

Identification of Agitated & Excessive Behaviours & Client-Centered Interventions

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Site Applicability

All VCH Residential Care sites

Practice Level

Basic Skills for all care staff

Policy Statements

- Goals; Client's history will be reviewed and observation of behaviours will occur on admission or a change in health status to identify contributing factors to agitation
- Clinical tools will be used to determine triggers and patterns of behaviour
- Common preventative measures will be implemented to reduce incidences of excessive behaviour.
- An individualized care plan will be developed by the team and implemented in a consistent manner.

Need to Know

Recognizing that all behaviours have meaning, and that individuals have patterns of behaviour, it becomes important for the interdisciplinary team to strive to identify the triggers of agitation in order to initiate preventative measures and appropriate interventions. An individualized care plan, implemented consistently by the care team, and taking into consideration environmental adaptations, supportive therapies, and pharmacotherapy, will assist in promoting a sense of well-being within the client.

Persons who present with cognitive impairments in later life often suffer from Dementia. "The percentage of Canadians over 65 years with dementia is 8% (1 in 13) and over 85 years is close to 35% (1 in 3)" (Canadian Study of Health & Aging Working Group, 1994). Agitation can occur "in as many as 70% to 90% of demented elderly nursing home patients, perhaps 50% of whom become frankly aggressive" (Gray, 2004, p. 69). Twenty percent (20%) of Canadians will personally experience a mental illness in their lifetime (Canadian Mental Health Association). Persons with Acquired Brain Injury (ABI) may have damage to one area of the brain (focal) or more than one area of the brain (diffuse) caused by stroke, trauma or anoxia. Some brain injuries are mild with symptoms disappearing over time while others are more severe and result in permanent disability. Younger adults are often affected as a result of a motor vehicle accident or trauma (University of Virginia Health Communication, 2006). An understanding of the impact of an injury, medical diagnosis including a history of mental health disorders, and the person's lifestyle routines will assist the interdisciplinary care team to implement meaningful, client-centered interventions.

This Clinical Practice Guideline (CPG) applies to clients who display anxiety, inner tension and other symptoms related to changes in memory, cognition and functional abilities often as a result of a Mild Cognitive Impairment (MCI), Dementia, Mental Health Disorder or an ABI. It is intended to promote client-centered care and therefore it is important for the members of the interdisciplinary team to get to know the client, attempt to identify the triggers of agitation, and implement individualized care measures to enhance the client's sense of well-being. Refer to Appendix C for *CPG Summary Flowchart*.

Goals include:

- To enhance the adult client's sense of well-being by identifying needs, internal/external triggers of agitation and developing individualized care plans to reduce discontent, irritation, or harm to the client or others.
- To provide knowledge, skills and tools for direct care staff to understand approaches and to use appropriate interventions that may prevent and/or minimize excessive behavior in the adult client.

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Equipment and Supplies

- Identification of Agitated & Excessive Behaviours CPG flowchart ([Appendix C](#))
- Identification of Behaviours and Guidelines for Interventions ([Appendix D](#))
- Behaviour Pattern Record ([Appendix E](#))
- Sleep Pattern Record ([Appendix G](#))
- Depression Scale ([Appendix H](#))
- Assessment of Cognitive Ability ([Appendix I](#))
- Personal Fact Sheet ([Appendix K](#))

Guideline

Standards of Care:

1. Client's health record will be reviewed for a history of agitation, excessive behaviours and mental health concerns as noted on the *Resident Assessment* or *Admission Assessment form*.
2. Any client with a record of repetitive restlessness, agitation or pattern of excessive behaviours will have an *Identification of Behaviours and Guidelines for Interventions* ([Appendix D](#)) completed by the staff member who best knows the client within 14 days of admission and as needed.
3. The *Behaviour Pattern Record* ([Appendix E](#)) will be initiated to identify triggers and patterns of agitation and/or excessive behaviour.
4. Summary of interviews with client/family will be documented in the *Progress Record*.
5. Summary of behaviour pattern tools with a description will be documented in *Progress Record*
6. Client's environment will be assessed and altered to promote a safe and calm atmosphere.
7. Supportive therapies, which promote positive interpersonal relationships and engagement, will be assessed and individualized interventions will be implemented before pharmacological interventions are introduced.
8. Only use neuroleptics for severe behavioural symptoms with documentation of targeted symptoms. (Canadian Coalition for Seniors' Mental Health, 2006, p36)
9. Medication ordered for an identified behaviour will be ordered as a regular dose, e.g. OD, BID, with p.r.n. for breakthrough.
10. The interdisciplinary team will develop an individualized Care Plan to promote security and comfort.

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Guidelines

A. Assessment

- includes history, collateral history, observation, and analysis (refer to Summary Flowchart - [Appendix C](#))

A.1 History

Current Diagnoses & Reason for Admission

- Medical history & status
- Chronic diseases, e.g. COPD, Diabetes, CVA, Arthritis, Viral Hepatitis
- History of Delirium (refer to Fraser Health North, CPG Assessment of and Interventions for Delirium)
- Medication profile
- Substance use and abuse, e.g. alcohol, street drugs, OTC medications
- Specialist referrals and results
- Current and past infections, e.g. UTI, HIV, TB, syphilis, respiratory
- Nutrition and fluid intake
- Persistent pain
- Skin condition
- Past and current psychiatric history, e.g. Acquired Brain Injury, diagnosis of Dementia, Delirium and/or Depression
- History of agitated or excessive behaviour
- Psychosocial history and interview with support persons
- Recent losses

Daily Patterns of Living

- Daily routine including likes and dislikes
- Mobility and Activities of Daily Living (ADL) aids, e.g. prosthetic, walker, cane, glasses, dentures
- Bowel and bladder pattern
- Sleep pattern
- Behaviour pattern
- Life story including life altering events, e.g. death, war, career changes
- Cultural milestones, e.g. baptism, religious traditions
- Work, volunteer, criminal history
- Coping abilities – past and present
- Important values and wishes, including the wish they hold dear to their heart

A.2 Collateral History

Review the following indicators with family, supports and care providers:

- Relationship with pertinent social supports
- Social and work interests, e.g. travel, career
- Completion of a social/personal history
- Cultural and spiritual beliefs and traditions
- Coping behaviours
- History of abuse
- Onset and duration of noted behaviours, strategies tried and their outcome

A.3 Observation

Consider using tools to track observations:

Identification of Behaviours and Guidelines for Interventions, ([Appendix D](#))

Behaviour Pattern Record ([Appendix E](#)) or *Client Observation Record*, ([Appendix F](#)); *Sleep Pattern Record*, ([Appendix G](#))

Observe, analyze and document:

1. Results of physical (head to toe) assessment
2. Benefits and adverse effects of medications
3. Facial expressions for affect, indicators of pain, anxiety, depression
4. Client's ability to be understood and to understand others
5. Personal factors: grooming, positioning, fatigue
6. Client's interpersonal relationships and impact on well being
7. Adaptation to present circumstances
8. Response to environment: lighting, noise, routines
9. Cognitive Assessment (Cognitive Performance Scale (CPS) and Assessment of Cognitive Abilities (Appendix I), other cognitive tests.
10. Refer to Fraser Health Persistent Pain CPG (2006), Fraser Health North Sleep Assessment and Interventions CPG (2003), and other applicable CPGs.

B. Analysis

Review *Identification of Behaviours and Guidelines for Interventions*. (Appendix B) to identify the noted behaviours and frequency.

- Note whether the behaviours are physical or verbal
- Review data collected on pattern tools *Behaviour Pattern Record* or *Client Observation Record* (Appendices [C](#) & [D](#)) and note:
 - 1) triggers leading to behaviour
 - 2) pattern of behaviour
 - 3) frequency
- Review & analyze other tools such as *Sleep Pattern Record* ([Appendix G](#))
- Use CPG Section 5.2 (Interventions) and Section 6.0 (Documentation) to develop *Care Plan* and guide documentation
- Communicate *Care Plan* to team members

C. Interventions

C.1 Common Preventative Measures

- Get to know the client as a person. Completion of a social history may be helpful. Refer to *Personal Fact Sheet* ([Appendix K](#))
- Actively listen to clients and their supports and validate concerns
- If sudden change in behaviour noted refer to Delirium CPG
- When communicating with client, position yourself at the same level as client
- Approach the client from the front and maintain eye contact
- One staff member at a time to speak with client in a calm manner
- DO NOT ARGUE with client; speak in a normal tone
- Maintain supportive stance when entering the client’s personal space (1.5 – 3 feet and 1 additional stride backwards)
- Respond to client’s concerns in a timely, consistent, and respectful manner
- Recognize and intervene early when the client is anxious – offer reassurance
- Implement measures to reduce physical irritations such as pain, dry or itchy skin
- Provide resident with choices
- Promote a calm, soothing and safe environment
- Involve client and supports in the development of a person-centered care plan
- Recognize your own values, feelings and responses to the client
- Develop consensus on approaches to client’s verbal and physical behaviours

C.2 Interventions

Verbal Behaviours

Physical Behaviours

Verbal Behaviours	Physical Behaviours
<p>Environment</p> <ul style="list-style-type: none"> - If the trigger of the behaviour is known, attempt to remove it and note client’s response - Alter environment to meet client’s personal needs, e.g. close to lounge, kitchen, nurses’ station, beside a window, bathroom - Comfortable chair to sit in, space for visitors - Client’s personal items within easy reach - Client able to see a calendar and other important items - Personalize client’s space to reflect important people and events in the client’s life - Provide a calming environment: consider client’s choice of music, whether they like a quiet or noisy environment, lighting to be bright or dim - Consider whether client likes to be with others or alone, roommate and visitors provide positive relationships - Implement consistent care plan to provide an environment that promotes the client’s abilities 	<p>Environment</p> <ul style="list-style-type: none"> - If the trigger of the behaviour is known, attempt to remove it, and note client’s response - Ensure staff safety by approaching the client from the front; speak to clients at their level and maintain eye contact - Maintain a supportive stance when speaking with client and remain 3 feet & an additional stride backwards - Respect client’s personal space - Place a ball, towel in client’s hands while providing care - Provide a soothing environment, lighting, music, quiet or noise level that the client likes - Cover the client as much as possible during care and provide warmth to promote relaxation, e.g. warm blanket - Provide care when client is relaxed and calm. If client is resistive to care withdraw and try later - Two persons to always provide care, one to maintain eye contact the other to provide care - Practice least restraint - Camouflage exit areas or place black grid on floor of entrance to area where you do not want the client to enter - Develop walking pathways

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<p>Social Supports</p> <ul style="list-style-type: none"> - Develop a consistent plan of care that will accommodate the client's key wish as well as visitors or events that promote the client's abilities - Speak in short, easily understood statements - Clarify the client's words and intent in order to decrease frustration - Do not speak over the client but with them in a conversational tone - Use non-verbal gestures to help clarify points - If necessary, initiate a talking board or book - If the client appears or expresses boredom and loneliness promote volunteer visitors or activities where they can participate appropriate to their abilities - Encourage rest periods to prevent fatigue - Inform team members of client's choices - Communicate when and how other persons and/or pets can support a positive relationship, e.g. spiritual leader in the a.m., spouse at dinner time - Communicate which activities and events support the client's well-being and build them into the Care Plan - When the client appears or expresses that they are agitated use a variety of techniques to validate the client's feelings and implement measures to promote calm and de-escalation. Examples might include: distraction by conversation, new physical location, touching an item, providing a warm blanket, pleasant odours, reminiscence - If the verbalization includes yelling or use of swear words that distress staff and others initiate a care conference with client input to develop an individualized care plan that will promote a positive living and working environment - Develop client-specific statements that staff consistently say in response to repetitive statements 	<p>Social Supports</p> <ul style="list-style-type: none"> - Develop a consistent care plan with input from the client and family - Inform staff and volunteers of potential for excessive physical behaviour - Care plan to assist visitors, volunteers and others to know when to visit and what activities might be appropriate during the visit - Guide visitors, supports, volunteers to observe for signs of agitation which may escalate and how to respond - Provide treasure/memory boxes to distract - Encourage exercise through out the day including walking/propelling a wheelchair - Activities to be meaningful for the client and appropriate to their abilities
<p>Pharmacology</p> <ul style="list-style-type: none"> - Review medication profile with pharmacist - Neuroleptics and adjunct medications may assist only some clients to reduce verbal outbursts and excessiveness as noted in Appendix B - Medications should be ordered as a regular dose medication according to the identified behaviour, e.g. OD, BID with p.r.n. for breakthrough - When a medication is ordered for an identified behaviour the dosage and schedule should be reviewed at least q1month - Sedatives should not be administered after 0100 hrs. 	<p>Pharmacology</p> <ul style="list-style-type: none"> - Review medication profile with pharmacist - Neuroleptics and adjunct medications may be indicated for physically excessive behaviour as noted in Appendix B - Medications should be ordered as a regular dose medication according to the identified behaviour, e.g. OD, BID with p.r.n. for breakthrough - When a medication is ordered for an identified behaviour the dosage and schedule should be reviewed at least q1month - Sedatives should not be administered after 0100 hrs.

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Patient/Client/Resident Education

- Discuss with client/family pathology of diagnosis and commonly displayed behaviours as well as stages of the condition, if applicable
- Identify and discuss goals of care to promote abilities of client and decrease harm to themselves and others
- Clearly outline to client and family all services that can be provided
- Involve client and family in development of *Care Plan*
- Provide client/family with education pamphlets
- Document client/family response to education
- Refer to community resources as appropriate e.g. Alzheimer Society
- Consult with ethical team if needed and available

Evaluation

- CPG Audit ([Appendix B](#)) will be completed as determined by the team
- Resident Care Family/Resident Surveys
- Admission and quarterly MDS assessments and RAPS/CAPS when triggered
- Provincial Residential Care Indicators for use of psychotropic medications

Client/Family Education

- Discuss with client/family pathology of diagnosis and commonly displayed behaviours as well as stages of the condition, if applicable
- Identify and discuss goals of care to promote abilities of client and decrease harm to themselves and others
- Clearly outline to client and family all services that can be provided
- Involve client and family in development of Care Plan
- Provide client/family with education pamphlets
- Document client/family response to education

Related Documents

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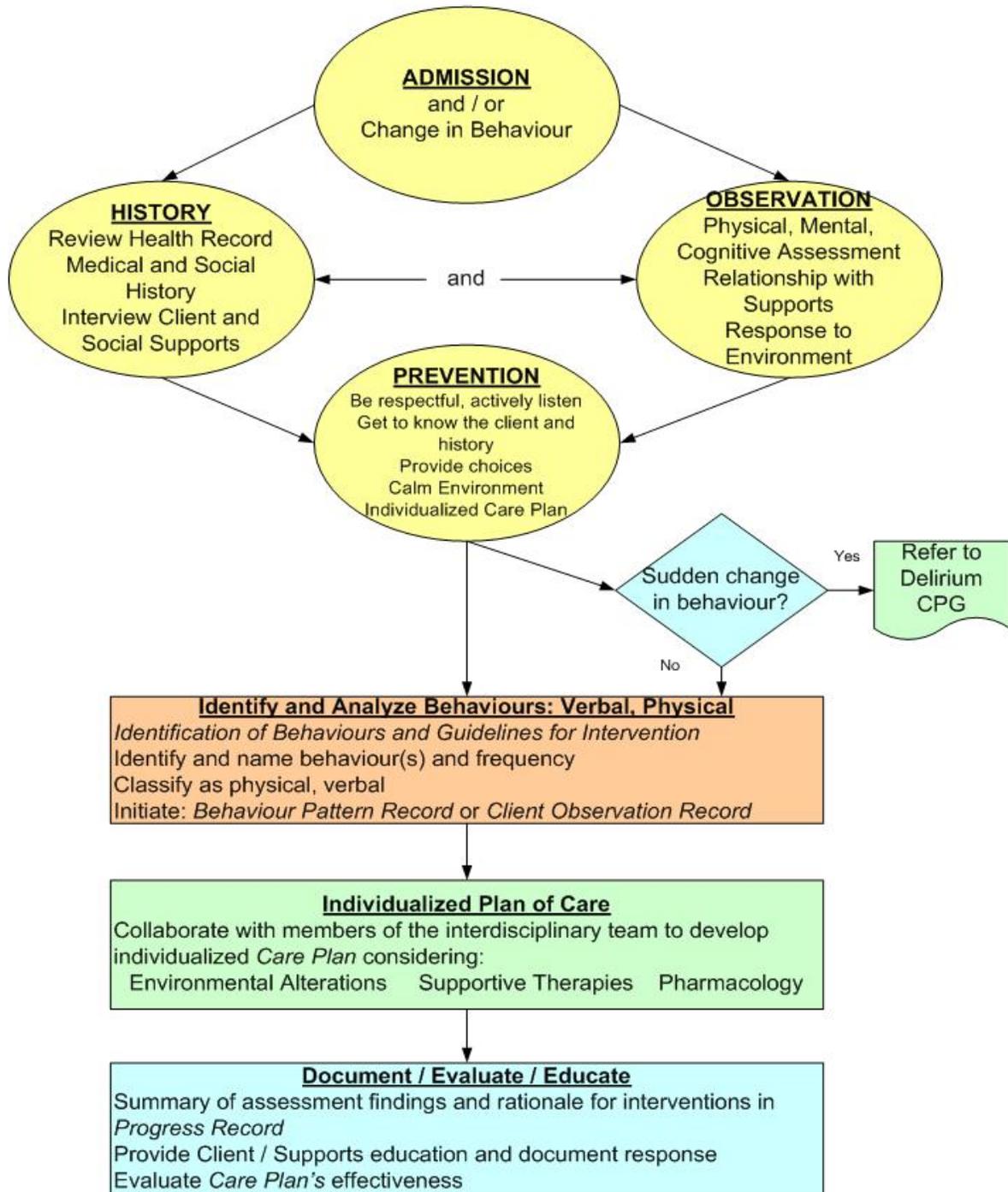
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APPENDIX A - Definitions

- 1 **ABC Model:** An Antecedent (or trigger) contributes to the Behaviour which results in a Consequence. Behaviour may be reinforced if attention is given to the person as the behaviour escalates (Cohen-Mansfield, 2003, p. 14).
- 2 **Acquired Brain Injury (ABI):** Damage to the brain that occurs after birth and is not related to a congenital disorder or a degenerative disease. Damage may be caused by a traumatic injury to the head or by a non-traumatic cause such as a tumor, aneurysm, anoxia or infection (Toronto Acquired Brain Injury (ABI) Network, 2006).
- 3 **Aggression:** Physical and/or verbal behaviours that are disruptive and/or pose a threat of physical harm to self or others (Worksafe BC, 2002).
- 4 **Agitation:** “A feeling of inner tension characterized by a cluster of related symptoms including anxiety and irritability, motor restlessness and abnormal vocalization. These symptoms are often associated with behaviours such as pacing, wandering, shouting and night-time disturbance” (Howard, Ballard, O’Brien & Burns, 2001, p. 714).
- 5 **Dementia:** A state of impaired memory with a loss of other cognitive abilities or change in personality that is persistent and interferes with previously achieved levels of social or occupational function (American Psychiatric Association, 2000; Geldmacher, 2004b).
- 6 **Environmental Press:** Stimulation in the environment which may contribute to inner tension, a sense of being overwhelmed or out of control. It is related to the individual’s ability to cope/manage the stimulation or press in the environment (Dawson, Wells & Kline, 1993).
- 7 **Excessive Behaviour:** Behaviours leading to discontent in a resident and/or causing irritation or harm to others including other residents, visitors or interdisciplinary team members. Behaviour may be inappropriate due to intensity, frequency, or the context in which it is exhibited (Gray, 2004; King, 1997).
- 8 **Mental Health Disorder:** Term used interchangeably with mental illness. A broad term for large categories of mental disorders such as mood disorders, anxiety disorders, schizophrenia, eating disorders, personality disorders, substance use disorders and addictions, and Alzheimer’s disease and related dementia (BC Partners for Mental Health and Addictions, 2006).
- 9 **Mild Cognitive Impairment (MCI):** Mild, repeated memory loss lying between the normal memory loss of aging and the more serious conditions of dementia and Alzheimer’s Disease (AD). MCI only involves problems with memory (Rosenblum, 2006).
- 10 **Need Driven Behaviour (NDB):** Behaviour related to the inability of the client to make needs known; an attempt by the person to communicate physical or psychological distress when faced with unmet needs, e.g. resisting movement due to pain, calling out related to stressful and overwhelming environment (Kovach, Noonan, Schildt & Wells, 2005).
- 11 **Protective Behaviour:** Related to the need to protect one’s dignity, integrity and body from a perceived threat. “The response focuses on the resident’s perspective of fear and the drive for self-protection” (Talerico & Evans, 2000).

APPENDIX C – CPG Flowchart

CPG SUMMARY FLOWCHART
Identification of Agitated & Excessive Behaviours
and Client-Centred Interventions
Clinical Practice Guideline



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APPENDIX D – Identification of Behaviours & Guidelines for Interventions

Data to be summarized in Progress Record

Frequency	Several times an	Once or twice a day	Several Times a	Less : once a week	Interventions
Mark an X in the column					Review Interventions below and choose appropriately for the client
Verbal Behaviours					Interventions for Verbal Excessive
Repetitive sentence/questions					<ol style="list-style-type: none"> 1. Name & state frequency of behaviour 2. Initiate <i>Behaviour Pattern Record</i> or <i>Client Observation Record</i> or screen for Delirium (refer to FH North Assessment of and Interventions for Delirium CPG) 3. Assess for pain, constipation, itchy skin, need for toilet 4. Assess tolerance for environmental press 5. Speak in short simple statements 6. Validate feelings, clarify meaning of their words 7. set limits 8. Encourage consistent visitors and times of visits 9. Neuroleptics & adjunct meds may assist some clients to reduce verbal outbursts
Making noises: crying, moaning, grinding teeth					
Complaining: somatic complaints, repetitive complaints					
Negativism: nothing is right					
Verbal sexual advances; sexually explicit talk					
Constant unwarranted requests for attention/help					
Screaming					
Swearing, verbal anger, criticisms					
Physical Behaviours					Interventions for Physical Excessive
Pacing or aimless wandering					<ol style="list-style-type: none"> 1. Name & state frequency of behaviour 2. Initiate <i>Behaviour Pattern Record</i> or <i>Client Observation Record</i> or screen for Delirium (refer to FH North Assessment of and Interventions for Delirium CPG) 3. Ensure staff safety: remain 3 feet and 1 additional stride backward, supportive stance 4. If client is resistive to care withdraw & try later 5. Assess for pain, constipation, need for toilet 6. Develop and implement consistent schedule 7. Provide meaningful activities and distractions 8. Develop team consensus on approaches to client 9. Consistent team response to behaviours 10. Clients demonstrating physical excessive behaviours may benefit from a neuroleptic or adjunct medication 11. Regular dosage as well as a p.r.n. dose
Trying to get to a different place					
Handling things: moving furniture					
Hiding things/hoarding					
Eating/drinking inappropriate substances					
General restlessness: fidgeting					
Resists or refuses care					
Performing repetitive mannerisms					
Hitting (including self)					
Kicking					
Grabbing / pushing people or things					
Making physical sexual advances					
Spitting, scratching					
Destroying property					

Adapted from Cohen – Mansfield Agitation Scale. Cohen-Mansfield, J. & Libin, A. (2004). Assessment of agitation in elderly patients with dementia: correlations between informant rating and direct observation. *International Journal of Geriatric Psychiatry*, 19:881-891.

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Data to be summarized in Progress Record

APPENDIX E – Behaviour Pattern Record

(See CPG Section 5.1.4 for review & analysis)

When	What What behaviour was observed? <i>Refer to Identification of Behaviour</i>	Where Where did the behaviour occur? BR, DR, beside bed	Why What was happening just before behaviour occurred? Who else was present? Unusual noises?	How What interventions were used? How were interventions implemented?	Outcome and suggestions for future Care Planning How did the client respond?
Date: Time: Initial's:					

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APPENDIX F – Client 7 Day Observation Record *Data to be summarized in Progress Records*

Use corresponding numbers to record in ½ hour intervals

Examples of Verbal Excessive Behaviour	Example of Excessive Physical	Other	Analyze the coded entries to determine if there is a pattern with identified triggers
1. Repetitive	5. Pacing	9.	
2. Making Noise	6. Striking out	10.	
3. Constant groaning	7. Restlessness	11.	
4. Swearing	8. Resists Care	12.	

Y/M/D							
Time							
0730							
0800							
0830							
0900							
0930							
1000							
1030							
1100							
1130							
1200							
1230							
1300							
1330							
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1600							
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1900							
1930							
2000							
2030							
2100							
2130							
2200							
2230							
2300							
2330							
2400							
0030							
0100							
0130							
0200							
0230							

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0300							
0330							
0400							
0430							
0500							
0530							
0600							
0630							
0700							

Adapted from P.I.E.C.E.S. program

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APPENDIX G Sleep Pattern Record

Connect the dots to indicate awake or asleep for the full 24 hours. Each dot represents a 15-minute interval.

When agitated or restless indicate with an asterisk (*).

(See CPG Section 5.1.4) *Data to be summarized in Progress Record*

	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700
Date:																								
Asleep
Awake
Date:																								
Asleep
Awake
Date:																								
Asleep
Awake
Date:																								
Asleep
Awake
Date:																								
Asleep
Awake
Date:																								
Asleep
Awake

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APPENDIX H - THE GERIATRIC DEPRESSION SCALE (GDS) – SHORT FORM

Choose the best answer for how you felt over the past week	Please Circle One	
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 staying at home to going out and doing new things?	YES	NO
10. Do you feel you have more problems with memory than most people?	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?	YES	NO

Scoring: A score of 0-5 is normal.

A score of 5 suggests depression.

One point for each of the following answers:

- | | | | |
|--------|--------|---------|---------|
| 1. NO | 5. NO | 9. YES | 13. NO |
| 2. YES | 6. YES | 10. YES | 14. YES |
| 3. YES | 7. NO | 11. NO | 15. YES |
| 4. YES | 8. YES | 12. YES | |

RESIDENTIAL CARE

Addressograph

APPENDIX I - The assessment of cognitive ability

Simon Fraser Health Area

Date: _____

Review

Initial

Mini-Mental State Examination (MMSE)

Maximum
Score

Score

The MMSE is a 30-point scale designed to assess a patient's cognitive performance in a clinical setting. It assesses orientation, attention, memory, and language.

ORIENTATION

5 _____ What is the (year) (season) (date) (day) (month)?

5 _____ Where are we: (province) (country) (town or city) (hospital) (floor)?

REGISTRATION

3 _____ Name 3 common objects (e.g., "apple", "table", "penny")

Take 1 second to say each. Then ask the patient to repeat all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Make a maximum of 6 trials and record. Trials: _____

ATTENTION AND CALCULATION

5 _____ Spell "world" backwards. The score is the number of letters in correct order (D_L_R_O_W_)

[Note: Instead of "world", the following may be used – subtract 7 from 100 and keep subtracting 7 from the result until you tell him/her to stop.]

RECALL

3 _____ Ask for the 3 object repeated above. Give 1 point for each correct answer.

[Note: Recall cannot be tested if all 3 objects were not remembered during registration.]

LANGUAGE

2 _____ Name a "pencil," and a "watch." (2 points)

1 _____ Repeat the following: "No ifs, ands, or buts." (1 point)

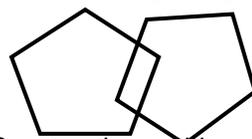
3 _____ Follow a 3-stage command: "Take a paper in you right hand, fold it in half, and put it on the floor." (3 points)

READ AND OBEY THE FOLLOWING:

1 _____ Close your eyes. (1 point)

1 _____ Write a sentence. (1 point)

1 _____ Copy the following design. (1 point)



No Construction problem

Total Score _____

Adopted from Fraser Health

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APPENDIX J - Instructions for Cognitive Assessment

Resident: _____

Instructions for Administering the Mini-Mental State Examination (MMSE)

- Orientation**
1. Ask for the date. Then ask specifically for parts omitted, e.g., “Can you also tell me what season it is?” Score one point for each correct answer.
 2. Ask in turn: “Can you tell me the name of this hospital?” (town, country, etc.) Score one point for each correct answer.
- Registration**
- Ask the patient if you may test his/her memory. Then say the names of 3 unrelated objects, clearly and slowly, about one second for each. After you have said all 3, ask him/her to repeat them. This first repetition determines his/her score (0-3) but keep saying them until he/she can repeat all 3, up to 6 trials. If all 3 are not eventually learned, recall cannot be meaningfully tested.
- Attention and Calculation**
- Ask the patient to spell the word “world” backwards. The score is the number of letters in correct order (e.g., DLROW = 5 DLRW=4 DLW=3 OW=2 LDRWO=1).
- Recall**
- Ask the patient if he/she can recall the 3 words you previously asked him/her to remember. Score 0-3.
- Language**
- Naming:** Show the patient a wristwatch and ask him/her what it is. Repeat for a pencil. Score 0-2.
- Repetition:** Ask the patient to repeat the sentence after you. Allow for one trial. Score 0 or 1.
- 3-stage command:** Give the patient a piece of plain blank paper and repeat the command. Score 1 point for each part correctly executed.
- Writing :** Give the patient a blank piece of paper and ask him/her to write a sentence for you. Do not dictate a sentence; it is to be written spontaneously. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.
- Copying:** On a clean piece of paper, draw intersecting pentagons, each side about 1 in., ask him/her to copy it exactly as it is. All 10 angles must be present and 2 must intersect to score 1 point. Tremor and rotation are ignored.

APPENDIX K - Personal Fact Sheet

<div style="text-align: center;">  <h3>Personal Fact Sheet</h3> </div> <p>Take a minute to get to know me! Much like you, my life has been filled with challenges, joys, sorrows, laughter and all sorts of adventures!</p> <p>Although I have difficulty expressing my memories of past years, I would love to share them with you. Here are some facts about my life which will help us visit and enjoy our time together.</p> <p>Thank you for bringing my world back to me.</p> <p>Name: _____</p> <p>Place of birth (village, city, country): _____</p> <p>Other places I called home: _____</p> <p>My parents were: _____</p> <p>Brothers & sisters (older/younger): _____</p> <p>Favorite pets (child/adulthood): _____</p> <p>Favorite pastimes (books, authors, music, instrument/song, sports, teams, special skills): _____</p> <p>I married _____ on _____ at (location) _____</p> <p>In our life, we enjoyed the following together: _____</p> <p>Our family included (names & birthdays of children or significant persons): _____</p>	<p>Today, I enjoy talking about: _____</p> <p>I enjoy using (list physical activity prop which elicits responsiveness): _____</p> <p>I enjoy looking at (name book or pictures preferred): _____</p> <p>My preferred Discover Kit to reminisce with is the: _____</p> <p>If we can sit together and read, I prefer: Poetry: _____ The newspaper (list preferences): _____ Humorous shorts: _____ Specific personal preference: _____</p> <p>I would enjoy a snack or beverage while we visit (state preference): _____</p> <p>Other points to ponder while preparing to visit might include: _____</p> <p>N.B. be sure to list family losses or cautionary areas to be sensitive to individual's emotional, physical or other personal needs.</p> <p>Discovering Adventure in Special Care/Rosemary Dunne/June 1995.</p> <p><small>Geriatric Psychiatry Programs Fraser Health Residential Services 2006. Reproduced with permission from Geropsychiatric Education Programs Vancouver Coastal Health</small></p>
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This Clinical Practice Guideline (CPG) was initiated developed by Fraser Health and since been reviewed, and adopted by the Vancouver Coastal Residential Complex Working Group.