



## Geriatric Delirium, Dementia and Depression Assessment Guide 2014

This guide provides a variety of tools to aid in the identification of delirium, dementia and depression.  
It is intended to be used as **part** of a comprehensive assessment

### Suggested approach to assessment:

1. **Conduct a general health assessment.**  
\*Suggested labs: UA, TSH, B12, CBC, chem 7, liver panel calcium, creatinine, glucose, HIV w/verbal consent documented
2. **Rule out delirium** for all patients with cognitive symptoms.
3. **Conduct assessment for suicidal thoughts** in all patients meeting criteria for depression.
4. **If unusual or atypical symptoms are present** (e.g., focal neurological symptoms, acute mental status changes):
  - a. Consider neuroimaging
  - b. Refer for specialty care



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DELIRIUM = PINK

DEMENTIA = YELLOW

DEPRESSION = BLUE

### DELIRIUM

The **CAM** (Confusion Assessment Method Diagnostic Algorithm)

**Delirium is diagnosed with the presence of feature 1 and 2, and either 3 or 4.**

**Feature 1: Acute Onset and Fluctuating Course**

Usually obtained from family member or caregiver: rapid change from baseline, and fluctuating severity during the day.

**Feature 2: Inattention**

Trouble with attention, being distractible, or having difficulty keeping track of what was said. **Example:** recite months of the year backwards.

**Feature 3: Disorganized Thinking**

Rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject.

**Feature 4: Altered Level of Consciousness**

Anything other than alert on scale of (Normal [alert], Vigilant [hyperalert], Lethargic [drowsy, easily aroused], Stupor [difficult to arouse], or Coma [unarousable]).

### Delirium - Additional Information

Also known as “Acute Brain Failure,” “Toxic-Metabolic Encephalopathy,” or “Acute Confusional State.”

- Delirium is a **medical condition** that causes a temporary problem with mental function.
- Delirium occurs **commonly** in **sick older adults**, in **hospital settings**, and in those with **pre-existing** cognitive problems, including a **history of dementia**.
- In the elderly, delirium is a **medical emergency** & often the presenting symptom of an underlying illness. Early diagnosis/treatment of the underlying condition offer the best chance of recovery.
- Marked by problems with **attention and concentration**, and shows a **waxing and waning course**; ( patients can seem normal at times).
- Consider delirium and work up potential causes of delirium in **ALL** cases of mental status change

**\*Most common medical causes:** metabolic disorders, infections, medications, hypoxemia, dehydration

**\*Most common medication causes:** anti-cholinergics, sedative hypnotics, opioids

Adapted from: Inouye SK, vanDyck CH, Alessi CA, Balkin S, Siegel AP, Horwitz RI. Clarifying confusion: The Confusion Assessment Method A new method for detection of delirium. *Ann Intern Med.* 1990;113:941-948. Confusion Assessment Method: Training Manual and Coding Guide, Copyright 2003, Sharon K. Inouye, M.D., MPH. Reprinted with permission.

## DEMENTIA: Assessment Tools ( Choose one or more as appropriate)

- Dementia represents a decline in cognitive abilities (e.g. memory, attention, language) and/or behavior.
- The decline must have a functional impact resulting in loss of independence in daily living activities.
- The most common causes of progressive dementia are Alzheimer’s Disease or Vascular injury. However, mixed etiology is common.
- Dementia is a diagnosis of exclusion; other causes of decline must be ruled out first.
- Brief cognitive tests can be useful to help identify possible dementia, and determine the need for further evaluation. Some examples include:

Mini-Cog: (see below for directions/scoring)

Montreal Cognitive Assessment (MoCA): [www.mocatest.org](http://www.mocatest.org)

St. Louis University Memory Status (SLUMS)  
<http://aging.slu.edu/pdfsurveys/mentalstatus.pdf>

For more info on VA-recommended brief cognitive tests visit:  
<http://vawww.mentalhealth.va.gov/mmse.asp>

### MINI-COG

1. Get the patient’s attention then say,  
**I am going to say three words that I want you to remember now and later.**  
**The words are:**  
**Banana Sunrise Chair. Please say them for me now.**

Give the patient 3 tries to repeat the words. If unable after 3 tries, go to next item.

2. Say all the following phrases in order,  
**Please draw a clock in the space below. Start by drawing a large circle.**  
When done, say, **Put all the numbers in the circle.**  
When done, say, **Now set the hands to show 11:10 (10 past 11).**

If subject has not finished clock drawing in 3 minutes, discontinue and ask for recall items.

3. **What were the three words I asked you to remember?**

**SCORING:** 1 point for each recalled word after the clock drawing test (no points for initial recall). Normal clock is 2 points; abnormal clock is 0 points. A normal clock has all of the following elements: all numbers 1-12, each only once, present in the correct order and direction (clockwise). Two hands are present, one pointing to 11 and one pointing to 2. Any clock missing any of these elements is scored abnormal. Refusal to draw a clock is scored abnormal.

**Total Score = 0-5 possible (3-item recall plus clock score)**

**0-2 = possible impairment; 3-5 suggests no impairment.**

**Abnormal clock = cognitively impaired**

**Normal clock= not cognitively impaired**

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**DEMENTIA Assessment, continued:**

**Dementia Warning Signs (DWS)**

DWS are ‘red flags’ or signs/symptoms a clinician, caregiver, or patient may notice. Use of DWS is recommended to prompt provider evaluation of cognition.

**Clinicians may notice:**

**Is Your Patient.....**

- Inattentive to appearance or unkempt, inappropriately dressed for weather or disheveled?
- A “poor historian” or forgetful?

**Does Your Patient.....**

- Fail to keep appointments, or appear on the wrong day or wrong time for an appointment?
- Have unexplained weight loss, “failure to thrive” or vague symptoms e.g., dizziness, weakness?
- Repeatedly and apparently unintentionally fail to follow directions e.g., not following through with medication changes?
- Defer to a caregiver or family member to answer questions?

**Patients or caregivers may report:**

- Asking the same questions over and over again
- Becoming lost in familiar places
- Not being able to follow directions
- Getting very confused about time, people & places
- Problems with self-care, nutrition, bathing or safety

For more information, visit: [www.prevention.va.gov/docs/0514\\_VANCP\\_Dementia\\_Fact\\_F.pdf](http://www.prevention.va.gov/docs/0514_VANCP_Dementia_Fact_F.pdf)

**Functional Activities Questionnaire (FAQ):**  
An informant-based measure of complex activities

**Scoring for each item:**

Dependent = **3**      Requires assistance = **2**  
 Has difficulty, but does by self = **1**      Normal = **0**  
 Never did (the activity), but could do now = **0**  
 Never did, but would have difficulty now = **1**

1. Writing checks, paying bills, balancing checkbook
2. Assembling tax records, business affairs or papers
3. Shopping alone for clothes, household goods, groceries
4. Playing a game of skill, working on a hobby
5. Heating water, making cup of coffee, turning off stove
6. Preparing a balanced meal
7. Keeping track of current events
8. Paying attention to, understanding, discussing a TV show, book or magazine
9. Remembering appointments, family occasions, holidays, medications
10. Traveling out of neighborhood, driving, taking buses

Sum scores to obtain total, which ranges from 0-30. Cut-off point of 9 (dependent in 3+ activities) suggests impaired function/possible cognition dysfunction

Pfeffer, R.I., Kurosaki, et al, 1982. *Measurement of functional activities in older adults in the community.* J Gerontology, 37(3), 323-329. Reprinted with permission of Oxford University Press.

**DEPRESSION**

Use These Assessment Tools:

**The PHQ-2 and The PHQ-9**

***A SUICIDE RISK EVALUATION REQUIRED WITHIN 24 HOURS IF:***  
**PHQ-2 total score is  $\geq 3$ . PHQ-9 total score is  $>10$**   
**OR**  
**Response to #9 is 1,2 or 3**

**PHQ-2**

A PHQ-2 total score of  $\geq 3$  merits completing the PHQ-9

Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	> Half the days	Nearly every day
1. Little or no interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3

**\*\*PHQ-2: A suicide risk evaluation is required within 24 hours if: A total score of 3 or greater.**

*If using Mental Health Assistant Software package, enter item score responses, total score and result.*

PHQ-2: Kroenke (2003) *MedCare* 41:1284.  
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**PHQ-9**

Use the same scoring and first two items as the PHQ-2, and the 7 other items in the PHQ-9:

3. Trouble falling asleep, staying asleep, or sleeping too much?
4. Feeling tired or having little energy?
5. Poor appetite or overeating?
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down?
7. Trouble concentrating on things such as reading the newspaper or watching television?
8. Moving or speaking so slowly that others could have noticed, or being so fidgety and restless that you have been moving around a lot more than usual?
9. Thinking that you would be better off dead or that you want to hurt yourself in some way?

*If using Mental Health Assistant Software Package, enter item score responses, total score and result.*

PHQ-9: Kroenke K, Spitzer RL, The PHQ-9: A depression and diagnostic severity measure, *Psychiatric Annals.* 2002, 32: pp. 509-21. Copy right © 1999 Pfizer Inc. All rights reserved. Reproduced with permission.

## DEMENTIA: Key Features in Delirium, Dementia & Depression

Feature	Delirium	Dementia	Depression
Onset	Acute	Gradual (years)	Gradual (weeks-months)
Course	Transient/reversible	Progressive/irreversible	Slowly fluctuating/reversible
Common Cognitive Deficit	Attention	Memory	Concentration
Consciousness	Fluctuations	Usually Normal	Normal
Hallucinations	Common	Less common early	Only if severely depressed
Agitation	Common	Less common early	Restlessness
Disorganized Thought	Common	Less common early	Rare
Speech	Sometimes slurred	Usually normal	Normal, slowed