Appendix 1. Cognitive Assessment of Older People

(including assessment of depression)

The 6CIT test:

What year is it? - Score 0 if correct, score 4 if incorrect.
What month is it? - Score 0 if correct, or 3 if incorrect.

Give an address to remember with 5 components e.g. John Brown, 42 West Street, Kensingston

About what time is it? - Score 0 if correct (within 1 hour), or 3 if incorrect
Count backwards from 20 to 1 - Score 0 if correct, score 2 if 1 error, score 4 if >1 error.
Say the months of the year in reverse? Score 0 if correct, score 2 if 1 error, score 4 if >l error

Recall the name and address - Score 2 if 1 error, 4 if 2 errors, score 6 if 3 errors, 8 if 4 errors, score 10 if all wrong.

Total score = 28. A score of up to 7 is normal, with 8 or more being suggestive of dementia

GPCOG

Firstly, ask the patient to remember the following name and address: *John Brown, 42 West Street, Kensingston*

Time orientation: What is the date (score 1 if exact, score 0 if any errors)

Clock drawing: Use a blank page and get the patient to draw a clock including all the hours shown by numbers. (Score 1 if correct spacing, score 0 if not the case)

Hands of the clock: Please mark in the hands to show the time as ten minutes past 11 o'clock (Score 1 if correct, score 0 if not the case)

Tell me something that happened in the news recently: (Score 1 if specific answer given, score 0 if not the case. "War" or "a lot of rain" do not score, as answers like that are too vague. However if the patient was able to give details when prompted, then a score could be awarded).

Recall: of the address given earlier. Each item scores one point, maximum score being 5

John (1) Brown (1) 42 (1) West (or West St) (1) Kensington (1)

Total maximum would be 9. If scores 9, no impairment and no further tests needed. If 5 – 8, more info needed from carer (see below). If 0 – 4, cognitive impairment is diagnosed.

GPCOG Carer Interview

Complete this if GPCOG score is intermediate, i.e. score 5 – 8. Ask the carer/informant to compare the patient to when he/she was well, say five to ten years ago. Answers to each question will either be

- "yes" (Score = 0) or
- "no", "don't know" or N/A (Score = 1)

Does he/she have more trouble remembering things that have happened recently, than he/she used to?

Does he/she have more trouble recalling conversations a few days later?

Does he/she have more difficulty find the right words to say, or use the wrong words more often?

Is he/she less able to manage money and financial affair (bills, budgeting)?

Is he/she less able to manage medication independently?

Does he/she need more assistance with transport (either private or public? (NB if there is a physical reason for this, e.g. osteoarthritis, then score as "No")

A high number of "yes" answers indicates that the carer has noticed signs of cognitive impairment. If the score is 0 – 3, consider cognitive impairment diagnosed.

PH2 Test for Depression

"***Over the last two weeks, how often have you been bothered by any of the following problems:***

- ***Little interest or pleasure in doing things***
- ***Feeling down, depressed, or hopeless?"***

For each option the respondent chooses from

- "not at all" (score 0),
- "several days" (1),
- "more than half the days" (2), or
- "nearly every day" (3).

Total score = 6. A score of ≥3 suggests depression.

Geriatric Depression Scale

"Choose the best answer for how you have felt over the last week…"

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?	**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 think 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 most people are better off than you are?	**Yes**/no

Answers in **Bold** indicate depression. Score 1 point for each bolded answer.

Score > 5 points in total suggests depression. This would warrant a follow-up comprehensive assessment.

Score > or = 10 almost always indicates depression

[Expert reviewer's comment on this appendix: Personally I really dislike the Geriatric Depression Scale, and feel a general conversation can be better. It really is dire to go through some of these gloomy questions, with someone who is clearly down. However it is well-recognised - so should be in this module.

The PH2 is shorter, and in my experience is easier to include in a consultation.]

(label)

Patient name:

Date of birth:

Patient number:

……

Date: **Time:**

Tester:

The 4A Test: screening instrument for cognitive impairment and delirium

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores < 7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	**0**
Yes	**4**

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE ☐

GUIDANCE NOTES Information and download: www.the4AT.com

The 4AT is a screening instrument designed for rapid and sensitive initial assessment of cognitive impairment and delirium. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. Items 1-3 are rated *solely on observation of the patient at the time of assessment.* Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the full AMT if done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?" In general hospital settings psychotic symptoms most often reflect delirium rather than functional psychosis (such as schizophrenia).