COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

OLDER ADULT SERVICES DIVISION

GERIATRIC FIELD SCREENING PROTOCOL

The instruments have been complied to help you to determine If further evaluation is needed by the older adult under your are. *Instruments Are For Those Trained in Their Specific Use Only.*

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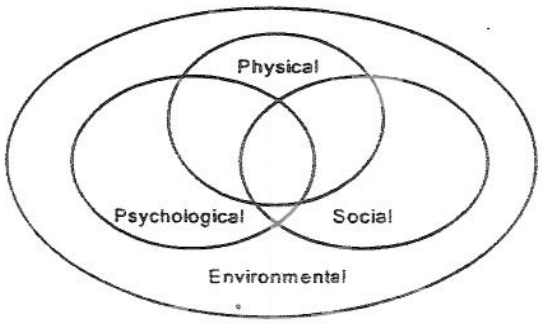
TIPS FOR INTERVIEWING OLDER ADULTS

- Consider that elders living alone may need and deserve reassurance that the stranger at the door is a provider.
- Use formal address when referring to older adult (Mr/Mrs Jones).
- Be aware of hearing and/or visual deficits that may interfere with interview.
- Eliminate background noises whenever possible and ensure client's comfort during the interview process.
- Slow down your speech and avoid technical terms/jargon.
- Address older adult directly. ASK THE OLDER ADULT, WHAT HE/SHE THINKS THE PROBLEM IS AND TYPE OF SERVICES WANTED/NEED.
- Be aware of non-verbal cues from client and family caregiver.
- Ask to see all over the counter and prescription medications. Record their names and how often taken.

- An older person's ability to manage may be influenced by his/her health, attitudes, cognitive skills, social skills and supports, financial status and/or environment.



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ELDER ADUSE AND NEGLECT

Note: All staff with direct client contact are Mandated Reporters

___ No Signs of Abuse or Neglect Evident

___ Self Neglect (Is considered to meet "Danger to Self" Criteria W & I Code 5150, as a result of mental disorder)
___ Financial Abuse or Theft
___ Physical Abuse (Deliberate Inappropriate Care, Direct Beating
___ Sexual Abuse
___ Abandonment
___ Isolation
___ Neglect
___ Psychological Abuse (Verbal Assault, Threats)

If possible determine factors associated with cause, such as:

___ Age or Frailty of Caregiver
___Caregiver Lack of Knowledge of Patient's Condition Failure to Give Care or Medicine Needed
___ Physical or Mental Illness of Caregiver
___ Lack of Support Systems for the Caregiver
___ Financial Difficulties

Suspected or Observed Physical, Sexual Abuse, Abandonment, Isolation, Financial Abuse, Neglect and Self Neglect MUST be reported to Adult Protective Services or Law Enforcement as soon as possible by phone and a written report submitted within 48 hours. (Psychological Abuse is a permissible report).

Los Angeles County Elder Abuse Hotline: (800) 992-1660
(Operates 24-hours a day)

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URGENT MEDICAL CLEARANCE RECOMMENDED, IF:

- Confusion and disorientation (perform MMSE and/or CAM)
- *Dementia and Delirium May Occur Separately or May Present Together.*
- Dizziness or trouble with balance and/or falls.
- Recent general weakness or trouble with right/ left-sided weakness.
- Chills or sweating.
- Coughing or difficulty breathing or speaking.
- Chest or abdominal pain.
- Nausea or vomiting.
- Urinary incontinence.
- Areas of tenderness, redness, swelling, and/or head trauma.
- Open sores.

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MINI-MENTAL STATE QUESTIONNAIRE

Approach the client with respect and encouragement.
Record client's years of school completed____
Ask: Do you have any trouble with your memory? __yes __no
Say: May I ask some questions about your memory? __yes __no

TIME ORIENTATION **Score (Max. Score)**
Ask: What is the Year__(1), Season__(1), Month__(1),
Date__(1), Day__(1) _____(5)

PLACE ORIENTATION
Ask: Where are we now? What is this State__(1),
City__(1), Part of City__(1), Building__(1), Floor __(1) _____(5)

REGISTRATION
Say: listen carefully. I am going say three words. You say them back after I stop. Ready? Here they are...PONY, QUARTER, ORANGE. What were those words?
Give 1 pt for each correct answer, then repeat them until the patient learns all three. _____(3)

ATTENTION & CALCULATION
Ask: Subtract 7 from 100 and continue to subtract 7 from each subsequent remainder until I tell you to stop.
What is 100 take away 7?__(1)
Say: Keep going__(1), __(1), __(1), __(1) _____(5)

RECALL OF THREE WORDS
Ask: What were the three words I asked you to remember?
Give one point for each correct answer__(1), __(1), __(1) _____(3)

NAMING
Ask: What is this? (show pencil) __(1).
What is this?(show watch) __(1) _____(2)

REPETITION
Ask: Now I am going to ask you to repeat what I say.
Ready? "No ifs , ands, or buts." Now you say that__(1) _____(1)

COMPREHENSION
Say: Listen carefully because I am going to ask you to do something. Take this paper in your hand __(1),
fold it in half __(1) , and put in on the floor __(1) _____(3)

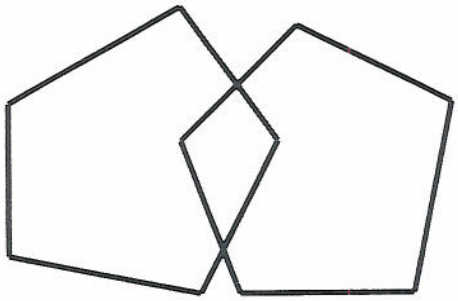
READING
Say: Please read the following sentence and do what it says, but do not say it out loud. __(1) _____(1)

CLOSE
YOUR EYES

WRITING
Say: Please write a sentence.
If pt does not respond, say: Write about the weather. _____(1)

DRAWING
Say: Please copy the design. _____(1)

Score_____(30)



Overall score of:
18-23 suggest MILD cognitive impairment AND
0-17 suggest MODERATE to SEVERE cognitive impairment .

CAUTION: further testing may be needed when client's are well educated or when family caregiver insist that there's a problem.

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DELIRIUM
CONFUSION ASSESSMENT METHOD (CAM)

I. ACUTE ONSET OR FLUCTUATING COURSE — NO YES

Is there evidence of an acute change in mental status from the patient's baseline? **Or**
Did the (abnormal) behavior fluctuate during the day, tend to come and go or increase and decrease in severity)?

II. INATTENTION — NO YES

Did the patient have difficulty focusing attention? (e.g. being easily distractible or having difficulty keeping track of what was being said).

III. DISORGANIZED THINKING — NO YES

Was the patient's thinking disorganized or incoherent (e.g. rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)

IV. ALTERED LEVEL OF CONSCIOUSNESS

Overall, how would you rate the patient's level of consciousness?
Alert ___

Vigilant (hyperalert) ___ Lethargic (drowsy, easily aroused) ___
Stupor (difficult to arouse) ___ Coma (unarousable) ___

Do any checks appear in the box ABOVE ? NO YES

The diagnosis of delirium is suggested with the presence of the first two criteria and either one of the third or fourth criteria.

RECENT CHANGES IN MENTAL STATUS REQUIRE URGENT MEDICAL ASSESSMENT

Inouye et al. "Clarifying confusion: the confusion assessment method." *Ann Intern Med. 1990; 113:941-948.* Reprinted with permission.

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SENSORY DEFICITS

Vision

Snellen Chart for gross visual acuity screening. May be helpful in determining severe visual deficits in older clients

COVERING ONE EYE AT A TIME
HOLD CARD IN GOOD LIGHT 14 INCHES FROM EYES
If Client Wears Glasses, Test Vision With Them On.

8 7 4	20/400
2 8 4 3	20/200
6 3 8 X O O	20/100
8 7 4 5 O X O	20/70
6 3 9 2 5 X O X	20/50
4 2 8 3 6 5 O X O	20/40

If visual acuity is less than 20/100 with glasses, if available, special attention should be given to prevent accidental tripping and assistance with reading should be offered. Record if client uses prescription glasses or other assistive devices.

Chandler, JM and Duncan, PW. *Geriatric Physical Assessment*, Mosby-Year Book (1993). Reprinted with permission.

Hearing

"Whisper" test. Record if client uses assistive devices.

Gait

"Get up and Go" test. Record if client uses assistive devices.

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GERIATRIC DEPRESSION SCALE (GDS) SHORT FORM

1. Are you basically satisfied with your life? YES NO
2. Have you dropped many of your activities and interests? YES NO
3. Do you feel that your life is empty? YES NO
4. Do you often get bored? YES NO
5. Are you in good spirits most of the time? YES NO
6. Are you afraid that something bad is going to happen to you? YES NO
7. Do you feel happy most of the time? YES NO
8. Do you often feel helpless? YES NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES NO
10. Do you feel you have more problems with memory than most? YES NO
11. Do you think it is wonderful to be alive now? YES NO
12. Do you feel pretty worthless the way you are now? YES NO
13. Do you feel full of energy? YES NO
14. Do you feel that your situation is hopeless? YES NO
15. Do you think that most people are better off than you are? YES NO

Score ___/15

One point for : NO on 1, 5, 7, 11,13 and YES on 2,3,4, 6,8, 9,10, 12, 14,15 *(Underlined Responses Indicates Depressed Answers)*

Normal score is 0-5; above 5 suggests depression.

The presence of depression requires a mental health assessment, including the potential need for antidepressant treatment.

Sheikh & Yesavage, Geriatric Depression Scale (Short Form)" *Clin Gerontol* 5:165 (1986). Reprinted with Permission.

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SUICIDE RISK ASSESSMENT

Note: Older Adults are the HIGHEST RISK group for completed suicides.

Are you feeling suicidal?

1. Have you or anyone you looked up to attempted/completed suicide?
2. Do you have a plan of how and when you would do it?
3. Do you have family, friends or others?

MODERATE Risk - 1 positive response. Requires a Mental Health Assessment. HIGH Risk - 2-3 positive responses. Requires an Urgent Mental Health Assessment and suicide precautions, including ensuring the presence of a caregiver at all times.

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ALCOHOL ABUSE (CAGE QUESTIONNAIRE)

1. Have you ever felt you should *cut* down on your drinking?
2. Have people *annoyed* you by criticizing your drinking ?
3. Have you ever felt bad or *guilty* about your drinking ?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (*eye-opener*)?

1 or more positive responses on this screen warrants a full diagnostic assessment for alcoholism.

Bush, B. et al. Screening for Alcohol abuse using the CAGE questionnaire. *Amer J of Med* (1987).

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ACTIVITIES OF DAILY LIVING (ADLs & IADLs)

PHYSICAL ADLs
- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Transfers
- ☐ Continence
- ☐ Feeding

Score___/6

INSTRUMENTAL (IADLs)
- ☐ Using the Telephone
- ☐ Shopping
- ☐ Food Preparation
- ☐ Housekeeping
- ☐ Laundry
- ☐ Transportation
- ☐ Taking Medicine
- ☐ Managing Money

Score___/8

These objective descriptors of client functioning range in score from a LOW of 0-1 indicating most independent to a HIGH of 6/8 indicating most dependent. Record date when client was last able to perform task independently and Function by Proxy (is someone else assisting client with task).

Lawton, E.B. Activities of daily living tests: Geriatric Considerations. *Phys & Occup Ther* (1980) . Katz et al. Studies of illness in the aged. *J AMA (1963)*.

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