation of Scores:

- If five symptoms are present, the person likely suffers from a major depressive episode which will likely require active treatment with antidepressants and other appropriate treatment, such as interventions, psychotherapy. Further investigation is required including referral to the appropriate interdisciplinary team member (e.g., attending physician) and services such as Geriatric Mental Health Outreach Team and Psychogeriatric Resource Consultant (PRC).

Addressograph with Resident's Name:

SIG E CAPS

Assessor: _____

Depressive Symptoms	**Initial Assessment Date:**	**Re-Assessment Date:**
At least five (5) of the following symptoms* have been present nearly every day, for most of the day, during the same two-week period and represent a change from previous functioning:		
S – Sleep is disturbed.	□ Yes □ No	□ Yes □ No
I – Interest is decreased.	□ Yes □ No	□ Yes □ No
G – Guilt (feelings of guilt are common, having regrets, etc.).	□ Yes □ No	□ Yes □ No
E – Energy is lower than usual.	□ Yes □ No	□ Yes □ No
C – Concentration is poor and memory problems may be exacerbated.	□ Yes □ No	□ Yes □ No
A – Appetite is disturbed, usually a loss of appetite accompanied (or not) by weight loss.	□ Yes □ No	□ Yes □ No
P – Psychomotor retardation or agitation (agitation may be misconstrued as a result of anxiety only).	□ Yes □ No	□ Yes □ No
S – Suicidal ideation, at least a passive wish to die, is frequently present.	□ Yes □ No	□ Yes □ No
Additional symptoms: At least one of the symptoms is either (1) Depressed Mood	□ Yes □ No	□ Yes □ No
(2) Loss of interest in pleasure	□ Yes □ No	□ Yes □ No
SIG E CAPS Score (Total number of "Yes" answers)		

(Adapted from DSM-IV, American Psychiatric Association, 1994.)

*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.

Comments:

_____
_____
_____
_____
_____
_____

Suicide Risk in the Older Adult

The Suicide Risk in the Older Adult is a screening tool that can be used to assess for suicidal intent and behaviours, and risk factors.

How to Administer the Suicide Risk Screening Tool?

Answer “yes” or “no” for every question in each of the 3 categories, suicidal intent, suicidal behaviour, and risk factors. Total the number of “yes” answers.

Please take note:

- Any concerns of suicidal risk, inform resident that you will be sharing your assessment with his/her Physician and healthcare team.

- Document assessment, discuss with Attending Physician and team if medium to high risk and has plan.

Addressograph with Resident's Name:

Suicide Risk in the Older Adult

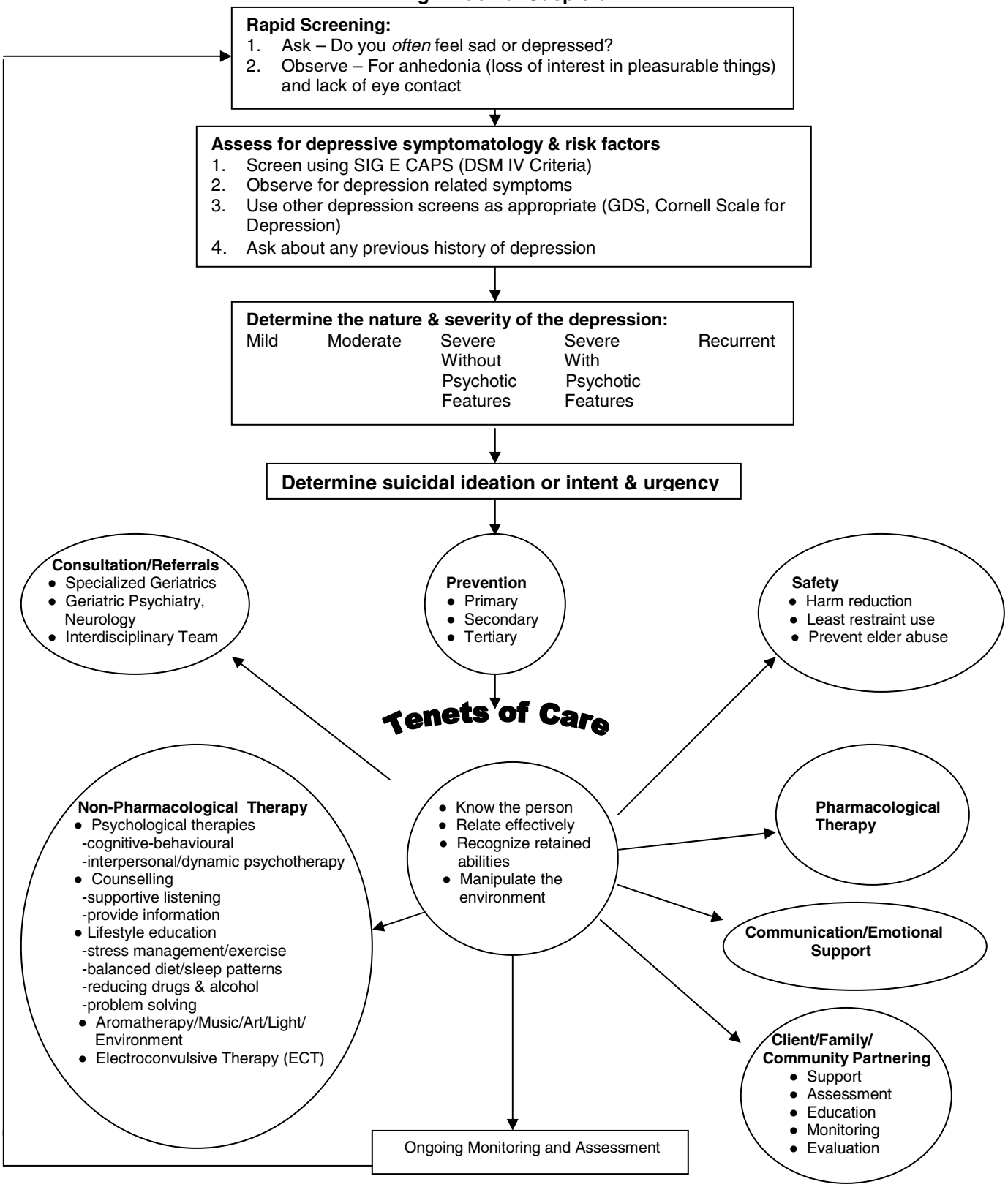
Assess for:		**Initial Assessment Date:**	**Re-Assessment Date:**	**Re-Assessment Date:**
Suicidal Intent	Verbalizes suicidal thoughts **(Flagging question: Do you ever go to sleep and wish of never waking up?)**	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Can outline a concrete realistic plan **(Flagging question: Have you ever thought of ending your life? If so, what is your plan?**	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Physical ability to carry out threat	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Describes suicidal intent	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Methods are available	□ Yes □ No	□ Yes □ No	□ Yes □ No
Suicidal Behaviour	Gives guarded answers to questions	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Increasing withdrawal	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Resolving depression	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Gives away possessions	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Drug/alcohol abuse	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Diverts interviewer off topic	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Depressed affect	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Sudden interest/disinterest in religion	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Put affairs in order	□ Yes □ No	□ Yes □ No	□ Yes □ No
Risk Factors	Male	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Low self-esteem	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Support systems: decreased or non-existent	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Decline in cognitive status	□ Yes □ No	□ Yes □ No	□ Yes □ No
	History of suicide attempts or violence	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Substance abuse	□ Yes □ No	□ Yes □ No	□ Yes □ No
	White	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Family history of suicide	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Decline in physical status	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Impulsivity	□ Yes □ No	□ Yes □ No	□ Yes □ No
	Recent loss or change in life	□ Yes □ No	□ Yes □ No	□ Yes □ No
Total number of "Yes" answers				
	Assessor			

NOTE:

- **Any concerns of suicidal risk, inform resident that you will be sharing your assessment with his/her Physician and healthcare team.**
- **Document assessment, discuss with Attending Physician and team if medium to high risk and has plan.**

Decision Tree: Strategies for Depression

High Index of Suspicion



Adapted from: Registered Nurses' Association of Ontario (2004). *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression.* Toronto, Canada: Registered Nurses' Association of Ontario.

DEMENTIA RESOURCES

Dementia Definition

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.

Predisposing Factors May Include:

- Memory impairment (impaired ability to learn new information or to recall previously learned information)
- Cognitive disturbances:
    - Aphasia (language disturbance)
    - Apraxia (impaired ability to carry out motor activities despite intact motor function)
    - Agnosia (failure to recognize or identify objects despite intact sensory function)
    - Disturbance in executive functioning (e.g., planning, organizing, sequencing, abstracting)
- Decline in social, occupational or day-to-day functioning

Best Practice Recommendations addressed in this section

- Nurses should maintain a high index of suspicion for 3D's in the older adult.

- Nurses should be aware of the differences in the clinical features of 3D's and use a structured assessment method to facilitate this process.

- Nurses should objectively assess for cognitive changes by using one or more standardized tools in order to substantiate clinical observations.

- Nurses should have knowledge of the most common presenting symptoms of: Alzheimer Disease, Vascular Dementia, Frontotemporal Lobe Dementia, Lewy Body Dementia and be aware that there are mixed dementias.

- Nurses should know their clients, recognize their retained abilities, understand the impact of the environment, and relate effectively when tailoring and implementing their caregiving strategies.

- Nurses caring for clients with dementia should be knowledgeable about non-pharmacological interventions for managing behaviour to promote physical and psychological well-being.

- Nurses caring for clients with dementia should be knowledgeable about pharmacological interventions and should advocate for medications that have fewer side effects.

What you will find in this section

- **Common Types of Dementia**

  Early recognition of dementia is essential since timely assessment and treatment are key to preventing excessive caregiver burden and improving the quality of life for persons with this condition. There are over 60 causes of dementia. The four most common types of dementia are Alzheimer Disease (60%), Vascular Dementia (15%), Frontotemporal Lobe Dementia (15%) and Lewy Body Dementia (20-25%). It is very important to distinguish the type of dementia in order to maximize functional capacity and independence. Care strategies should be tailored to the person's remaining abilities (which will vary depending on the type of dementia) rather than focusing only on their lost abilities. In so doing, nurses can minimize excess disability and promote well-being.

- **Dementia Assessment Tools**

  The assessment tools listed below are not inclusive but have been selected by the Toronto Best Practice Implementation Steering Committee to screen for dementia. The evidence does not support a specific tool and one tool is not considered superior to another. It is stressed that screening tools can augment, but not replace a comprehensive "head to toe" nursing assessment. Thus, it is recommended that LTC Homes should use the screening tools in combination with the "head to toe" nursing assessment on admission.

  - **Folstein Mini Mental Status Exam (MMSE)**
  - **Clock Drawing Test (CDT)**
  - **Mini-Cog**
  - **Cohen-Mansfield Agitation Inventory (CMAI)**

- **Decision Tree: Strategies for Dementia**

- **Care Strategies for Dementia**

Common Types of Dementia

	Alzheimer's Disease (AD)	Diffuse Lewy Body Disease (DLBD)	Vascular Dementia (VaD)	FrontoTemporal Dementia
Onset	Insidious	Insidious	Abrupt but may be insidious (small vessel disease)	Insidious
Course	Gradually Progressive	Progressive	Step wise or gradual progression	Gradually Progressive
Symptoms	1. Functional decline 2. Cognitive dysfunction • Lack of insight • Memory deficits • Inability to carry out purposeful movements • Speech disturbance • Impaired comprehension • Inability to recognize objects for what they are • Disturbance in planning, problem solving, organizing, abstracting, sequencing	1. Functional decline Plus, a triad of symptoms: 2. Signs of Parkinsonism 3. Fluctuating cognitive impairment over weeks & months; also day-to-day and intraday (pronounced variations in attention and alertness) 4. Recurrent vivid visual hallucinations; delusions or non-visual hallucinations may be present 5. Other common symptoms: depression, a history of falls or gait difficulty, or sleep disturbance	1. Cognitive problems depends on where the lesions are: • Right Parietal lobe: denial, loss of sense of time, loss of language, intonation • Frontal Lobe = impulsive, pseudobulbar, crying or laughing, disinhibited, amotivated, patchy memory 2. Focal neurologic signs • Gait abnormalities • Weakness of extremity 3. Personality & mood changes	1. Behaviour • Personality change • Early neuropsychiatric symptoms • Early loss of social graces • Early signs of disinhibition • Fixed ideas • Perseverative • Hyperorality • Emotional unconcern • Somatic preoccupation • Early lack of judgment • Severe loss of abstract ability • Memory may improve with cueing • Poor verbal fluency • Poor set shifting 2. Early speech problems 3. Neurological: • Grasp reflex • Late akinesia, rigidity
Comments	1. Rule out Delirium – underlying treatable illness / drugs / alcohol 2. Rule out Depression 3. Other symptoms: • Depression • Psychosis	1. Rule out Delirium & Depression 2. Memory problems maybe relatively mild or not present in early stages. High mini mental score. 3. Visual hallucinations are colourful, complex and repeated 4. Neuroleptic sensitivity even with low doses	1. Rule out Delirium & Depression 2. Memory problems maybe relatively mild or not present in early stages. High Mini Mental Status Exam score. 3. High incidence of depression associated with emotional incontinence 4. Apathy can be a major feature	1. Rule out Delirium & Depression 2. Memory problems maybe relatively mild or not present in early stages. High Mini Mental Status Exam score 3. Prominent Behavioral and Personality changes early in the course of the illness 4. Presents in relatively younger people (usually < age 65)
Specific Management	<u>Early / moderate stages:</u> Cholinesterase inhibitors (CI) - Aricept, Reminyl, Exelon <u>Moderate / severe stages:</u> NMDA receptor antagonist - Ebixa (Memantine) **Risk factor treatment*	Cholinesterase inhibitors (CI) - Aricept, Reminyl, Exelon Avoid neuroleptics	Cholinesterase inhibitors - Aricept, Reminyl, Exelon Reduce vascular risk factors: weight, smoking, lower cholesterol, alter lifestyle; ?ASA as prophylaxis **Risk factor treatment*	Monitor for safety issues because of poor judgment & problem solving ability Serotinergic not cholinergic deficit; therefore CI's not indicated. SSRI are used for symptomatic treatment.

Note: <u>Mixed Dementia</u> (AD and VaD) commonly co-exist. Two presentations: a) Clinical - gradual progression punctuated by episode(s) of stepwise decline (TIA/CVA) usually with focal neurological symptoms/signs. (2) Radiological - gradual, slow progression *without* stepwise decline/neurological symptoms or signs but brain neuroimaging positive (CT/MRI).

***Reduce vascular risk factors: weight, atrial fib, high BP, DM, smoking, lower cholesterol, alter lifestyle, ECASA unless contraindicated**

Folstein Mini Mental Status Exam (MMSE)

Folstein MMSE is quick and easy test to administer and is considered reliable and valid as a cognitive screening tool for older persons. It measures the main areas of mental status or cognitive function: memory, orientation, language, attention, visuospatial, and constructional skills. It is to be used as a screening test for cognitive impairment and is the first line of mental assessment only. This screening tool should be used in conjunction with other assessments such as functional and physical examination.

How to Administer the Folstein MMSE?

- Explain the nature of the Folstein MMSE and why you are using it; keep the explanations simple: "This is a general test of memory that will help identify problems you may be experiencing with your memory."

- Obtain the person's permission to begin the test and provide reassurance by telling the person, "Some questions may be very simple and others more tricky. Try not to worry; if you do not know an answer, just try your best."

- Ask each question up to three times; if no response is given, score 0.

- Any incorrect answer is scored 0. Do not provide any hints, prompts, or cues. If a person asks, "Was that right" say, "You are doing fine," and move on to the next question. If you wish to examine an area further and provide prompts, note that on your worksheet.

Interpretation of Scores:

- The entire score is out of 30. Alter the total score accordingly, if there are questions omitted (i.e., orientation to place may be altered if the individual is not familiar with the area; the sentence and diagram may be omitted if the individual is physically unable to attempt to answer).

- The individual receives points for each correct answer as indicated on the tool.

- The results will help the clinician determine whether or not there may be cognitive impairment. One must be careful to consider all reasons, i.e., education status, language and cultural background, hearing/vision/speech.

- The Folstein MMSE should be used in conjunction with other assessments and is a screening tool only (not diagnostic).

Score	Interpretation
25-30	Normal cognitive functioning
20-24	Mild cognitive impairment
10-20	Moderate cognitive impairment
<10	Severe cognitive impairment

Please Note: There is more than one version of the MMSE; however, the committee has chosen the Folstein MMSE which is the most common tool.

How to differentiate the 3D's using the Folstein MMSE?

Orientation Questions

- Delirium fluctuates; may not be orientated.
- Depressed people are fully orientated; may say, "I'm not sure," initially and take longer to answer; however, typically will be correct.
- People with dementia will not be fully orientated, likely wrong about season and year yet not be aware of this, or may look for external cues such as the date on a newspaper; may say things like "I don't pay attention to those things anymore."

Recall Questions

- Delirium – fluctuations in attention, distractible, act startled, poor memory.
- Depressed – may get obvious apathy, lack of concentration – "I don't know" answers.
- Dementia – 0/3 recall; information is typically gone from memory in Alzheimer Disease; if the dementia is due to multiple infarcts, often the information can be retrieved with cueing; individuals try attending; often make an effort to conceal or deny. More likely misinformation that fits their reality.

Three-stage Command

- Delirium – have trouble; can't remember or attend to instructions.
- Depressed – can usually do this; may not have the energy.
- Dementia – have trouble; can't remember all the instructions.

Design Copy

- Delirium – cannot attend to task.
- Depressed – no problems; may complain and say this is too hard or just refuses to try.
- Dementia – cannot do; may separate two figures; draw only one, produce figures with too few sides, or neglect to close the figures; impacts on ability to drive car.

Addressograph with Resident's Name:

Folstein Mini Mental Status Exam (MMSE)

Assessor: _____
Date Administered (d/m/y): _____

Questions		Point Score	Resident Score
Orientation	What is the *(year) (season) (month) (date) (day)*	5 pts	
	Where are we? (*country) (province) (city) (floor in building, room number)* or *(name of building, address)*	5 pts	
Registration	Name 3 words (*apple, table, penny*). Ask the Resident to repeat all three after you have said them. One point for each correct word. Then repeat them until he/she learns them. Count trials and record _____	3 pts	
Attention & Calculation	Ask resident to spell "WORLD" forward and then backwards. One point for each letter in the correct order for a total of 5. If language is a problem use serial 7's backwards (i.e.,100 take away 7 equals ?). Correct answers are: 93, 86, 79, 72, 65. One point for each correct answer.	5 pts	
Recall	Ask for the 3 words *(apple, table, penny).* One point for each correct word.	3 pts	
Language Tests	Name: pencil, watch	2 pts	
	Repeat after me: *"no ifs, ands, or buts"*	1 pt	
	Follow a three-stage command: *"Take the paper in your right/left hand* (ask resident to use non-dominant hand)*, fold it in half, and put it on the floor".*	3 pts	
	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 pt	
	Write a sentence spontaneously. The sentence should have a noun and verb and make sense. Ignore spelling mistakes. (Provide separate sheet of paper.)	1 pt	
Design	Copy the design. (Show design on separate sheet of paper and ask Resident to copy. Allow multiple tries).	1 pt	
	Total Score	30 pts	

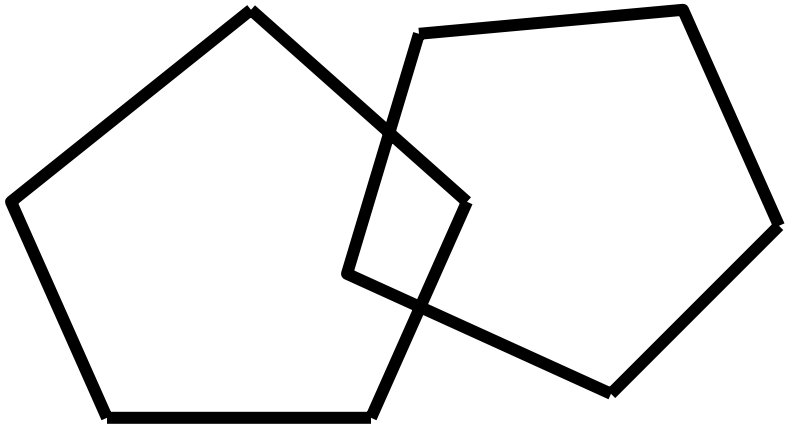
Scoring:

25-30: normal cognitive functioning
20-24: mild cognitive impairment
10-20: moderate cognitive impairment
< 10: severe cognitive impairment

CLOSE YOUR EYES

Write a sentence.

Copy the picture.



Clock Drawing Test (CDT)

CDT is easily administered, valid, and economical; it correlates with other clinical measures of dementia severity. This test is complementary to other tests that focus on memory/language and can be used in detection and diagnosis; monitoring a course of an illness; useful for education of family and others in terms of capacity of the person; can be administered to hearing impaired (with written instructions). It measures abstraction, attention, concentration, and visuospatial capabilities. It also measures impairment in geriatric depression (fronto-temporal dysfunction). CDT requires executive control and it therefore correlates with IADL.

How to Administer the CDT?

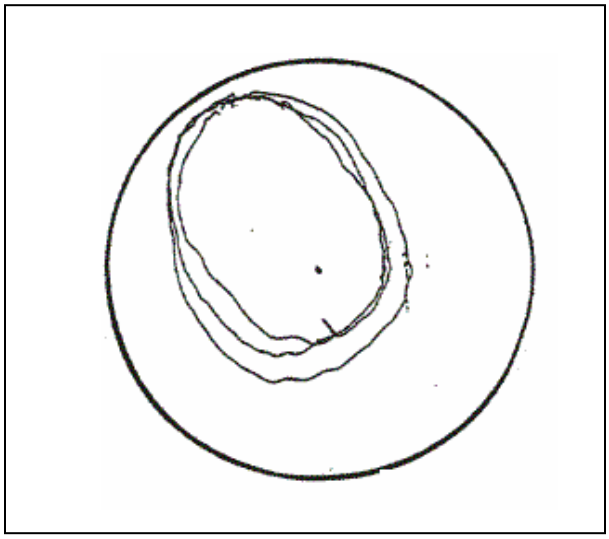
- Provide the individual with a large pre-drawn circle on a plain piece of paper.
- Ask the individual to “make the circle look like a clock”.
- If the individual does not understand the instructions, give more direction such as placing “numbers” on the circle to make it look like a clock. Be sure to note that you have given this exra prompt.
- If the completed clock looks abnormal, ask the individual if the clock looks right to them. If they indicate that it does not, attempt to re-administer with another circle. Encourage the individual to take his/her time and try his/her best.
- Ask the individual to “make the clock say 10 after 11”. If further prompting is required, i.e., use of the word “hands”; note this on your worksheet. If the drawn clock is not drawn well enough to place a correct time on it, draw your own for the individual to use.

  Note: The request of “10 after 11” is important as this produces hands that are in both spheres, are asymmetrical, and it is not as common a time reference as for example, 5 o’clock.

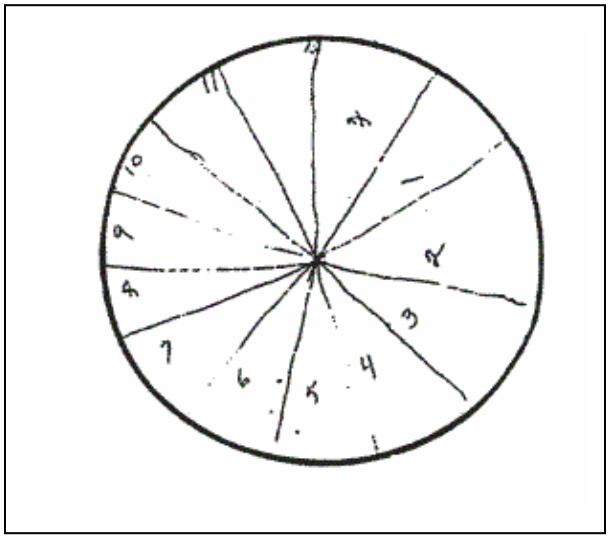
Scoring Procedure:

There are a variety of suggestions on applying a scoring system to the CDT. Such scoring procedures may be viewed as confusing and time-consuming. A brief description of the results provides consistent, understandable and meaningful information.

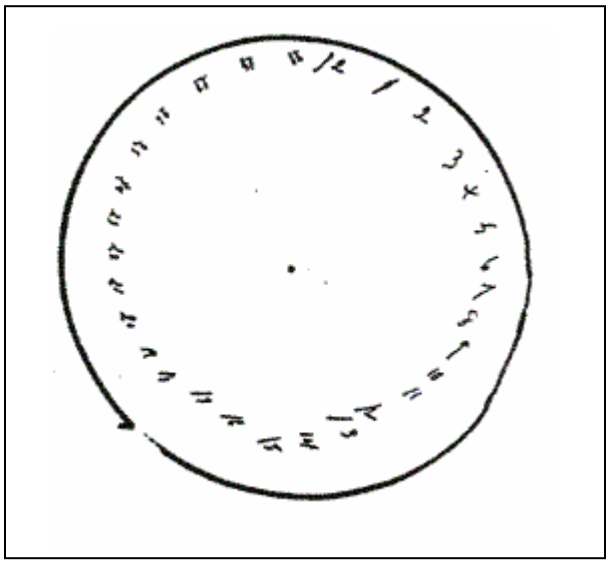
Clock Drawing Test (CDT): Interpretation of Results



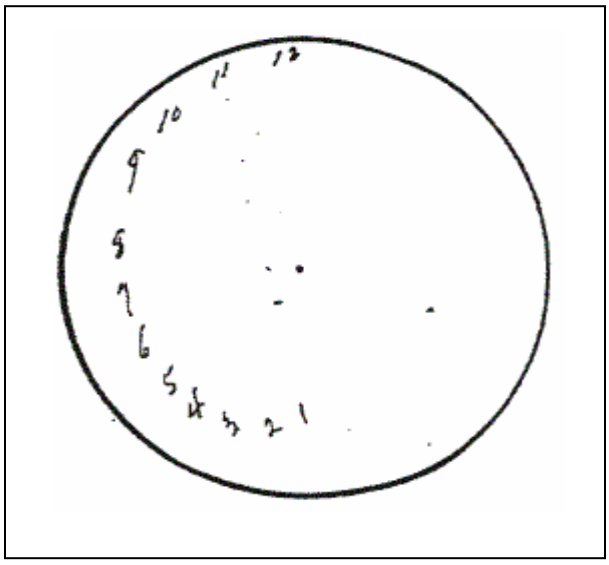
Significant impairment, perseverating, stimulus bound.



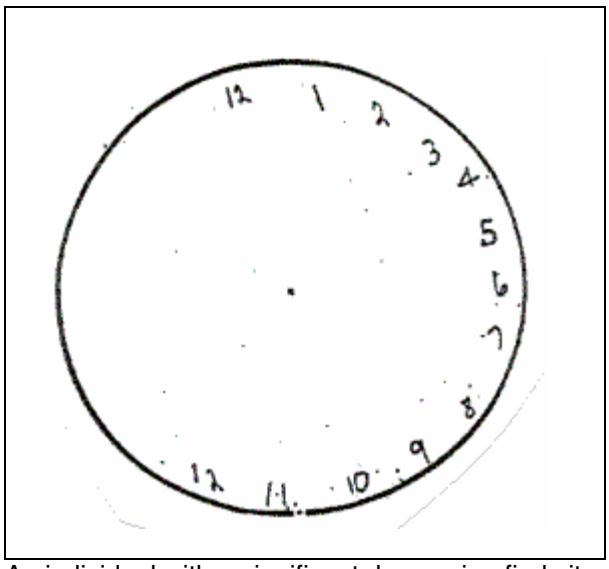
Significant impairment: perseverating; dividing into pie-like shapes; individual knows that numbers belong on clock but gets side tracked by numbering sections.



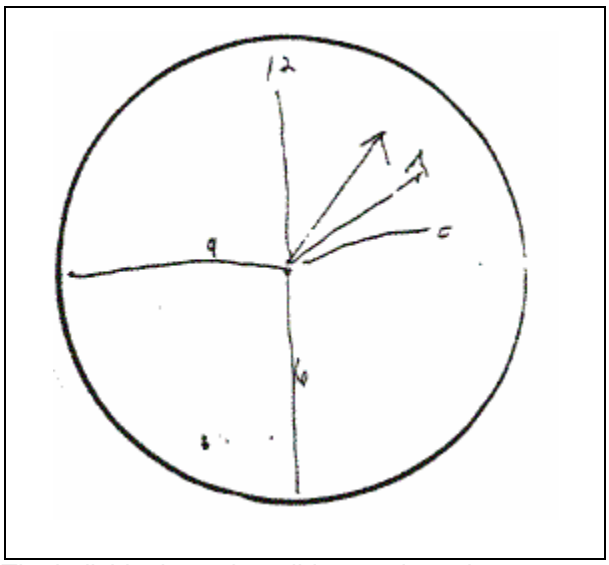
Severe to moderate impairment; perseverative with numbering; individual knows numbers belong on clock but is unable to space properly; seeks closure by numbering until clock is filled.



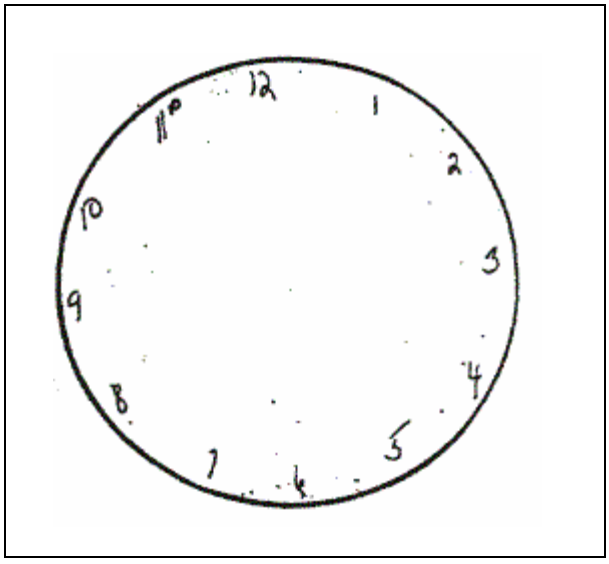
Difficult to assess degree of impairment based on clock alone; numbers may occur on either side and may suggest neglect. Look for other indicators of neglect. It is important to ask the individual if he/she feels this clock is incorrect and in what way.



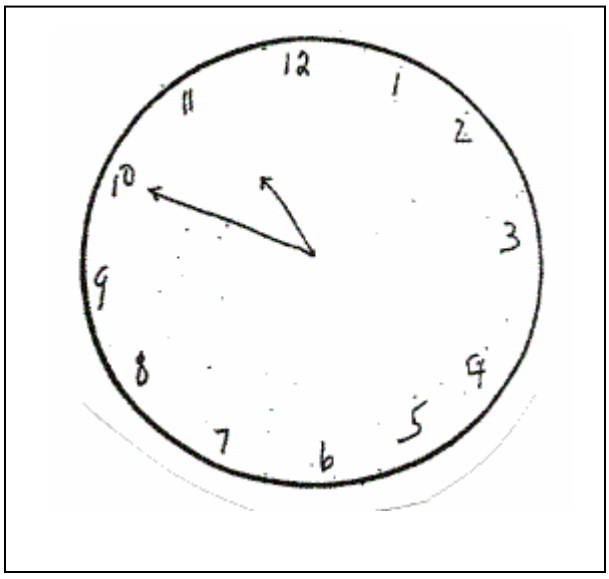
An individual with a significant depression finds it difficult to concentrate when completing the clock and often misplaces the numbers. If asked, the person will admit that the numbers are not in the correct spaces and may even be able to self-correct. Could suggest neglect.



The individual may be mild to moderately impaired; important to note that the individual attempted to use markers in placing the numbers; the use of hands indicates that he/she is able to think in an abstract fashion.



This is a typical clock for mild to moderate impairment; the individual is unable to think abstractly and place hands on the clock.



This is a typical clock for mild impairment; it is important to ask the individual if he/she feels the hands are in the correct places. The inability to place the hands in the correct place indicates difficulty in abstraction.

How to differentiate the 3D's using CDT?

Delirium

- Highly distractible, unable to sustain attention
- High degree of variability in performance over time
- Clock becomes more normal as person comes out of delirium
- Important to administer test over time

Depression

- Often requires encouragement to initiate and carry out the task but usually able to correctly place numbers on clock and set clock.

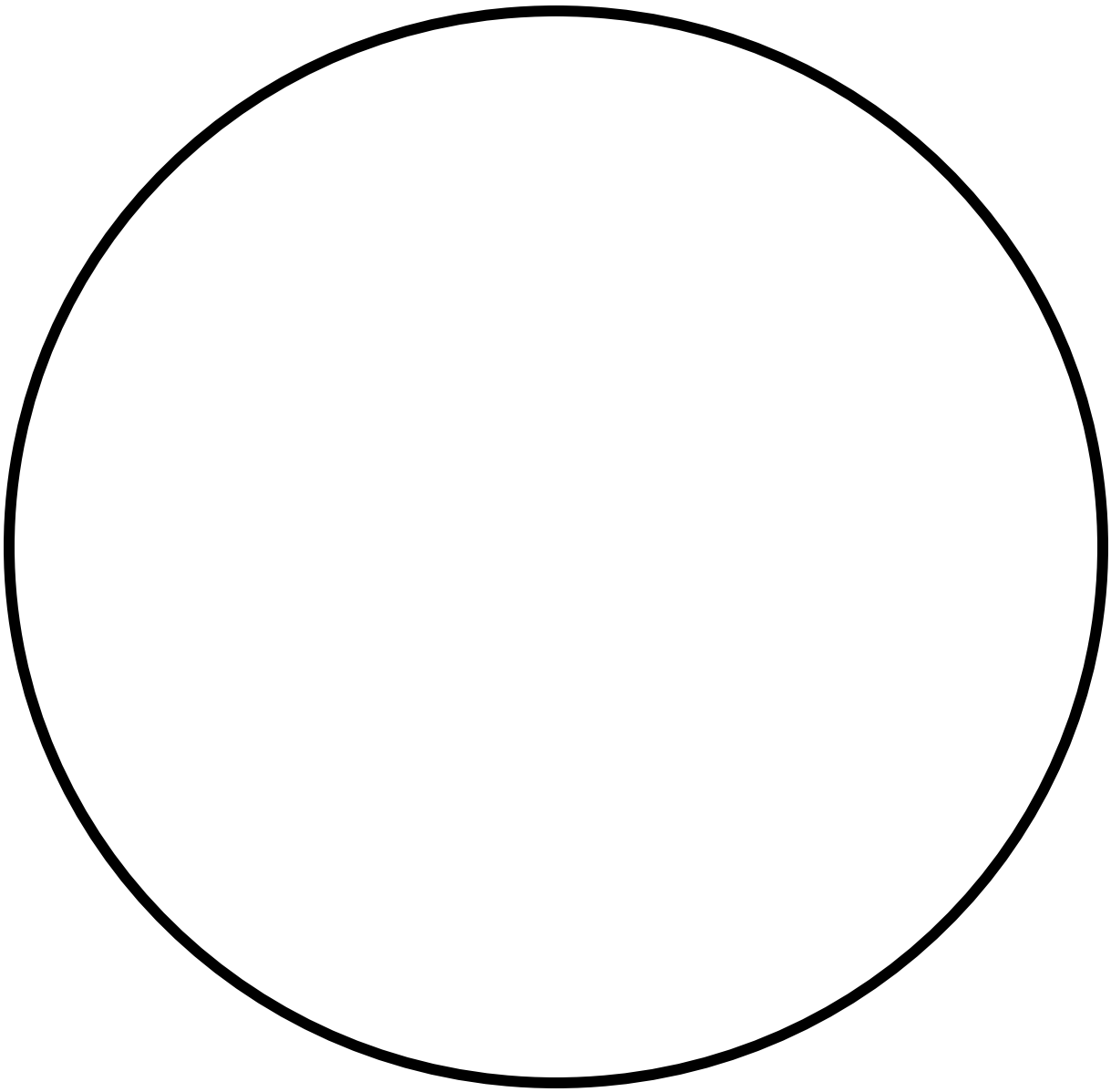
Dementia and Neurological Illness

- Performance on clock test correlates with severity of dementia.
- Those individuals who have had a stroke may show neglect i.e., clock done only on one half.
- Individuals may do a clock with small numbers or number concentrated in one corner.
- Person makes genuine attempt to complete test.
- Performance deteriorates gradually with dementia progression; no acute fluctuations except for multi-infarct dementia.
- Persons with dementia tend to produce clocks with:
    - poor contour, omission of numbers
    - extra numbers
    - numbers in the incorrect order
    - failure to draw two hands
    - poor placement of minute hand
    - superfluous markings
    - poor placement of centre
    - writing minutes next to hour target number
    - writing the time across clock face
    - perseveration of numbers
    - numbers outside clock
    - drawing spokes of a wheel

Addressograph with Resident's Name:

Clock Drawing Test (CDT)

Assessor: _____
Date Administered (d/m/y): _____



Mini-Cog Dementia Screen

The Mini-Cog is a 3-minute cognitive screen. It was developed in a purposively ethnolinguistically diverse sample. It is a validated tool and it detects clinically significant cognitive impairment as well as or better than the MMSE in multiethnic elderly individuals. This tool is easier to administer to non-English speakers, and less biased by low education and literacy.

How to Administer the Mini-Cog?

- Ensure the resident has his/her hearing aids, glasses before administering any cognitive screen.
- Provide a quiet, undistracted environment if possible.
- Introduce the Mini-Cog by a statement such as, "I am going to ask you a few questions just to see how clear your thinking is today."
- Obtain the person's permission to begin the test (will need pen/pencil for clock drawing test).

Features of the Mini-Cog:

The Mini-Cog combines a three-item word-learning and recall task (0-3 points; each correctly recalled word = 1 point), with a simple clock drawing task (abnormal clock = 0 points; normal clock = 2 points) used as distraction task before word recall.

Scoring:

Mini-Cog total possible scores range from 0 to 5.
0 to 2 = high likelihood of cognitive impairment
3 to 5 = low likelihood of cognitive impairment.

Addressograph with Resident's Name:

Mini-Cog Dementia Screen

Assessor: _____

Date Administered (d/m/y): _____

The Mini-Cog is a 3 question validated tool to screen for dementia.

A. Immediate registration (3 words) _____ _____ _____

B. Clock Drawing Test (CDT) *[see attached]*
- □ Normal
- □ Abnormal

Comments:

C. Recent recall (3 words) _____ _____ _____

Reference: Borson, S., Scanlan, J., Brush, M. et al. (2000). The Mini-Cog: A Cognitive Vital Signs Measure for Dementia Screening in Multi-Lingual Elderly. *International Journal of Geriatric Psychiatry* ***15,*** 1021-1027

Scoring:

The Mini-Cog combines a three-item word-learning and recall task (0-3 points; each correctly recalled word = 1 point), with a simple clock drawing task (abnormal clock = 0 points; normal clock = 2 points) used as distraction task before word recall.

The CDT is considered normal if all numbers are present in the correct sequence and position and the hands readably display the requested time of ten past eleven.

Results:

Mini-Cog total possible scores range from 0 to 5.
0 to 2 = high likelihood of cognitive impairment
3 to 5 = low likelihood of cognitive impairment.

Resident Score: ___/5

Comments/Plan:

Cohen-Mansfield Agitation Inventory (CMAI)

CMAI is used to assess the frequency of manifestations of agitated behaviour in older persons ranging from vocal disruption to overt physical aggression. It can track the occurrence of behaviour of interest (target behaviour) as frequently as "several times an hour". It is a useful tool because it provides descriptive data so that clinical decisions are based on evidence, not impressions alone. It replaces opinion with measurable data by:

- Establishing the occurrence of distinct behavioural entities
- Establishing the frequency of the target behaviours
- Categorizing behavioural events so the team is clear about those behaviours that represent RISKS and those behaviours that should be accommodated
- Serving as a baseline measure to track change

CMAI is used when:

- there is a change of concern in the person's typical behaviour profile
- attempting to evaluate the impact of a specific interventions on the behaviour profile
- the clinical team needs an outcome measure to determine if the target behaviour has changed in frequency

How to Administer the CMAI?

- Complete the CMAI by summarizing data that is available in the behavioural monitoring records in the person's chart.
- Education is required to be able to collect the data using information from direct care providers by interviewing them. The best clinical application is to have a discussion with a group of direct care providers using the tool as a focus.
- If the data is to be used as an outcome it must truly reflect where the person is, behaviourally. Therefore, co-ordinate the completion of the CMAI using the following process:

    1. Read the progress notes.
    2. Analyze the person's observation record or **ABC** documentation. (**Antecedent** – What happened just before behavioural problem? **Behaviour** – What did the person do? **Consequence** – What happened immediately after the behaviour?)
    3. Fill out the form as a "draft".
    4. Discuss the frequency/disruptiveness categories with staff familiar with the person, coming to consensus about the responses.
    5. Direct evening and night shift staff to complete the CMAI for their shift, using the steps outlined above.
    6. Complete the 30th item (other) if there is a distinct behavioural entity that the direct care providers agree is a challenge for them and that they need to monitor more closely.

    Principles to keep in mind:

    - When interviewing direct care providers or the carer and family, they know more about the person than you do.

- Completing the CMAI together will ensure that the data is the most accurate reflection of the person's behavioural profile as possible; explain this to the family/carer.

- Reassure staff that assigning a "high" frequency score is not a personal criticism of the person.

- Reassure staff that you are trying to get them to focus on a very specific time period; you require the most recent behavioural events rather than what happened six weeks ago.

- Encourage staff to consult with other informants, if the carer and family are unsure about certain behaviour. Remember the goal is to achieve the most accurate reflection of the frequency at which these behaviours occurred.

Interpretation of Results:

- Results can assist the team to estimate risk that a particular set of behaviours represents, as well as the resources needed to assist with management. SEVERITY or RISKS associated with the behavioural profile can be based on how many of the 29 behaviours are present (i.e., the person who displays "hitting, kicking, biting, pushing, throwing" at a level of "several times a day" represents a greater risk than the person who displays only "hitting" at a level of "less than once a week").

- Results can assist with the identification of criteria for transfer/discharge.

- Results can assist with evaluating the impact of titrating psychopharmacological interventions up or down.

- Results should NEVER be considered in isolation of other data; use as a supportive piece to clinical observations.

- Results are a method of quantifying behavioural data; results tell us something about the frequency.

- Results can help focus on those behaviours that represent a RISK and those behaviours that can be accommodated.

Addressograph with Resident's Name:

Cohen-Mansfield Agitation Inventory (CMAI)

Assessor: _____
Date Administered (d/m/y): _____

Frequency
1 = Never
2 = Less than once a week
3 = Once or twice a week
4 = Several times a week
5 = Once or twice a day
6 = Several times a day
7 = Several times an hour
9 = Don't know

Disruptiveness
1 = Not at all
2 = A little
3 = Moderately
4 = Very much
5 = Extremely
9 = Don't know

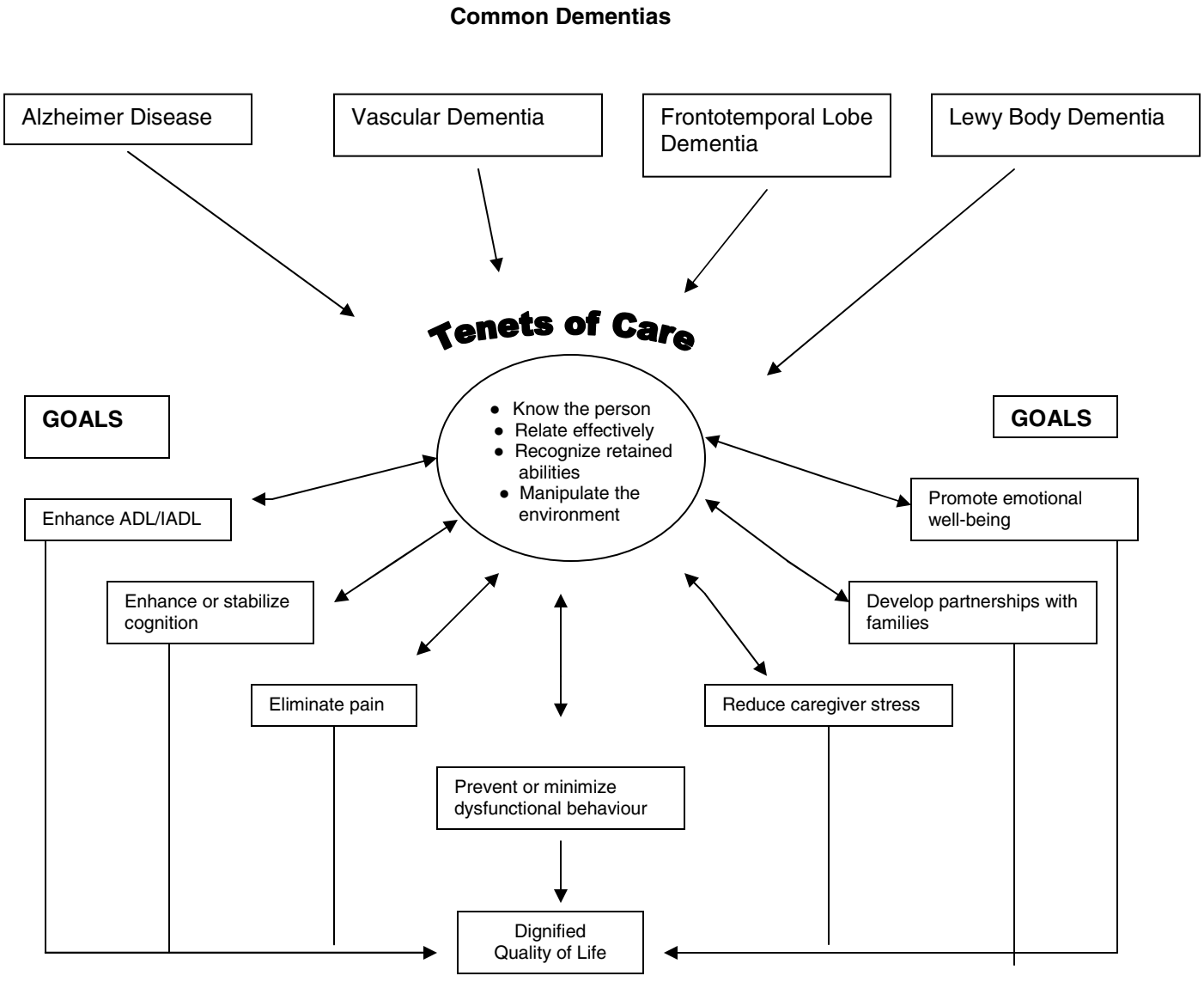
Please read each of the 30 agitated behaviours, and circle the frequency and disruptiveness of each during the past two weeks. (Level of disruptiveness: How disturbing it is to staff, other residents, or family members. If disruptive to anyone, rate the highest it is for those for whom it disrupts).

	Frequency	**Disruptiveness**
1. Pace, aimless wandering	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
2. Inappropriate dress, disrobing	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
3. Spitting (include at meals)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
4. Cursing or verbal aggression	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
5. Constant unwarranted request attention for help	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
6. Repetitive sentences/questions	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
7. Hitting (including self)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
8. Kicking	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
9. Grabbing onto people	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
10. Pushing	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
11. Throwing things	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
12. Strange noises (weird laughter or crying)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
13. Screaming	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
14. Biting	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
15. Scratching	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
16. Trying to get to a different place (e.g., out of the room or building)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
17. Intentional falling	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
18. Complaining	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
19. Negativism	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
20. Eating/drinking/inappropriate substances	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
21. Hurt self of others (with cigarette, hot water, etc.)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
22. Handling things inappropriately	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
23. Hiding things	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
24. Hoarding things	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
25. Tearing things or destroying property	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
26. Performing repetitious mannerisms	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
27. Making verbal sexual advances	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
28. Making physical sexual advances	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
29. General restlessness	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
30. Other inappropriate behaviour. Specify: _____	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9

Reference: Cohen-Mansfield, J. (1986). Agitated behaviours in the elderly II: Preliminary results in the cognitively deteriorated. *Journal of the American Geriatrics Society, 34*(10), 722-727.

Cohen-Mansfield, J., Marx, M. S., & Rosenthal, A. S. (1989). A description of agitation in a nursing home. *Journal of Gerontology, 44*, M77-M84.

Decision Tree: Strategies for Dementia



Adapted from: Registered Nurses' Association of Ontario (2004). *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression.* Toronto, Canada: Registered Nurses' Association of Ontario.

Care Strategies for Dementia

I. Early-Stage Manifestations and Behavioural Interventions

Manifestations	Behavioural Interventions
• Impaired recall of recent events	• Use reminders (notes, single-day calendars, cues) • Talk with the resident about recent events
• Impaired functioning, especially complex tasks • Gradual withdrawal from activities • Lowered tolerance of new ideas and changes in routine	• Avoid stressful situations • Do not ask for more than the resident can do • Keep the environment, schedule, routine the same • Maintain normal mealtime routine • Have items in the same place and in view
• Difficulty finding words	• Anticipate what the resident is trying to say • Provide word or respond to thought/feeling
• Repetitive statements	• Be tolerant and respond like it is the first time stated or heard
• Decreased judgment and reasoning	• Assess safety of driving and other desired activities • Allow performance of skills as long as safe
• Becoming lost	• Accompany on walks • Provide safe and secure walking area
• Inconsistency in ordinary tasks of daily living	• Ignore inconsistencies • Help to maintain consistency by keeping needed items in view and maintaining routines
• Increasing tendency to misplace things	• Keep items in the same place and in view • Find things and replace or hand to the resident without focusing on the forgetfulness
• Narrowing of interest • Living in the past	• Maintain familiar social, physical, mental, and work activities
• Self-centred thoughts; restlessness or apathy	• Focus on the resident and listen • Allow pacing or sleeping
• Preoccupation with physical functions	• Assist in maintaining normal physical functions (basic and instrumental activities of daily living)

Sparks, M. (2001). Assessment and management of Alzheimer's disease. Medscape [On-line] Available: http://www.medscape.com/viewarticle/408

II. Intermediate-Stage Manifestations and Environmental Interventions

Manifestations	Behavioural Interventions
• Increased forgetfulness (meals, medications, people, self)	• Place food where resident can see and reach it • Hand medications to resident • Remove mirrors
• Untidiness, hoarding, rummaging	• Put things away as desired; do not expect resident to put them away • Provide a chest of drawers for hoarding or rummaging
• Difficulty with basic activities of daily living	• Keep needed objects in sight/reach • Do for the resident what he or she cannot, but allow the resident to do as much as possible • Provide assistive equipment; shower stool, elevated seat
• Wandering, becoming lost	• Close and perhaps lock doors on stairways and rooms that the resident should not access • Fence the yard • Place cues to help recognize rooms or objects • Avoid physical and chemical restraints while providing areas for wandering and resting
• Uncoordinated motor skills, poor balance	• Have a non-shiny floors without contrasting colours or patterns • Provide soft environment
• Repetition of words or activities	• Provide environment where repetitive activities can occur safely
• Reversed sleep-wake cycles	• Provide activities in daytime • Provide room where the resident can safely be up alone for a time • Put back to bed with usual bedtime routine
• Loss of contact with reality; hallucinations, confusion	• Make available materials for activities that the resident enjoyed throughout life • Keep picture albums with old pictures • Keep the resident's room location and layout unchanged • Remove confusing stimuli • Ignore hallucinations unless they are distressing to the resident; remain calm; act normally
• Withdrawal	• Provide meaningful stimuli • Provide place for quiet time
• Agitation	• Remove objects that could be damaging • Provide space
• Impaired judgment	• Provide safe environment • Keep unsafe objects out of sight
• Altered sensory-perceptual functioning	• Provide good lighting • Have non-shiny floors without contrasting colours or patterns

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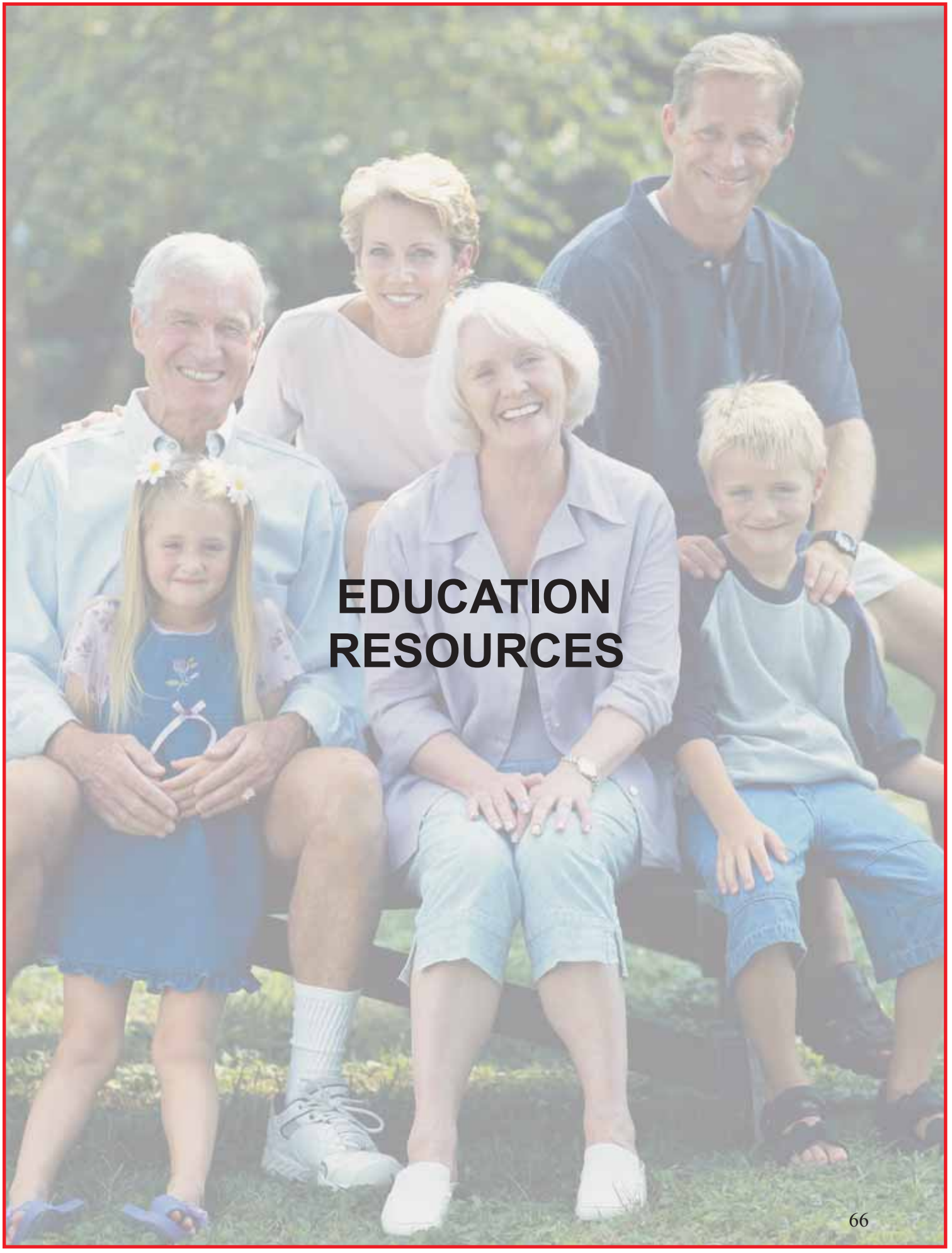

EDUCATION RESOURCES

Website List of Available Resources

The following resources are intended to assist in supporting education on delirium, depression and dementia. These are sample resources only, and are not intended to be a comprehensive listing.

Organization/Networks	Websites
Alzheimer Knowledge Exchange	www.akeontario.org
Alzheimer's Research Exchange	www.alzheimersresearchexchange.ca
Alzheimer Society of Canada	www.alzheimer.ca
Alzheimer Society of Ontario (for a listing of PRCs, etc.)	alzheimerontario.org
Canadian Coalition for Seniors' Mental Health (CCSMH)	www.ccsmh.ca
Canadian Mental Health Association	www.cmha.ca
Canadian Nurses Association (CNA)	www.cna-nurses.ca
College of Nurses of Ontario (CNO)	www.cno.org
Continuing Gerontological Education Cooperative.	www.fhs.mcmaster.ca/mcah.cgec
Ontario Psychogeriatric Association (OPGA)	www.opga.on.ca
P.I.E.C.E.S.	www.piecescanada.com
Regional Geriatric Programs of Ontario	www.rgps.on.ca
Registered Nurses' Association of Ontario (RNAO)	www.rnao.org/bespractices
Seniors' Health and Research Transfer Network (SHRTN)	www.shrtn.on.ca
Toronto Dementia Network	www.dementiatoronto.org
Vancouver Island Health Authority	www.viha.ca/ppo/learning/delirium/Tools.htm
Yale-New Haven Hospital	www.hospitalelderlifeprogram.org

Teaching Resources for Families and Friends of Residents

Below are some teaching resources for families and friends of residents who may have delirium, depression, and/or dementia. These teaching resources are not intended to be a comprehensive listing and there may be others available that have not been included. For information on other teaching resources, visit the website of the organizations/networks as listed in the previous page.

RNAO Health Education Fact Sheets

- Recognizing Delirium, Dementia and Depression
- Caring for Persons with Delirium, Dementia and Depression

The two health education fact sheets are available through the Registered Nurses' Association of Ontario. For more information, an order form or to download the health education fact sheets, visit www.rnao.org/bestpractices.

Vancouver Island Health Authority (VIHA)

- DVD on Delirium in the Older Person: A Medical Emergency
- Teaching tools including pamphlet on delirium for families and healthcare providers

To order the DVD, email MediaSales@viha.ca or visit www.viha.ca/ppo/learning, print the order form (PDF) and mail in. The teaching tools are available for free download from their website.

References

American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.

Borson, S., Scanlan, J., Brush, M. et al. (2000). The Mini-Cog: A Cognitive Vital Signs Measure for Dementia Screening in Multi-Lingual Elderly. *International Journal of Geriatric Psychiatry* ***15,*** 1021-1027.

Borson, S., Scanlan, J. M., Watanabe, J., Tu, S.-P. & Lessig, M. (2005). Simplifying detection of cognitive impairment: Comparison of the Mini-Cog and Mini-Mental State Examination in a multiethnic sample. *Journal of the American Geriatrics Society, 53*(5), 871-874.

Canadian Coalition for Seniors' Mental Health (CCSMH) (2006). *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behaviour Symptoms).* Toronto, Canada: Canadian Coalition for Seniors' Mental Health. [On-line]. Available: www.ccsmh.ca

Cohen-Mansfield, J. (1986). Agitated behaviours in the elderly II: Preliminary results in the cognitively deteriorated. *Journal of the American Geriatrics Society, 34*(10), 722-727.

Cohen-Mansfield, J., Marx, M. S., & Rosenthal, A. S. (1989). A description of agitation in a nursing home. *Journal of Gerontology, 44*, M77-M84.

Drance, E. (2005). Brief to the Senate Standing Committee on Social Affairs, Science and Technology. Vancouver, British Columbia, 2.

Health Canada (1999). Canada's Seniors. Ottawa, Canada: Division of Health and Aging [On-line]. Available: http://www.phac-aspc.gc.ca/senors-aines/pubs/factoids/1999/pdf/entire_e.pdf

Inouye, S. K., van Dyck, CH., Alessi, C. A., Balkin, S., Siegal, A. P., & Horowitz, R. I. (1990). Clarifying Confusion: The Confusion Assessment Method. A new method for detection of delirium. *Annals of Internal Medicine, 113*(12), 941-948

Ontario Psychogeriatric Association (OPGA) (2005). Basics of the 3D's.

PIECES Consultation Team (2005-2006). Putting the PIECES Together. Fifth Edition.

Rapp, C. G., & The Iowa Veterans Affairs Nursing Research Consortium (1998). Research-Based Protocol: Acute confusion/delirium. In M. G. Titler (Series Ed.). *Series on Evidence-Based Practice for Older Adults* (pp. 10-13). Iowa City, IA: The University of Iowa College of Nursing Gerontology Nursing Interventions Research Center, Research Dissemination Core.

Registered Nurses' Association of Ontario (2004). *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression.* Toronto, Canada: Registered Nurses' Association of Ontario.

Registered Nurses' Association of Ontario (2003). *Screening for Delirium, Dementia and Depression in Older Adults.* Toronto, Canada: Registered Nurses' Association of Ontario.

Rovner, B. W., German, P. S., Broadhead, J., Morriss, R. K., Brant, L. J., Blaustein, J. et al. (1990). The prevalence and management of dementia and other psychiatric disorders in nursing homes. *International Psychogeriatric, 2*(1), 13-24.

Smith, M. (2004). Commitment to Care: A Plan for Long-Term Care in Ontario. Toronto, Canada: Ministry of Health and Long-Term Care [On-line]. Available: http://www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_04/mohltc_report04.pdf

Sparks, M. (2001). Assessment and management of Alzheimer's disease. Medscape [On-line] Available: http://www.medscape.com/viewarticle/408

Vancouver Island Health Authority (2006). The 3D's. Comparison of Depression, Delirium, and Dementia.