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## Introduction

### Values:

- Seeking first to understand.
- Treating the patient and carer with respect.
- Treating the patient with dignity.

### Competencies:

**(1) Active Listening, (2) Asking Open-ended questions, (3) Preparation, and (4) Attitude**

### ***(1) Active Listening***

**Outcome:** Person being listened to feels the other is seeking to really understand. The person being listened to feels they have been truly heard and understood.

**How:** Active listening involves the effective (being genuine) use of the any of the following listening activities:

***Restating*** what the other has said to their satisfaction.

***Paraphrasing*** what the other has said to their satisfaction.

***Acknowledging the Emotion*** the other has communicated to their satisfaction.

***Acknowledging the Meaning*** the other has said to their satisfaction.

***Summarising*** what the other has said to their satisfaction

### **(2) Open-ended questions**

**Outcome:** Indicates a true seeking to understand and encourages the sharing of more information. By using questions where the answers are not any version of "yes" or "no" (closed end questions).

**How:**

*How did you do that?"*

*What did you do?"*

*How did that work?"*

*Can you say some more about that?"*

### **(3) Preparation**

### **(4) Attitude--Staying calm, patient, and focused on the person.**

### Generic Critical Success Factors (CSAs):

*These critical success factors need to be reviewed prior to assessment.*

#### **1. Indicators (for Collection)**

Staff member identifies indicators for assessment in relation to performance criteria and selects the appropriate assessment or screening instrument for collecting data.

#### **2. Equipment Required**

Staff member plans for and organizes the equipment and tools required to complete the assessment or screening, based on the performance criteria.

#### **3. Safe Practice Maintained**

Patient safety and privacy, the environment and the context in which the assessment is conducted in considered in relation to the performance criteria.

#### **4. Domains of Assessment**

Staff member has read the screening or assessment procedural documents and completes the assessment based on the performance criteria.

#### **5. Documentation and Action**

Staff member appropriately documents and actions assessment outcomes based on performance criteria

## Critical Success Factor (CSA) Assessment Tool

### **CSA: Assessing Delirium Using the *Confusion Assessment Method (CAM)***

**Outcome:** Successfully administer the CAM and documents outcomes

The **GSAHS using cognition and delirium screening tools resource and procedure guide for CAM p 16 – 18**, should be read in conjunction with practical training prior to completion of this competency assessment.

Elements of CSA: CAM	Performance Criteria	C	NYC	Comments
<b>1. INDICATORS (FOR COLLECTION)</b>	<p>Staff member able to communicate indicators for completion of the Confusion Assessment Method as:</p> <p>Any person of any age with a pre existing diagnosis of dementia or other cognitive deficit.</p> <p>When there is occurrence of any sudden change in a patients behaviour, cognition, functional ability or level of consciousness either on presentation to ED, admission to the ward or throughout the length of their admission.</p> <p>When the baseline AMT score <math>\leq 7</math> OR the SMMSE or RUDAS <math>\leq 24</math>.</p> <p>When there is a loss of two points or more in scoring for a repeat cognition testing with the AMT, SMMSE or RUDAS. in 2 points or more</p>			
<b>2. EQUIPMENT REQUIRED</b>	<p>Hard copy of the CAM assessment form</p> <p>Pen/Pencil</p>			

Elements of CSA: CAM	Performance Criteria	C	NYC	Comments
	Notes to record outcome Delirium alert for Medical Record file if required			
<b>3. SAFE PRACTICE MAINTAINED</b>	<p>Patient safety and privacy is considered. Environment considerations are taken into account for any cognition screening that is being completed to support the CAM .</p> <p>The staff member is able to communicate that completion of the CAM requires incorporation of ;</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Information from family/Carer/others who know the person to ascertain their baseline cognitive and functional ability and onset of any change.</li> <li><input type="checkbox"/> Cognition screening with AMT/SMMSE/RUDAS if able to be completed</li> <li><input type="checkbox"/> General assessment, including past history and observations and when last bowel action occurred.</li> <li><input type="checkbox"/> Direct Observation</li> </ul>			
<b>4.DOMAINS OF CAM ASSESSMENT</b>	<p><b>1. Acute onset and fluctuating course</b> The staff member assesses for acute change in mental status from the patients baseline</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Interviews family/ carer/ relevant other to corroborate this; noting, if when and how change occurred.</li> <li><input type="checkbox"/> Identifies that assessment of acute onset can include changes in memory, orientation, perceptual disturbances such as onset of hallucinations or delusions;</li> <li><input type="checkbox"/> Asks appropriate questions of family/carers/staff, observes or reads through medical record documentation to</li> </ul>			

Elements of CSA: CAM	Performance Criteria	C	NYC	Comments
	<p>determine if abnormal behavior fluctuated during the day. Assesses whether there are there differing reports on the level of confusion or is the behaviour changeable or increases and decreases in severity?</p> <p><input type="checkbox"/> Assesses if there has been alteration in the sleep wake cycle</p>			
	<p><b>2. Inattention</b> The staff member assesses appropriately to determine if the patient have difficulty focusing attention Appropriately assessed inattention utilizing one or more of the following;</p> <p><input type="checkbox"/> Direct observation during questioning to determine if they have difficulty keeping track of what is being said.</p> <p><input type="checkbox"/> Asking the family/carer/staff if the patient has been unable to concentrate on normal activities such as reading or watching TV.</p> <p><input type="checkbox"/> Asking the patients to count backwards from 20 to 1.</p> <p><input type="checkbox"/> Asking the patients to say months of the year backwards</p> <p><input type="checkbox"/> Asking patient to complete the clock drawing test</p> <p><input type="checkbox"/> Referring to completion of serial 7's or spelling the word WORLD backwards as part of the SMMSE.</p>			
	<p><b>3. Disorganised thinking</b> The staff member is able to communicate the meaning of disorganized thinking as the patient's speech is disorganized or incoherent, including rambling, irrelevant conversation or there is evidence of unclear or illogical flow of ideas, or unpredictable switching from subject to subject?"</p>			

Elements of CSA: CAM	Performance Criteria	C	NYC	Comments
	<p>The staff member assesses appropriately to determine if the patient has disorganized thinking by using one or more of the following;</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Direct observation and questioning</li> <li><input type="checkbox"/> Completion of cognition screening using the AMT or SMMSE/RUDAS.</li> <li><input type="checkbox"/> Identifies that assessment of disorganized thinking can be informed by evidence of disorientation, memory impairment and perceptual disturbances such as hallucinations, delusions.</li> </ul>			
	<p><b>4. Altered level of consciousness</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Appropriately assesses for Psychomotor agitation through direct interview/observation to determine if the patient showed an unusually increased level of motor activity such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position?</li> <li><input type="checkbox"/> Appropriately assesses for Psychomotor retardation through direct observation/interview to identify if the patient showed unusually decreased level of motor activity such as sluggishness, staring into space, staying in one position for a long time or moving very slowly?</li> <li><input type="checkbox"/> Is able to appropriately identify from observation if the patient's level of consciousness was: alert (normal), vigilant, (hyper-alert), lethargic, ( drowsy, early aroused)</li> </ul>			



### General knowledge questions pertaining to the use of the Confusion Assessment Method

1. When is the CAM indicated ?
2. What scores on the SMMSE and AMT indicate that the CAM should be completed?
3. For a diagnosis of delirium what features are required on the CAM?
4. What other assessment needs to be taken into consideration when assessing with the CAM?  
(Assessment should include a detailed history comprising alcohol use, onset and course of confusion, previous episodes of confusion, sensory deficits, safety issues and social circumstances. Premorbid functional activities of daily living, symptoms of underlying causes and co morbid illnesses)
5. If the CAM indicates the likelihood of a delirium what steps need to be taken?
6. If a delirium is indicated what needs to be put in each patients notes?
7. What are some of the non pharmacological strategies to management delirium?
8. Identify 5 risk factors for delirium

### Critical Success Factor (CSA) assessment tool

#### *Cognition screening using the Standardised Mini Mental State Examination and Clock Drawing Test Form*

**Outcome:** Consistent and Standardised, practice by staff in understanding the rationale for and completing cognition screening using the GSAHS Standardised Mini Mental State Examination (SMMSE) and clock drawing test

The *GSAHS using cognition and delirium screening tools resource and procedure guide p 4 – 15* should be read in conjunction with practical training prior to completion of this CSA assessment.

Elements of CSA	Performance Criteria	C	NYC	Comments
<b>1. INDICATORS (FOR COLLECTION)</b>	<p><b>Screening tool used to;</b> Assess baseline cognitive function. Find suggestive evidence of cognitive decline or delirium</p> <p><b>Indications from screening</b></p> <p><b>On admission</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> ED presentations 65+ years (45+ for Aboriginal/Torres Strait Islander people (ATSI) (or use Abbreviated Mental Test)</li> <li><input type="checkbox"/> All medical and surgical patients 65+years (45+ ATSI)</li> <li><input type="checkbox"/> Clients of any age with a diagnosis of dementia or evidence of cognitive impairment.</li> </ul> <p><b>Repeat assessment;</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> When there is a sudden change in level of consciousness, behavior or cognition and/or decline in ability to perform ADLs.</li> </ul> <p><b>On D/C;</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Clients identified as having delirium to establish D/C baseline.</li> </ul>			

## Critical Success Factors (CSF):

Factors that are critical to a clinician's success in dementia assessment task,  
e.g. assessing delirium

Elements of CSA	Performance Criteria	C	NYC	Comments
<b>2. EQUIPMENT REQUIRED</b>	<ul style="list-style-type: none"> <li>* SMMSE</li> <li>* Pen</li> <li>* Watch</li> <li>* Spare piece of paper</li> <li>* Pencil</li> <li>* Eraser</li> </ul> <p>Quiet, private area</p>			
<b>3. SAFE PRACTICE MAINTAINED</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Client informed of procedure/tool and provided with appropriate explanation of purpose of routine screening</li> <li><input type="checkbox"/> Consent gained from client.</li> <li><input type="checkbox"/> Client safety, privacy and comfort maintained.</li> <li><input type="checkbox"/> Aids such as glasses/hearing aids are in place</li> <li><input type="checkbox"/> Clinician positions self to maximise communication.</li> <li><input type="checkbox"/> Allow client to set the pace.</li> <li><input type="checkbox"/> If the assessment is a baseline, ensure medically stable i.e. post blood transfusion, not in pain</li> <li><input type="checkbox"/> Adheres to procedure requirements including-environment and considerations, times to avoid the SMMSE, introduction and delivery style.</li> <li><input type="checkbox"/> Adheres to specific scoring guidelines.</li> </ul>			
<b>4. DOMAINS OF ASSESSMENT</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Asks questions appropriately as per standardised guidelines.</li> <li><input type="checkbox"/> Asks questions appropriately in relation to standardized procedure guidelines for temporal and geographical orientation, registration, attention and calculation, recall, language, instruction and praxis.</li> <li><input type="checkbox"/> Requests patient to completed the Clock Drawing Test as</li> </ul>			



### General knowledge questions pertaining to the use of the MMSE and Clock Drawing Test.

1. Is the SMMSE a screening or diagnostic tool?
2. A reduction of 2 points or more on the SMMSE is indicative of cognitive decline and suggestive of delirium.  
TRUE/FALSE
3. A rise of 3 points or more is the best indicator for detecting resolution of a delirium. TRUE/FALSE
4. Name 4 limitations of using the SMMSE.  
a \_\_\_\_\_  
b \_\_\_\_\_ c \_\_\_\_\_  
\_\_\_\_\_ d \_\_\_\_\_
5. Why is the Clock Drawing Test included in the assessment?
6. When and on who should the SMMSE/Clock test be completed?
7. List some environmental and other considerations to be aware of when attending the MMSE.
8. How would you introduce and deliver SMMSE tool?
9. How many times would you repeat each question?

10 How is the SMMSE scored if the patient was unable to attend all areas of assessment e.g. due to vision impairment?

11. What else should be included in a cognitive assessment?

(Assessment should include a detailed history comprising alcohol use, onset and course of confusion, previous episodes of confusion, sensory deficits, safety issues and social circumstances. Premorbid functional activities of daily living, symptoms of underlying causes and co morbid illnesses.