Saint Louis University
Geriatric Valuation
Nemonics and Screening Tools
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Division of Geriatric Medicine
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JOSEPH H. FLAHERTY, M.D.
NINA TUMOSA, PH.D.
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**INTRODUCTION**

Mnemonics have long been used as memory aids (especially to assist people in passing examinations). The mnemonics here have been developed because of the often complex and multifactorial nature of illnesses and syndromes in the elderly and the time constraints of the present health care environment.

These mnemonics are intended to assist the clinician in developing differential diagnoses, risk assessments, or evaluation and management plans for common geriatric problems. These mnemonics will also enable the clinician to do this in a quick, yet comprehensive manner.

The screening tools have been chosen to complement the problems, syndromes, and illnesses that are covered by the mnemonics.
Saint Louis University Division of Geriatrics

Passport to Aging Successfully*

Please complete this questionnaire before seeing your physician and take it with you when you go.

NAME ____________________________ AGE ____________

BLOOD PRESSURE laying down: ________ standing: ________

WEIGHT now: ________ 6 months ago: ________ change: ________

HEIGHT at age 20: ________ now: ________

CHOLESTEROL LDL: ________ HDL: ________

VACCINATIONS ☐Influenza (yearly) ☐Pneumococcal ☐Tetanus (every 10 years)

TSH Date: ____________ FASTING GLUCOSE Date: ____________

Do you SMOKE? ________

How much ALCOHOL do you drink? ________ per day

Do you use your SEATBELT? ________

Do you chew TOBACCO? ________

EXERCISE: How often do you...

do endurance exercises (walk briskly 20 to 30 minutes/day or climb 10 flights of stairs) ________/week

do resistance exercises? ________/week do balance exercises? ________/week

do posture exercises? ________/week do flexibility exercises? ________/week

Can you SEE ADEQUATELY in poor light? ________

Can you HEAR in a noisy environment? ________

Are you INCONTINENT? ________

Have you a LIVING WILL or durable POWER OF ATTORNEY FOR HEALTH? ________

Do you take ASPIRIN daily (only if you have had a heart attack or have diabetes)? ________

Do you have any concerns about your PERSONAL SAFETY? ________

When did you last have your STOOL TESTED for blood? ________

When were you last screened for OSTEOPOROSIS? ________

Are you having trouble REMEMBERING THINGS? ________

Do you have enough FOOD? ________

Are you SAD? ________

Do you have PAIN? ________

If so, which face best describes your pain?

[Smiley faces from 0 to 5]

Do you have trouble passing urine? ________

Have you discussed PSA testing with your doctor? ________

What is your ADAM score? ________

When was your last pap smear? ________

When was your last mammogram? ________

Do you check your breasts monthly? ________

Are you satisfied with your sex life? ________

* This questionnaire is based on the health promotion and prevention guidelines developed by Gerimed® and Saint Louis University Division of Geriatric Medicine.
Aging Successfully

A Guide to Health Promotion over the Life Span

PRIOR TO BIRTH

1. Choose long-lived parents
2. Have your mother get regular check-ups during pregnancy
3. Have your mother not smoke or drink alcohol
4. Have your mother take pre-natal vitamins including folate.

0-20 YEARS

1. Exercise regularly
2. Avoid obesity
3. Ingest adequate calcium
4. Eat nutritious foods
5. Wear your seatbelt
6. Do not smoke or drink
7. Get your vaccinations
8. Avoid violence and illicit drugs

20-40 YEARS

1. Exercise regularly
2. Avoid obesity
3. Ingest adequate calcium
4. Eat fish
5. Wear your seatbelt
6. Drink in moderation and do not smoke
7. Avoid violence and illicit drugs
8. Check your breasts regularly (females)

80+

1. Exercise regularly, including balance and resistance exercises
2. Avoid weight loss
3. Ingest adequate calcium
4. Be screened for osteoporosis
5. Wear your seatbelt
6. Drink in moderation and do not smoke
7. Have your blood pressure checked
8. Do monthly breast self-exams
9. Have flu and pneumococcal vaccinations
10. Safety-proof your home to prevent falls. If you are unsteady, use a cane and consider hip protectors
11. Have regular mental activity. Socialize, and avoid being depressed.
12. Avoid taking too many medicines
13. Keep doing what you are doing. Remember, most of your physicians won’t reach your age!

0-20 YEARS

1. Exercise regularly
2. Avoid obesity
3. Ingest adequate calcium
4. Eat nutritious foods
5. Wear your seatbelt
6. Do not smoke or drink
7. Get your vaccinations
8. Avoid violence and illicit drugs

20-40 YEARS

1. Exercise regularly
2. Avoid obesity
3. Ingest adequate calcium
4. Eat fish
5. Wear your seatbelt
6. Drink in moderation and do not smoke
7. Avoid violence and illicit drugs

8. Check your breasts regularly (females)
Aging Successfully

Successful Nutrition Over the Lifespan

40-60 Years

1. Exercise regularly
2. Avoid obesity
3. Ingest adequate calcium and vitamin D
4. Eat fish
5. Wear your seatbelt
6. Drink in moderation and do not smoke
7. Have your blood pressure checked
8. Get your cholesterol and glucose checked
9. Screen for breast and colon cancer, high blood pressure, osteoporosis, and diabetes
10. Have Pap smears (females)
11. Have regular mental activity and socialize!
12. Avoid taking too many medicines
13. Consider hormone replacement (men)

60-80 Years

1. Exercise regularly, including balance and resistance exercises
2. Avoid weight loss
3. Ingest adequate calcium and vitamin D
4. Eat fish
5. Wear your seatbelt
6. Drink in moderation and do not smoke
7. Screen for breast and colon cancer, high blood pressure, osteoporosis, and diabetes
8. Get your cholesterol checked
9. Have flu and pneumococcal vaccinations
10. Have Pap smears (females)
11. Have regular mental activity and socialize!
12. Avoid taking too many medicines

80+

1. Exercise regularly, including balance and resistance exercises
2. Avoid weight loss
3. Ingest adequate calcium and vitamin D
4. Be screened for osteoporosis
5. Wear your seatbelt
6. Drink in moderation and do not smoke
7. Have your blood pressure checked
8. Do monthly breast self-exams
9. Have flu and pneumococcal vaccinations
10. Safety-proof your home to prevent falls. If you are unsteady, use a cane and consider hip protectors
11. Have regular mental activity. Socialize, and avoid being depressed.
12. Avoid taking too many medicines
13. Keep doing what you are doing. Remember, most of your physicians won't reach your age!
CAGE QUESTIONNAIRE FOR ALCOHOLISM*

Ever felt the need to cut down on your drinking?

Yes/No

Ever felt annoyed by criticism of your drinking?

Yes/No

Ever felt guilty about your drinking?

Yes/No

Ever take a morning drink (eye-opener)?

Yes/No

*Two affirmative answers may be suggestive of alcoholism.

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**Hemorrhages**

- **H** epatic or renal disease 1
- **E** thanol abuse 1
- **M** alignancy 1
- **O**lder (age >75 years) 1
- **R** educed platelet count or function 1
- **R** e-bleeding **R**isk 2
- **H** ypertension (uncontrolled) 1
- **A** nemia 1
- **G** enetic factors 1
- **E** xcessive fall risk 1
- **S** troke 1

**TOTAL SCORE**

Scoring:
Risk of Hemorrhage: With each additional point, the rate of bleeding per 100 patient-years of warfarin increases:

- 1.9 (0.6-4.4) for 0
- 2.5 (1.3-4.3) for 1
- 5.3 (3.4-8.1) for 2
- 8.4 (4.9-13.6) for 3
- 10.4 (5.1-18.9) for 4
- 12.3 (5.8-23.1) for ≥ 5

Anticoagulation

CHADS$_2$
Risk of Stroke for People with Atrial Fibrillation if Warfarin* Not Used

- **C** ongestive heart failure 1
- **H** ypertension 1
- **A** ge 75 or older 1
- **D** iabetes 1
- **S** troke or TIA in the past 2

TOTAL SCORE

Risk of stroke: With each additional point, the rate of stroke per 100 patient-years without antithrombotic therapy (i.e., the use of aspirin instead of warfarin) increases:

- 1.9 (95% CI, 1.2-3.0) for a score of 0;
- 2.8 (95% CI, 2.0-3.8) for 1;
- 4.0 (95% CI, 3.1-5.1) for 2;
- 5.9 (95% CI, 4.6-7.3) for 3;
- 8.5 (95% CI, 6.3-11.1) for 4;
- 12.5 (95% CI, 8.2-17.5) for 5;
- 18.2 (95% CI, 10.5-27.4) for 6.


*For calculating warfarin dosing, see www.warfarindosing.org.
CAUTION
Cancer Warning Signs

C hange in bowel or bladder habits
A sore that does not heal
U nusual bleeding or discharge
T hickening or lump in breast or elsewhere
I ndigestion or difficulty in swallowing
O bvious change in wart or mole
N agging cough or hoarseness
**SIMPLE SCREEN FOR DEHYDRATION**

- D rugs, *e.g.*, diuretics
- E nd of life
- H igh fever
- Y ellow urine turns dark
- D izziness (orthostasis)
- R educed oral intake
- A xilla dry
- T achycardia
- I ncontinence (fear of)
- O ral problems/sippers
- N eurological impairment (confusion)
- S unken eyes

ACUTE CHANGE IN MS
Medications that can Cause or have been Reported to Cause an Acute Change in Mental Status

A ntiparkinson’s drugs
C orticosteroids
U rinary incontinence drugs
T heophylline
E mptying drugs

C ardiovascular drugs
H$_2$ blockers
A ntibiotics
N SAIDs
G eropsychiatry drugs
E NT drugs

I nsomnia drugs
N arcotics

M uscle relaxants
S eizure drugs

1 E.g., metoclopramide, compazine.
2 In particular, centrally-acting drugs (e.g., clonidine), digoxin, some antiarrhythmics.
3 Particularly for patients with renal insufficiency because these drugs are renally excreted.
4 Although not a common cause of mental status change, several antibiotics have been reported in the literature in the form of case reports.
5 Also not common, but case reports exist.
6 A large category because, in general, most of these are centrally-acting.
7 Some are worse than others. In general, non-sedating antihistamines are probably safe, but combination drugs are risky.
8 Beware of over-the-counter sleeping agents. Most contain diphenhydramine.
9 Usually only seen with acute use, not chronic. Meperidine (Demerol) not recommended in the elderly.
10 These are centrally-acting, not locally at muscles.

Mental Status: DELIRIUM

CAM
The Confusion Assessment Method Diagnostic Algorithm

Feature 1: Acute Onset and Fluctuating Course
This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient’s baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: Inattention
This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: Disorganized thinking
This feature is shown by a positive response to the following question: Was the patient’s thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of Consciousness
This feature is shown by any answer other than “alert” to the following question: Overall, how would you rate this patient’s level of consciousness? (Alert [normal], Vigilant [hyperalert], Lethargic [drowsy, easily aroused], Stupor [difficult to arouse], or Coma [unarousable]).

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.

**COCOA PHSS**
Differentiating Delirium from Dementia

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<tr>
<td><strong>C</strong>onsciousness</td>
<td>Decreased or hyperalert, “clouded”</td>
<td>Alert</td>
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<tr>
<td><strong>O</strong>rientation</td>
<td>Disorganized</td>
<td>Disoriented</td>
</tr>
<tr>
<td><strong>C</strong>ourse</td>
<td>Fluctuating</td>
<td>Steady slow decline</td>
</tr>
<tr>
<td><strong>O</strong>nset</td>
<td>Acute or subacute</td>
<td>Chronic</td>
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<tr>
<td><strong>A</strong>ttention</td>
<td>Impaired</td>
<td>Usually normal</td>
</tr>
<tr>
<td><strong>P</strong>syhomotor</td>
<td>Agitated or lethargic</td>
<td>Usually normal</td>
</tr>
<tr>
<td><strong>H</strong>allucinations</td>
<td>Perceptual disturbances, may have hallucinations</td>
<td>Usually not present</td>
</tr>
<tr>
<td><strong>S</strong>leep-wake cycle</td>
<td>Abnormal</td>
<td>Usually normal</td>
</tr>
<tr>
<td><strong>S</strong>peech</td>
<td>Slow, incoherent</td>
<td>Aphasic, anomic, difficulty finding words</td>
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**Mental Status: DELIRIUM**

**SLU Geriatric Evaluation Mnemonic Screening Tools**
**DELIRIUM(s)**

Differential Diagnosis for Patients with Delirium
(Remember, delirium usually has more than one cause)

- **D** rugs\(^1\)
- **E** yes, ears\(^2\)
- **L** ow \(O_2\) states (MI, stroke, PE)\(^3\)
- **I** nfection
- **R** etention (of urine or stool)
- **I**ctal
- **U** nderhydration/Undernutrition
- **M** etabolic
- **(S)** ubdural

---

1. See mnemonic **ACUTE CHANGE IN MS** (page 11)
2. Poor vision and hearing are considered more risk factors than true cause, but should be “fixed” or improved, if possible. Cerumen is common cause of hearing impairment.
3. Low \(O_2\) state does NOT necessarily mean hypoxia, rather it is a reminder that patients with a hypoxic insult (e.g., MI, stroke, PE) may present with mental status changes with or without other typical symptoms/signs of these diagnoses.
Mental Status: DELIRIUM

**BE AWARE PREVENT**
Risk Factors for Delirium (B-E A-W-A-R-E) and Targeted Interventions (P-R-E-V-E-N-T) Based on Intervention Trial to Prevent Delirium.*

- **B** aseline dementia?
- **E** ye problems?
- **A** ltered sleep/wake cycle?
- **W** ater or dehydration problems?
- **A** dding >3 medications, especially sedating and psychoactive ones?
- **R** estricted mobility?
- **E** ar problems?
- **P** rotocol for sleep (back massage, relaxation music, decreased noise, warm milk or caffeine-free herbal tea)
- **R** eplenish fluids and recognize volume depletion
- **E** ar aids (amplifier or patient’s own hearing aid)
- **V** isual aids (patient’s own glasses, magnifying lens)
- **E** xercise or ambulation as soon as possible
- **N** ame person, place and time frequently for reorientation
- **T**aper or discontinue unnecessary medications. Use alternative and less harmful medications.

Mental Status: DELIRIUM

AVOID RESTRAINTS
Non-Pharmacological Approaches to Patients with Behavioral Problems (Associated with Dementia or Delirium)

A void exacerbating factors
V ague complaints? May represent delirium or other medical illness
O ut of room; out of bed
I nsomnia protocol (e.g., warm milk, back rub/massage)
D istraction techniques

R elatives or friends to sit with/visit patient
E nvironmental adaptations
S cheduled acetaminophen for possible pain
T herapies (RT, PT, OT)
R eview medications as cause of problems
A larm on bed; low beds
I Vs or other tubes, monitors bothering patients? Discontinue if possible or “hide” them
N urses’ station (bring patient out to station to sit)
T oilet frequently
S ensory impairments? Get glasses, hearing aides
Mental Status: DEMENTIA

VAMC SLUMS Examination
Questions about this assessment tool? E-mail aging@slu.edu.

Name ___________________________ Age _______ Level of education _______
Is patient alert? ___________ Level of education _______

1. What day of the week is it?

2. What is the year?

3. What state are we in?

4. Please remember these five objects. I will ask you what they are later.
   Apple, Pen, Tie, House, Car

5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
   How much did you spend?
   How much do you have left?

6. Please name as many animals as you can in one minute.
   0-4 animals 1-5 animals 6-10 animals 11-15 animals

7. What were the five objects I asked you to remember? 1 point for each one correct.

8. I am going to give you a series of numbers and I would like you to give them to me backwards.
   For example, if I say 42, you would say 24.
   87 649 853?

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
   Hour markers okay
   Time correct

10. Please place an X in the triangle.

   Which of the above figures is largest?

11. I am going to tell you a story. Please listen carefully because afterwards, I’m going to ask you
    some questions about it.
    Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met
    Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago.
    She then stopped work and stayed at home to bring up her children. When they were teenagers, she
    went back to work. She and Jack lived happily ever after.

   What was the female’s name?
   What work did she do?
   When did she go back to work?
   What state did she live in?

TOTAL SCORE

Department of Veterans Affairs

SAINT LOUIS UNIVERSITY

SCORING

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<td>Normal</td>
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<td>21-26</td>
<td>MNCD*</td>
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<td>1-20</td>
<td>Dementia</td>
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</table>

* Mild Neurocognitive Disorder

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status
(SLUMS) Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini-
MENTIA
Potential Reversible Causes of Dementia

D rugs
E yes, ears
M etabolic (e.g., thyroid, calcium)
E motion (i.e., depression)
N ormal pressure hydrocephalus (Wacky, Wobbly, and Wet)
T umor (or other space-occupying lesion)
I nfection (e.g., neurosyphilis)
A nemia (i.e., B₁₂ deficiency)
Mental Status: DEMENTIA

THE CARING GUIDE
Management Guidelines for Caregivers of Persons with Dementia

T ime¹
H ome Health²
E yes, Ears³

C ar⁴
A dvance Directive
R estraints⁵
I ncontinence
N o $$$
G roup Support⁶

G ait⁷
U ndernutrition/Underhydration
I dentification (ID bracelet)⁸
D rugs⁹
E motions¹⁰

¹ Evaluate amount of time caregiver (CG) is spending with patient; consider respite.
² Does CG need help in the home (e.g., choreworker, nursing aide)?
³ Impaired communication can be stressful and burdensome for CG. Cerumen is common cause of hearing deficit.
⁴ Is patient still driving?
⁵ Restraints (especially physical) can be associated with increased agitation.
⁶ The Alzheimer’s Association (AA) is a good source of support groups for CGs. Visit www.alz.org.
⁷ Dementia may be a risk factor for falls.
⁸ Check with the AA for details about their Safe Return program (web or call).
⁹ See mnemonic ACUTE CHANGE IN MS on page 11.
¹⁰ Both patient and CG are at increased risk for depression.
Mental Status: DEPRESSION

GDS
Geriatric Depression Scale (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 your situation is hopeless? YES NO
15. Do you think that most persons are better off than you? YES NO

Scoring: Score one point for each “depressed” answer (in box). Score of >5 suggests probable depression.

For other languages, see http://www.stanford.edu/~yesavage/GDS.html
**SIG E CAPS**

Signs and Symptoms of Depression

- **S** leep problems
- **I**nterest (lack of) (Anhedonia)
- **G** uilt/“Worthlessness”
- **E** nergy (lack of)
- **C** oncentration problems
- **A** ppetite problems
- **P**sychomotor retardation
- **S** uicide ideations
### Cornell Scale for Depression in Dementia

**Name___________________________**  
**Age___  Sex___  Date___________**

Inpatient  Nursing Home Resident  Outpatient  
Person performing evaluation: Clinician  Nurse  Family Member  Other

#### Scoring System

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

Base ratings on symptoms and signs occurring during the week prior to interview. No score should be given in symptoms resulting from physical disability or illness.

#### A. Mood-Related Signs

1. Anxiety: anxious expression, ruminations, worrying  
   - Scoring: 0 1 2
2. Sadness: sad expression, sad voice, tearfulness  
   - Scoring: 0 1 2
3. Lack of reactivity to pleasant events  
   - Scoring: 0 1 2
4. Irritability: easily annoyed, short-tempered  
   - Scoring: 0 1 2

#### B. Behavioral Disturbance

5. Agitation: restlessness, handwringing, hairpulling  
   - Scoring: 0 1 2
6. Retardation: slow movement, slow speech, slow reactions  
   - Scoring: 0 1 2
7. Multiple physical complaints (score 0 if GI symptoms only)  
   - Scoring: 0 1 2
8. Loss of interest: less involved in usual activities  
   - Scoring: 0 1 2
   
   *(score only if change occurred acutely, i.e., in less than one month)*

#### C. Physical Signs

9. Appetite loss: eating less than usual  
   - Scoring: 0 1 2
10. Weight loss (score 2 if greater than 5 lbs. in one month)  
    - Scoring: 0 1 2
11. Lack of energy: fatigues easily, unable to sustain activities  
    - Scoring: 0 1 2
    
    *(score only if change occurred acutely, i.e., in less than one month)*

#### D. Cyclic Functions

12. Diurnal variation of mood: symptoms worse in morning  
    - Scoring: 0 1 2
13. Difficulty falling asleep: later than usual for this individual  
    - Scoring: 0 1 2
14. Multiple awakenings during sleep  
    - Scoring: 0 1 2
15. Early morning awakening: earlier than usual for this individual  
    - Scoring: 0 1 2

#### E. Ideational Disturbance

16. Suicide: feels life is not worth living, has suicidal wishes or makes suicide attempt  
    - Scoring: 0 1 2
17. Poor self-esteem: self-blame, self-deprecation, feelings of failure  
    - Scoring: 0 1 2
18. Pessimism: anticipation of the worst  
    - Scoring: 0 1 2
19. Mood congruent delusions: delusions of poverty, illness, loss  
    - Scoring: 0 1 2

A score of ≥8 suggests significant depressive symptoms.

BENIGN PAROXYSMAL POSITIONAL VERTIGO (BPPV)

BPPV is one of the most common causes of dizziness. It is often characterized by vertigo that occurs a few seconds after specific head movements, such as rolling over in bed, bending over, or looking upward. The vertigo usually lasts no more than a minute. The symptoms are most often experienced when patients lie down, which distinguishes BPPV from orthostatic hypotension. BPPV may be recurrent.

The Dix-Hallpike test is specific for the diagnosis of BPPV.

While sitting on an examining table, the patient’s head is turned either to the right or to the left by about 45°. The patient is then moved rapidly from a sitting position to a supine position with the head hanging off of the back of the examining table while the head continues to be in the same 45° position. The patient is instructed to keep his/her eyes open so that the examiner can see eye movement during the entire procedure. If BPPV is present, vertigo will begin after a latency of 5 to 10 seconds and usually will last 30 seconds to a minute. Rotary nystagmus will occur and the patient will complain of dizziness.

After the nystagmus and the vertigo subside, the patient is returned to the sitting position. The rotary nystagmus may reverse in direction and the patient may again experience vertigo. If a positive response occurs, the same maneuver is repeated. Usually, the severity of the vertigo and the rotary nystagmus are reduced during the repeat maneuver. This reduction is termed “fatigue.” The opposite ear is then tested in a similar fashion. The offending ear is the one that is toward the ground when BPPV occurs during the Dix-Hallpike maneuver.

# Classification of Dizziness

<table>
<thead>
<tr>
<th>Primary Symptom</th>
<th>Features</th>
<th>Duration</th>
<th>Diagnosis</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness</td>
<td>Lightheadedness 1-30 min after standing</td>
<td>Seconds to minutes (E)</td>
<td>Orthostatic hypotension</td>
<td>Treat underlying cause; stop or decrease offending medications. Use medications for postural hypotension.</td>
</tr>
<tr>
<td>Impairment in &gt;1 of the following: vision, vestibular function, spinal proprioception, cerebellum, lower-extremity peripheral nerves</td>
<td>Occurs with ambulation (C)</td>
<td>Multiple sensory impairments</td>
<td>Correct or maximize sensory deficits; PT for balance and strength training.</td>
<td></td>
</tr>
<tr>
<td>Unsteady gait with short steps, reflexes and/or tone.</td>
<td>Occurs with ambulation (C)</td>
<td>Ischemic cerebral disease</td>
<td>Aspirin; modification of vascular risk factors; PT</td>
<td></td>
</tr>
<tr>
<td>Provoked by head or neck movement; reduced neck range of motion</td>
<td>Seconds to minutes (E)</td>
<td>Cervical spondylosis</td>
<td>Behavior modification; reduce cervical spasm and inflammation</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
<td>Duration</td>
<td>Treatment</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>-------------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Drop attacks</td>
<td>Provoked by head or neck movement; reduced vertebral artery flow</td>
<td>Seconds to minutes (E)</td>
<td>Behavior modification postural impingement of vertebral artery</td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>Brought on by position change, positive Dix-Hallpike test</td>
<td>Seconds to minutes (E)</td>
<td>Epley maneuver to reposition crystalline debris (see <a href="http://www.audiometrics.com/bppv.htm">www.audiometrics.com/bppv.htm</a>); exercises provoking symptoms may be of help.</td>
<td></td>
</tr>
<tr>
<td>Vertigo</td>
<td>Acute onset, non-positional</td>
<td>Days</td>
<td>Labyrinthitis (vestibular neuronitis)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low-frequency sensorineural hearing loss and tinnitus</td>
<td>Minutes to hours (E)</td>
<td>Meniere’s disease</td>
<td></td>
</tr>
<tr>
<td>Vascular disease risk factors, cranial nerve abnormalities</td>
<td>10 min to several hours (E)</td>
<td>TIAs</td>
<td>Aspirin; modification of vascular risk factors</td>
<td></td>
</tr>
</tbody>
</table>

Note: C=chronic; E=episodic.
Dizziness

**V₂ERTIGO PM**

- Vision problem, hyperVentilation
- Equilibrium disorders
- Depression
  - Transient ischemic attacks, heart disease
  - Infarction (cerebral)
  - Growths (tumors)
  - Orthostatic dysregulation
- Paroxymal positioning vertigo
- Medications
**Neglect Abuse**

Risk Factors and Clues for Possibility* of Neglect or Abuse**

- No money or low income
- E motion (depression) of either patient or caregiver
- G rave illness (cancer, Alzheimer’s)
- L oss of weight or dehydration
- E arlier evidence of neglect or abuse
- C ognitive or physical impairment
- T oo many or too few doctor/emergency department visits
- A lcohol or drug use
- B ehavioral problems
- U nkempt or poor hygiene
- S kin tears, bruises or sores
- E asily frightened

*Caution should be used before labeling someone neglectful or abusive without complete information.

**Neglect and abuse are combined in this mnemonic because it is often difficult to differentiate between the two, and both may be a consequence of the patient’s or caregiver’s circumstances. They may not be intentional.
Snellen Chart
Near Vision Assessment

Hold in good light, 14 inches from eye.
THE HEARING HANDICAP INVENTORY FOR THE ELDERLY (HHIE) SCREENING VERSION

(4 points for each positive answer)

Note: One of the most common causes of impaired hearing is cerumen. **ALWAYS examine ear canals when hearing is abnormal.**

1. Does a hearing problem cause you to feel embarrassed when you meet new people?
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?
3. Do you have difficulty hearing when someone speaks in a whisper?
4. Do you feel handicapped by a hearing problem?
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
6. Does a hearing problem cause you to attend religious services less often than you would like?
7. Does a hearing problem cause you to have arguments with family members?
8. Does a hearing problem cause you difficulty when listening to television or radio?
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?

<table>
<thead>
<tr>
<th>Probability of hearing impairment given an HHIE score:</th>
<th>Score</th>
<th>Likelihood ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-8</td>
<td>0.36 (0.19-0.68)</td>
<td></td>
</tr>
<tr>
<td>10-24</td>
<td>2.30 (1.22-4.32)</td>
<td></td>
</tr>
<tr>
<td>26-40</td>
<td>12.00 (2.62-55.0)</td>
<td></td>
</tr>
</tbody>
</table>

**DUAL TASKING**

**Determining Fall Risk**

Good balance requires an interaction of both the central and peripheral nervous systems. In older adults, cognitive ability plays a key role in maintaining that good balance. With aging, there is a decline in the ability to perform these two tasks (thinking and moving) at the same time (dual tasking). This is a major reason for increasing rates of falls with aging. Persons who are identified as having trouble dual tasking can be treated with physical therapy to reduce their fall risks.

Testing a person’s ability to dual task, to maintain postural control in the concurrent performance of cognitive tasks, allows healthcare providers to predict a person’s risk of falling. Cognitive function and basic balance can be tested together with some basic paradigms. These include:

1. **WALKING SPEED**
   a. Determine average walking speed
   b. Determine average walking speed while counting backward from 100 by sevens
   c. If dual tasking doubles the average walking speed then the patient should be referred to physical therapy.
II. GET-UP-AND-GO TEST
   a. Determine the time required to perform the Get-Up-And-Go test
   b. Determine the time required to perform the Get-Up-And-Go test while holding a full glass of water
   c. If dual tasking results in doubling the time the person requires to perform the Get-Up-And-Go task, then the person should be referred to physical therapy.

III. DANCING
   a. Determine how well a patient can dance a simple waltz
   b. Determine how well a patient can execute an unexpected turn while waltzing
   c. If dual tasking results in the patient stumbling during the turn, then the person should be referred to physical therapy.

IV. ONE-LEG STAND
   a. Determine how long a patient can stand on one leg without falling
   b. Determine how long a patient can stand on one leg with eyes closed without falling
   c. If shutting the eyes results in the patient falling in less than half the time they can stand on one leg without falling when their eyes are closed, then the person should be referred to physical therapy.
Falls

AGAIN I’VE FALLEN
Evaluation/Causes/Risk Factors for Falls

A gain¹
Gait and balance
A DL loss
Impaired cognition
Number and type of drugs²

Illness³
Vestibular function
Yes, ears

Feet
Alcohol
Low blood pressure⁴
Lower extremity weakness
Environment
Neurological

¹ Those who have fallen before are at higher risk to fall again compared to non-fallers.
² At least 4 types of drugs according to one meta-analysis (40 studies) are associated with increased risk for falls: antipsychotics, antidepressants, anxiolytics, sedative/hypnotics (Leipzig RM. J Am Geriatr Soc 47:40-50, 1999). Both SSRIs and TCAs (secondary amines) increase risk according to case control study (n=8,239). (Liu B, et al. Lancet 351:1303-7, 1998).
³ Look for new illness. Up to one-third of hospital visits for falls may be associated with an acute illness. A fall also may be considered a DELIRIUM equivalent.
⁴ Including orthostatic or postural hypotension.
**Timed “Up and Go” Test**

Patients who require >10 seconds for this test have limited physical mobility and may be at risk for falls.

Instructions: Have the patient
- rise from the chair
- walk 10 feet (or 3 meters) forward
- turn around
- walk back to the chair
- and sit down

Normal time to complete the test = 7-10 seconds.
Also, observe gait and balance for abnormalities during the test.

SAFE AND SOUND
Home Assessment for Falls

S trength problems
A lcohol
F ood associated hypotension
E nvironmental factors

Atherosclerotic disease (syncope)
N o freedom (restraints)
D rugs

S ight problems
O rthostatic hypotension
U nsteady balance
N octuria
D elirium or dementia
ONE-LEG STANDING
Standing on One Foot

Purpose:
Improve balance.

Starting position:
Stand close to a wall, chair, or table for balance.

Action:
• Shift your weight onto one leg. Stand on that foot and stretch the other leg out in front of you, a few inches off the floor.
• Stand on one leg for eight counts.
• For an extra workout, flex and point your lifted foot. That is, bend the ankle so your toes point away from you, then flex the ankle to bring the toes back towards you. Flex and point eight times.
• Slowly return your leg to the starting position. Repeat with the other leg.

Repeat 6 to 8 times.
Falls

THE 5 CHAIR-STANDS*

Instructions:
Have patient sit in a chair (preferably without armrests). Cross arms at chest. Stand and sit 5 times (keeping arms crossed). Can the patient complete the task? Yes/No   Amount of time to complete: ________

Scoring:
Lower extremity weakness is one of the most important risk factors for falls. In one guideline review of studies on falls, this was the risk factor (out of 11) most consistently found to be associated with falls. On average, lower extremity weakness (measured in various ways) had an odds ratio or relative risk associated with falls of 4.4 (range was 1.5 to 10.3) compared to people without lower extremity weakness.**

Since this is a proxy measure of lower extremity strength,*** scoring does not have specific cut off points, but should be used to determine degree of abnormality based on healthy elderly and risk for falls.

The average time it takes healthy sexagenarians to complete the test is 11.34±2.44 seconds****

If unable to do within 30 seconds, the risk of ≥1 falls in next 6 months increases (OR 2.5, CI 1.5-4.1) compared to those who can do this, and the risk of recurrent falls (≥2) in the next 6 months increases (OR 4.8, CI 2.5-9.3). All patients in this study were over 70 years of age.*****

*** It is a dynamic measure, and is better than the traditional neurological exam for lower limb strength based on the 0-5 scale.
F R A I L

F atigue

R esistance (ability to climb one flight of stairs)

A mbulation (ability to walking one block)

I llnesses (more than five)

L oss of weight (more than five percent in one year)

Frailty

Preventive Strategies to Slow the Onset of Frailty

F ood intake maintenance

R esistance exercises

Atherosclerosis prevention

I solation avoidance (i.e., depression)

L imit pain

T ai Chi and other balance exercises

Y early check for testosterone deficiency (see ADAM on page 58)
ADLs
Activities of Daily Living

**BASIC ADLS**
Bathing  
Dressing  
Toileting  
Transfers  
Continence  
Feeding

ADL Score: ____/6

**INSTRUMENTAL ADLS (IADLS)**
Using the telephone  
Shopping  
Food preparation  
Housekeeping  
Laundry  
Transportation  
Taking medicine  
Managing money

IADL Score: ____/8

GRECC 1998  
Supported by the Office of Geriatrics and Extended Care. Department of Veterans Affairs, Washington, DC, 3rd Edition.
INDICATORS FOR PATIENTS NEEDING PHYSICAL THERAPY

A – Range of Motion and Strength.
Patient unable to do actively or passively:
  • Flex shoulder 90°
  • Bring hand to mouth
  • Bring hand to overhead
  • Bring hand to low back
  • Flex hip 90°
  • Bend knee 90°
  • Dorsiflex foot (foot drop)
  • Arm/leg shakes

B – Bed Mobility
Patient requires more than minimal assist for:
  • Rolling in bed
  • Sitting up
  • Getting up from chair/bed

C – Balance and Gait
  • Patients who drop a level in ambulation on the activity section of the nursing admission assessment.
  • Any patient admitted due to fall or with history (Hx) of falling.
  • Patients unable to stand in one spot with both feet on the ground for 30 seconds without holding on.
  • Patients unable to walk straight forward, need hand hold assist, or need assistive device to walk. Patients afraid to walk, hesitates.
  • Patients who need reassessment on equipment currently being used with walker, cane.
  • Patients unable to go up/down stairs safely.
INDICATORS FOR PATIENTS NEEDING OCCUPATIONAL THERAPY

A – Patients having difficulty in self-care, homemaking, leisure, or working skills.

B – Patients who display a decrease in cognitive, perceptual, or sensorial awareness of their surroundings.

C – Patients who have positioning problems with arms or legs due to recent onset of trauma or illness (a splint or orthotic device may improve positioning, *i.e.*, resting hand or drop foot splint).

INDICATORS FOR PATIENTS NEEDING SPEECH THERAPY

A – Patients who demonstrate swallowing difficulty such as pocketing within mouth, drooling, excessive chewing, decreased attempts at food intake, significant weight loss, significant increased time required for mealtime intake.

B – Patients who demonstrate decreased communication abilities, expressively and/or receptively.

C – Patients who demonstrate difficulty with organizing/processing thoughts, memory, sequencing, problem-solving, and judgment.
Potential Areas for Iatrogenesis Related to Hospitalization

The following can be used as a daily checklist to prevent iatrogenesis.

**D**rug use\(^1\)

**R**estraints\(^2\)

**I**nfection\(^3\)

**A**ltered mental status (delirium)\(^4\)

**T**herapy (immobility)

**R**etention (of urine or feces)

**O**verzealous labeling

**S**tarvation\(^5\)

---

1 Risk of adverse drug event increases with number of medications. Risk approaches 100% at 10 medications.
2 Physical restraints do not prevent falls; may cause harm.
3 Most common nosocomial infection is UTI, associated with an indwelling urinary catheter. Risk of infection from straight catheterization is far less than from an indwelling catheter.
4 Develops during hospitalization, not just on admission.
5 Restricted diets (e.g., “heart healthy,” “1800 calorie ADA”) not indicated for older hospitalized patients who are malnourished (see pages 32-33).
**Bed Rest is Bad**

- **B** ed sores
- **E** motion (depression risk)
- **D** VT risk

- **R** etention of stool or urine
- **E** at less
- **S** leep-wake cycle disruptions
- **T** akes longer to recover

- **I** nfection risk (pneumonia)
- **S** tool or urinary incontinence

- **B** one loss
- **A** trophy of muscle
- **D** rop in blood pressure after getting up (orthostatic hypotension)
DC PLAN
Discharge Planning Check List

D rugs are all appropriate

C called family

P CP notified or is aware of plan

L low income or money issues addressed (e.g., paying for meds)

A appointments made and appropriate

N note for transfer (dictation) done if going to another facility
Use of an indwelling urinary catheter (Foley catheter) is associated with bacteruria, urinary tract infections, bacteremia, even death. Other associations include nephrolithiasis, bladder stones, epididymis, chronic renal inflammation, and pyelonephritis. It can also be considered a one-point restraint.

Thus, use of Foley catheters should be reserved for the following:

- Short-term decompression of acute urinary retention
- Chronic retention not manageable by intermittent catheterization
- To aid in urologic surgery or other surgery on contiguous structures
- Very ill patients who cannot tolerate garment changes or are at end-of-life
- Patients who request catheterization despite informed consent regarding risks

Incontinence and risk of pressure ulcers are not indications for a urinary catheter.
**ADAM**

Androgen Deficiency in Aging Males

1. Do you have a decrease in libido (sex drive)?
2. Do you have a lack of energy?
3. Do you have a decrease in strength and/or endurance?
4. Have you lost height?
5. Have you noticed a decreased enjoyment of life?
6. Are you sad and/or grumpy?
7. Are your erections less strong?
8. During sexual intercourse, has it been difficult to maintain your erection to completion of intercourse?
9. Are you falling asleep after dinner?
10. Has there been a recent deterioration in your work performance?

Scoring: Yes to #1 and #7, or any 3 others is a positive screen for possible hypogonadism.

DRIP\(^2\) OR DOUSE  
Urinary Incontinence

DRIP: Acute causes of urinary incontinence

- Drugs, Delirium
- Retention of urine, Restraints
- Infection, Impaction of stool
- Polyuria, Prostatitis

DOUSE: Chronic causes of urinary incontinence

- DHIC\(^*\)
- Overflow (Lower Urinary Tract Symptomatology)\(^+\)
- Urge
- Stress
- External causes (e.g., functional)

\(^*\) Detrusor hyperactivity, impaired contractility  
\(^+\) Includes BPH but also dysynchrony of bladder contractions in both women and men.
**INTERNATIONAL PROSTATE SYMPTOM SCORE (IPSS)**

1. **Incomplete emptying**
   Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

   - 0 points = not at all
   - 1 point = less than 1 time in 5
   - 2 points = less than half the time
   - 3 points = about half the time
   - 4 points = more than half the time
   - 5 points = almost always

2. **Frequency**
   Over the past month, how often have you had the urge to urinate again less than two hours after you finished urinating?

   - 0 points = not at all
   - 1 point = less than 1 time in 5
   - 2 points = less than half the time
   - 3 points = about half the time
   - 4 points = more than half the time
   - 5 points = almost always

3. **Intermittency**
   Over the past month, how often have you found you stopped and started again several times when you urinated?

   - 0 points = not at all
   - 1 point = less than 1 time in 5
   - 2 points = less than half the time
   - 3 points = about half the time
   - 4 points = more than half the time
   - 5 points = almost always

4. **Urgency**
   Over the past month, how often have you found it difficult to postpone urination?

   - 0 points = not at all
   - 1 point = less than 1 time in 5
   - 2 points = less than half the time
   - 3 points = about half the time
   - 4 points = more than half the time
   - 5 points = almost always

---

For more information, see www.patient.co.uk/showdoc/40002437.
1. Incomplete emptying
Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

2. Frequency
Over the past month, how often have you had the urge to urinate again less than two hours after you finished urinating?

3. Intermittency
Over the past month, how often have you found you stopped and started again several times when you urinated?

4. Urgency
Over the past month, how often have you found it difficult to postpone urination?

5. Weak stream
Over the past month, how often have you had a weak urinary stream?

6. Straining
Over the past month, how often have you had to push or strain to begin urination?

7. Nocturia
Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

Total I-PSS Score (max 35):
(mild = less than 6; Moderate = 6-19; Severe = 20-35.)

Quality of life due to urinary symptoms
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?

0 points = not at all
1 point = less than 1 time in 5
2 points = less than half the time
3 points = about half the time
4 points = more than half the time
5 points = almost always
**OAB-V8**

*Overactive Bladder – Validated 8 Question Awareness Tool*¹

<table>
<thead>
<tr>
<th>RESPONSE CHOICES</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>A little bit</td>
<td>1</td>
</tr>
<tr>
<td>Somewhat</td>
<td>2</td>
</tr>
<tr>
<td>Quite a bit</td>
<td>3</td>
</tr>
<tr>
<td>A great deal</td>
<td>4</td>
</tr>
<tr>
<td>A very great deal</td>
<td>5</td>
</tr>
</tbody>
</table>

How bothered have you been by…

1. Frequent urination during the daytime hours?
2. An uncomfortable urge to urinate?
3. A sudden urge to urinate with little or no warning?
4. Accidental loss of small amounts of urine?
5. Nighttime urination?
6. Waking up at night because you had to urinate?
7. An uncontrollable urge to urinate?
8. Urine loss associated with a strong desire to urinate?

Add 2 points to your score if you are male.

Add points for your responses to the questions above. If your score is 8 or greater, you may have overactive bladder.

---

HELP ME SLEEP
Checklist for Evaluation of and Interventions for Insomnia

H erbal tea or warm milk
E valuate medication list for causes of insomnia
L imit nighttime interruptions (e.g., vital signs)*
P ostpone morning labs*

M assage
E valuate daytime activity

S ound reduction
L ight reduction at night
E nvironment changes (e.g., temperature of room, single room)
E asy listening music or white sound
P ain relief

*only pertains to hospitalized persons
## Potentially Inappropriate Medications for Older Adults Independent of Diagnosis (partial list)*

<table>
<thead>
<tr>
<th>DRUG</th>
<th>CONCERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Propoxyphene (Darvon) and combinations (Darvon with ASA, Darvon-N, Darvocet-N)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Offers few analgesic advantages over acetaminophen, yet has the adverse effects of other narcotics</td>
</tr>
<tr>
<td>Indomethacin</td>
<td>Of all available NSAIDs, this drug produces most CNS adverse effects</td>
</tr>
<tr>
<td>Muscle relaxants and antispasmodics: methocarbamol (Robaxin), carisoprodol (Soma), Chlorzoxazone (Paraflex), metaxalone (Skelaxin), cyclobenzaprine (Flexeril)</td>
<td>Most muscle relaxants and antispasmodics are poorly tolerated by elderly patients, since these cause anticholinergic adverse effects, sedation, and weakness. Additionally, their effectiveness at doses tolerated by elderly is questionable.</td>
</tr>
<tr>
<td>Amitriptyline(Elavil), Imipramine, Chlordiazepoxide-amitriptyline (Limbitrol), and perphenazine-amitriptyline (Triavil)</td>
<td>Because of its strong anticholinergic and sedation properties, amitriptyline is rarely the antidepressant of choice for elderly.</td>
</tr>
<tr>
<td>Doses of short-acting benzodiazepines (BDZ): doses greater than lorazepam (Ativan), 3 mg; oxazepam (Serax), 60 mg; alprazolam (Xanax), 2 mg; temazepam (Restoril), 15 mg; triazolam (Halcion), 0.25 mg</td>
<td>Because of increased sensitivity to benzodiazepines in elderly patients, smaller doses may be effective as well as safer. Total daily doses should rarely exceed the suggested maximums.</td>
</tr>
<tr>
<td>Long-acting benzodiazepines: chlordiazepoxide (Librium), diazepam (Valium), chlorazepate (Tranxene)</td>
<td>These drugs have a long half-life in elderly patients, producing sedation and increasing risk of falls and fractures.</td>
</tr>
</tbody>
</table>

<sup>1</sup>While this drug has high-addicting potential and in most patients less pain control, it inhibits NMDA which plays a role in perpetuating chronic pain. However, some persons get better relief of pain with propoxyphene and this should be documented.
### Potentially Inappropriate Medications for Older Adults Independent of Diagnosis (partial list)* (continued)

<table>
<thead>
<tr>
<th>DRUG</th>
<th>CONCERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digoxin (Lanoxin) (should not exceed &gt;.125 mg/day except when treating atrial arrhythmias)</td>
<td>Decreased renal clearance may lead to increased risk of toxic effects.</td>
</tr>
<tr>
<td>Meperidine (Demerol)</td>
<td>Not an effective oral analgesic in doses commonly used, may cause confusion and has many disadvantages to other narcotics</td>
</tr>
<tr>
<td>Ketorolac (Toradol)</td>
<td>Immediate and long-term use should be avoided.</td>
</tr>
<tr>
<td>Daily fluoxetine (Prozac)</td>
<td>Long half-life and risk of producing excessive side effects, sleep disturbance, and increasing agitation. Safer antidepressants available.</td>
</tr>
<tr>
<td>Short acting nifedipine</td>
<td>Potential for hypotension</td>
</tr>
<tr>
<td>(Procardia, Adalat)</td>
<td></td>
</tr>
<tr>
<td>Clonidine (Catapres)</td>
<td>Potential for CNS adverse effects.</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>May cause confusion and sedations. Should not be used as a hypnotic, and when used to treat emergency allergic reactions, it should be used in smallest possible doses.</td>
</tr>
</tbody>
</table>

AVOID TOO MANY
Guidelines for Proper Medication Prescribing, Prevention of Polypharmacy, and Medication Reduction

A lternatives¹
V ague history or symptoms²
O TC³
I nteractions (drug-drug, drug-disease)
D uration⁴

T herapeutic vs. preventive⁵
O nce a day vs. BID, TID, QID⁶
O ther MDs

M oney issues
A dverse drug effects of other drugs⁷
N eed⁸
Y es/No⁹

¹ Use non-pharmacological therapies whenever possible (e.g., warm milk instead of a sleeping agent).
² Do not treat vague symptoms with drugs (e.g., vague gastrointestinal “upset” with H₂ blocker).
³ Over-the-counter drugs do count as drugs.
⁴ If possible (e.g., symptomatic drugs), decide on duration of therapy. If no positive effect after trial period, stop before adding another medication.
⁵ Depending on life expectancy, preventive drug therapy may not benefit patient. In general, therapeutic drugs should have priority over preventive drugs.
⁶ In general, once a day improves compliance, but may be more expensive than TID or QID drugs.
⁷ Do not treat adverse drug effects with a different drug if offending agent can be stopped or changed.
⁸ Does the person really need a medication now?
⁹ Refers to compliance. Is the person taking the current medication?
MEALS ON WHEELS
Common causes of malnutrition in older persons

M edications¹
E motion (i.e., depression)
A norexia (nervosa or tardive), Alcoholism, Abuse (elder)
L ate-life paranoia or alcoholism
S wallowing disorders

O ral factors (see DENTAL on page 36)
N o money, Nosocomial infections

W andering and other dementia-related behaviors
H yperthyroidism, Hyperparathyroidism, Hypoadrenalism, Hyperglycemia
E ntry problems/Malabsorption
E ating problems²
L ow-salt or low-cholesterol diet
S hopping and food prep problems, Stores

¹ Digoxin, theophylline, psychotropic drugs.
² Severe tremor, stroke, weakness.
SNAQ
Simplified Nutritional Assessment Questionnaire

Name:__________________________________________________ Sex: M F
Age:______ Height:___________ Weight:_________ Date:________

My appetite is
a. very poor
b. poor
c. average
d. good
e. very good

Food tastes
a. very bad
b. bad
c. average
d. good
e. very good

When I eat
a. I feel full after eating only a few mouthfuls.
b. I feel full after eating about a third of a meal.
c. I feel full after eating over half a meal.
d. I feel full after eating most of the meal.
e. I hardly ever feel full.

Normally I eat
a. less than one meal a day.
b. one meal a day.
c. two meals a day.
d. three meals a day.
e. more than three meals a day.

Tally the results based on the following numerical scale: a=1; b=2, c=3, d=4, e=5. The sum of the scores for the individual items constitutes the SNAQ score. A SNAQ score of \( \leq 14 \) indicates significant risk of at least 5% weight loss within six months.

**Geriatric Evaluation Mnemonic Screening Tools**

- **sNaQ** (Simplified Nutritional Assessment Questionnaire)
- **BMI**

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Body Weight (pounds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>91 96 100 105 110 115 119 124 129 134 138</td>
</tr>
<tr>
<td>59</td>
<td>94 99 104 109 114 119 124 128 133 138 143</td>
</tr>
<tr>
<td>60</td>
<td>97 102 107 112 118 123 128 133 138 143 148</td>
</tr>
<tr>
<td>61</td>
<td>100 106 111 116 122 127 132 137 143 148 153</td>
</tr>
<tr>
<td>62</td>
<td>104 109 115 120 126 131 136 142 147 153 158</td>
</tr>
<tr>
<td>63</td>
<td>107 113 118 124 130 135 141 146 152 158 163</td>
</tr>
<tr>
<td>64</td>
<td>110 116 122 128 134 140 145 151 157 163 169</td>
</tr>
<tr>
<td>65</td>
<td>114 120 126 132 138 144 150 156 162 168 174</td>
</tr>
<tr>
<td>66</td>
<td>118 124 130 136 142 148 155 161 167 173 179</td>
</tr>
<tr>
<td>67</td>
<td>121 127 134 140 146 153 159 166 172 178 185</td>
</tr>
<tr>
<td>68</td>
<td>125 131 138 144 151 158 164 171 177 184 190</td>
</tr>
<tr>
<td>69</td>
<td>128 135 142 149 155 162 169 176 182 189 196</td>
</tr>
<tr>
<td>70</td>
<td>132 139 146 153 160 167 174 181 188 195 202</td>
</tr>
<tr>
<td>71</td>
<td>136 143 150 157 165 172 179 186 193 200 207</td>
</tr>
<tr>
<td>72</td>
<td>140 147 154 162 169 177 184 191 199 206 213</td>
</tr>
<tr>
<td>73</td>
<td>144 151 159 166 174 182 189 197 204 212 219</td>
</tr>
<tr>
<td>74</td>
<td>148 155 163 171 179 186 194 202 210 218 225</td>
</tr>
<tr>
<td>75</td>
<td>152 160 168 176 184 192 200 208 216 224 232</td>
</tr>
<tr>
<td>76</td>
<td>156 164 172 180 189 197 205 213 221 230 238</td>
</tr>
</tbody>
</table>

Mini Nutritional Assessment
MNA®

<table>
<thead>
<tr>
<th>Last name:</th>
<th>First name:</th>
<th>Sex:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Complete the screen by filling in the boxes with the appropriate numbers. Add the numbers for the screen. If score is 11 or less, continue with the assessment to gain a Malnutrition Indicator Score.

### Screening

<table>
<thead>
<tr>
<th>A.</th>
<th>Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>severe loss of appetite</td>
</tr>
<tr>
<td>1</td>
<td>moderate loss of appetite</td>
</tr>
<tr>
<td>2</td>
<td>no loss of appetite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.</th>
<th>Weight loss during the last 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>weight loss greater than 3 kg (6.6 lbs)</td>
</tr>
<tr>
<td>1</td>
<td>does not know</td>
</tr>
<tr>
<td>2</td>
<td>weight loss between 1 and 3 kg (2.2 and 6.6 lbs)</td>
</tr>
<tr>
<td>3</td>
<td>no weight loss</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C.</th>
<th>Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>bed or chair bound</td>
</tr>
<tr>
<td>1</td>
<td>able to get out of bed or chair but does not go out</td>
</tr>
<tr>
<td>2</td>
<td>goes out</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D.</th>
<th>Has suffered psychological stress or acute disease in the past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>J.</th>
<th>How many full meals does the patient eat daily?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1 meal</td>
</tr>
<tr>
<td>1</td>
<td>2 meals</td>
</tr>
<tr>
<td>2</td>
<td>3 meals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>K.</th>
<th>Selected consumption markers for protein intake</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At least one serving of dairy products (milk, cheese, yogurt) per day</td>
</tr>
<tr>
<td></td>
<td>two or more servings of legumes or eggs per week</td>
</tr>
<tr>
<td></td>
<td>meat, fish or poultry every day</td>
</tr>
<tr>
<td>0.0</td>
<td>yes, no</td>
</tr>
<tr>
<td>0.5</td>
<td>yes, no</td>
</tr>
<tr>
<td>1.0</td>
<td>yes, no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>L.</th>
<th>Consumes two or more servings of fruits or vegetables per day?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>no</td>
</tr>
<tr>
<td>1</td>
<td>yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M.</th>
<th>How much fluid (water, juice, coffee, tea, milk) is consumed per day?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0</td>
<td>less than 3 cups</td>
</tr>
<tr>
<td>0.5</td>
<td>3 to 5 cups</td>
</tr>
<tr>
<td>1.0</td>
<td>more than 5 cups</td>
</tr>
</tbody>
</table>
### Nutritional Screening Tools

#### Assessment

<table>
<thead>
<tr>
<th>E</th>
<th>Neuropsychological problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>severe dementia or depression</td>
</tr>
<tr>
<td>1</td>
<td>mild dementia</td>
</tr>
<tr>
<td>2</td>
<td>no psychological problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F</th>
<th>Body Mass Index (BMI) (weight in kg) / (height in m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>BMI less than 19</td>
</tr>
<tr>
<td>1</td>
<td>BMI 19 to less than 21</td>
</tr>
<tr>
<td>2</td>
<td>BMI 21 to less than 23</td>
</tr>
<tr>
<td>3</td>
<td>BMI 23 or greater</td>
</tr>
</tbody>
</table>

**Screening score** (total max. 14 points)
- 12 points or greater: Normal — not at risk — no need to complete assessment
- 11 points or below: Possible malnutrition — continue assessment

<table>
<thead>
<tr>
<th>G</th>
<th>Lives independently (not in a nursing home or hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>no</td>
</tr>
<tr>
<td>1</td>
<td>yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H</th>
<th>Takes more than 3 prescription drugs per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>yes</td>
</tr>
<tr>
<td>1</td>
<td>no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I</th>
<th>Pressure sores or skin ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>yes</td>
</tr>
<tr>
<td>1</td>
<td>no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N</th>
<th>Mode of feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>unable to eat without assistance</td>
</tr>
<tr>
<td>1</td>
<td>self-fed with some difficulty</td>
</tr>
<tr>
<td>2</td>
<td>self-fed without any problem</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>O</th>
<th>Self-view of nutritional status</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>views self as being malnourished</td>
</tr>
<tr>
<td>1</td>
<td>is uncertain of nutritional state</td>
</tr>
<tr>
<td>2</td>
<td>views self as having no nutritional problem</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P</th>
<th>In comparison with other people of the same age, how does the patient consider his/her health status?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0</td>
<td>not as good</td>
</tr>
<tr>
<td>0.5</td>
<td>does not know</td>
</tr>
<tr>
<td>1.0</td>
<td>as good</td>
</tr>
<tr>
<td>2.0</td>
<td>better</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q</th>
<th>Mid-arm circumference (MAC) in cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0</td>
<td>MAC less than 21</td>
</tr>
<tr>
<td>0.5</td>
<td>MAC 21 to 22</td>
</tr>
<tr>
<td>1.0</td>
<td>MAC 22 or greater</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Call circumference (CC) in cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>CC less than 31</td>
</tr>
<tr>
<td>1</td>
<td>CC 31 or greather</td>
</tr>
</tbody>
</table>

**Assessment** (max. 16 points)

**Screening score**

**Total Assessment** (max. 30 points)

**Malnutrition Indicator Score**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 to 23.5 points</td>
<td>at risk of malnutrition</td>
</tr>
<tr>
<td>Less than 17 points</td>
<td>malnourished</td>
</tr>
</tbody>
</table>
SCALES

Protocol for Evaluating Risk of Malnutrition in the Elderly

S adness: GDS of 10-14 = 1 point
       GDS of ≥ 15 = 2 points

C holesterol: <160 mg/dl = 1 point

A lbumin: 3.5-4 mg/dl = 1 point
       < 3.5 mg/dl = 2 points

L oss of weight: 1 kg / 1 month = 1 point
       3 kg / 6 months = 2 points

E at: Does person need assistance? Yes = 1 point

S hopping: Does person need assistance? Yes = 1 point

Scoring: ≥ 3 points indicates patient is at risk.

DENTAL Screening Assessment Tool for Dental Conditions that may Interfere with Proper Nutritional Intake and Possibly Dispose a Person to Involuntary Weight Loss

- D ry mouth (2 points)
- E ating difficulty (1 point)
- N o recent dental care\(^1\) (1 point)
- T ooth or mouth pain (2 points)
- A lterations or change in food selection (1 point)
- L esions, sores, or lumps in mouth (2 points)

Scoring: A score of $\geq 3$ points could indicate a dental problem. Patient may need evaluation by dentist.

\(^1\) within 2 years
RISK FACTORS FOR OSTEOPOROSIS

Low calcium intake
Seizure medications (anticonvulsants)
Thin build
Ethanol (excess alcohol)

Hypogonadism
Prior fracture

Thyroid excess
Race (Caucasian/Asian)

Other relatives with osteoporosis/fractures
Steroids
Inactivity
Smoking
PAIN ASSESSMENT TOOL

Name _________________________________________________

1. Do you have any pain?       YES □     NO □

1a. How much pain do you have? Circle 0 if no pain.

   0  1  2  3  4  5  6  7  8  9  10
   NO Pain Mild Moderate Severe Very Severe Worst Possible Pain

1b. Which face best describes how you feel?

2. Are you sad/blue/unhappy?       YES □     NO □

3. What would you say your overall quality of health has been over the past month?

4. What would you say your overall quality of life has been over the past month?

IF YOU HAVE PAIN OR ARE SAD, TELL YOUR HEALTH PROVIDER. THEY CAN HELP YOU.
PAINS
Evaluation of the Different Characteristics of Pain

P rocovative factors¹

A ggravating factors²

I s the pain aching, gnawing, knife-like, burning, cramping?

N ame where the pain is/where it goes

S everity³

¹What brings on the pain?
²What makes it worse?
³Rate on a scale of 1-10.
PAIN WISDOM

Ten Potential Problems that Occur in a Terminally Ill Person

P ain
A nxiety
I mpaction of stool
N utrition problems
W ater (hydration problems)
I nfection
S ocial and spiritual issues
D epressed mood
O xygen (dyspnea vs. hypoxia)
M outh, skin, eyes which are dry
### Palliative Care and End-of-Life

#### Management of End-of-Life Symptoms

<table>
<thead>
<tr>
<th><strong>Non-Pharmacological</strong></th>
<th><strong>Pharmacological</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fatigue</strong></td>
<td><strong>Depression</strong></td>
</tr>
<tr>
<td>Provide psychological support and regular visitors/outings.</td>
<td>Megestrol acetate (if anorexic use new formulation to enhance absorption). Dronabinol (causes munchies, use only when weight gain is not a major concern). Testosterone (effectiveness uncertain).</td>
</tr>
<tr>
<td><strong>Anorexia/Cachexia</strong></td>
<td><strong>Diabetes</strong></td>
</tr>
<tr>
<td>Sit upright (may need armchair). Reduce room temperature. Maintain humidity. Avoid activities that increase dyspnea. Avoid irritants, e.g., smoke. Raise head of bed. Use O₂ when wanted. (Remember, cannula/mask can be irritating). Use a fan.</td>
<td>Use mainly osmotic laxatives: Sorbitol, Lactulose, Polyethylene glycol.</td>
</tr>
<tr>
<td>Consider drugs as cause. Increase fluid intake. Exclude fecal impaction. Toilet after meals with gastrocolic reflex.</td>
<td>Check to make sure diarrhea is not due to osmotic laxative. Rehydrate. Use mainly osmotic laxatives: Sorbitol, Lactulose, Polyethylene glycol.</td>
</tr>
<tr>
<td><strong>Dyspnea</strong></td>
<td><strong>Diarrhea</strong></td>
</tr>
<tr>
<td><strong>Fatigue</strong></td>
<td><strong>Depression</strong></td>
</tr>
<tr>
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<tr>
<td>Consider drugs as cause. Increase fluid intake. Exclude fecal impaction. Toilet after meals with gastrocolic reflex.</td>
<td>Check to make sure diarrhea is not due to osmotic laxative. Rehydrate. Use mainly osmotic laxatives: Sorbitol, Lactulose, Polyethylene glycol.</td>
</tr>
</tbody>
</table>
## Management of End-of-Life Symptoms

<table>
<thead>
<tr>
<th><strong>NON-PHARMACOLOGICAL</strong></th>
<th><strong>PHARMACOLOGICAL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Check to make sure it is not due to drugs.</td>
<td></td>
</tr>
<tr>
<td><strong>INSOMNIA</strong></td>
<td>Avoid sleeping all day. Increase daytime activity. Control pain. Indulge in warm milk before sleeping. Get out of bed during the daytime. No reading or television in bed.</td>
</tr>
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<td>Avoid sleeping all day. Increase daytime activity. Control pain. Indulge in warm milk before sleeping. Get out of bed during the daytime. No reading or television in bed.</td>
<td>Treat depression.</td>
</tr>
<tr>
<td><strong>ANXIETY</strong></td>
<td>Try supportive therapy and/or relaxation therapy. Consider various causes such as pulmonary embolus or myocardial infarction.</td>
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<td>Try supportive therapy and/or relaxation therapy. Consider various causes such as pulmonary embolus or myocardial infarction.</td>
<td>Lorazepam.</td>
</tr>
<tr>
<td><strong>D Delirium</strong></td>
<td>Supportive nursing. Consider drugs as possible cause. Ensure adequately lighted room. Avoid illusional objects. Have someone in room (e.g., use delirium ICU).</td>
</tr>
<tr>
<td>Supportive nursing. Consider drugs as possible cause. Ensure adequately lighted room. Avoid illusional objects. Have someone in room (e.g., use delirium ICU).</td>
<td>Avoid drugs. If essential: Trazodone (25-50mg 2-4 times per day), for agitation. Haloperidol (0.5-1mg q d). Respiridol (1-2mg q d) for paranoia, hallucinations, rarely for agitation. IV Lorazepam (0.25-1mg) for sedation to allow for medical procedures.</td>
</tr>
<tr>
<td><strong>PAIN</strong></td>
<td>Make use of massage therapy. Try heat/cold, Transcutaneous Electrical Nerve Stimulation (TENS), lidocaine patch, and activity/distraction therapy.</td>
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<td>Make use of massage therapy. Try heat/cold, Transcutaneous Electrical Nerve Stimulation (TENS), lidocaine patch, and activity/distraction therapy.</td>
<td>Use WHO Analgesic Ladder. Try acetaminophen, NSAIDS, weak opioids, strong opioids, adjuvant drugs, e.g., Neurontin®, (Gabapentin). All drugs scheduled by the clock and use PRNs for breakthrough pain. DO NOT USE MEPEPERIDINE due to seizure potential.</td>
</tr>
<tr>
<td><strong>END-OF-LIFE ISSUES</strong></td>
<td>Provide psychological support, help with social issues, and spiritual support. Limit loneliness. Increase activities within patient’s limitations. Keep out of bed.</td>
</tr>
</tbody>
</table>
**Stage 1**
Non-blanchable erythema of intact skin. The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.

**Stage 2**
Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

**Stage 3**
Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

**Stage 4**
Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers.

**Reverse Staging**
Clinical studies indicate that as deep ulcers heal, the lost muscle, fat, and dermis is NOT replaced. Instead, granulation tissue fills the defect before re-epithelialization. Given this information, it is not appropriate to reverse stage a healing ulcer. For example, a pressure ulcer stage 3 does not become a stage 2 or a stage 1 in your documentation during healing. You must chart the progress by noting an improvement in the characteristics (size, depth, amount of necrotic tissue, amount of exudate, etc.) One tool to do so is called the PUSH Tool 3.0. See www.npuap.org for details.
## Pressure Ulcers

### Management Guidelines

**Principles:**
- Relieve pain
- Relieve pressure
- Avoid dehydration
- Remove necrotic debris

**Stage I and II:**
- **Needs:**
  - Clean, moist surface
  - Protect from external environment
- **Options:**
  - Wet-to-moist saline gauze
  - Thin film polymer
  - Hydrocolloid

**Stage III and IV with deadspace, exudate**
- **Needs:**
  - Clean, moist surface
  - Protect from external environment
  - Absorption of exudate
  - Obliteration of dead space
- **Options:**
  - Wet-to-moist saline gauze
  - Hydrocolloid dressing
  - Synthetic absorption dressing
  - Hydrogel

**Stage III and IV with necrosis**
- **Needs:**
  - Clean, moist surface
  - Protect from external environment
  - Debridement
- **Options:**
  - Surgical; Autolytic; Enzymatic

**Heel Ulcers**
- **Needs:**
  - Protect from external environment
  - Complete Pressure-reduction
  - DO NOT debride (unless abscess, infection)
EPWORTH SLEEPINESS QUESTIONNAIRE
Screening for Sleep Disorders

How likely are you to doze off or to fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0</td>
</tr>
<tr>
<td>Watching TV</td>
<td>0</td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td>0</td>
</tr>
<tr>
<td>As a passenger in a car for an hour</td>
<td>0</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon</td>
<td>0</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0</td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td>0</td>
</tr>
<tr>
<td>In a car while stopped for a few minutes</td>
<td>0</td>
</tr>
</tbody>
</table>

Scoring: Out of 24, the higher the number, the more likely patient has a sleeping disorder.

HEALTH LITERACY

“The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”

Risk Factors for Health Literacy

H ealth information difficult to locate
E ducation level may be low
A frican American*
L earning disabilities
T erminology: lack of understanding of medical terms
H ispanic*

L ow income
I mmigrant*
T reatment options may be poorly understood
E lderly*
R eading ability may be below 7th grade level
A ctivity limitations
C ognitively impaired
Y aho (older persons may struggle with computer literacy)

*Older people in these populations often had limited access to education.