3-137 Which assessment tool

TIPS Question:

What indicators do you consider when determining what assessment tool to use? Are all of them reliable? Does the degree of dementia play a factor?

Response:

Assessment tools are good in "describing and recording what we see" as we go beyond our "hunch" or one word description such as 'agitated.' Are all of the tools reliable? The tools for the P.I.E.C.E.S. project were selected because they are widely recognized such as the Folstein Mini-Mental Status Examination (MMSE), which means the score is meaningful to most clinicians. However, the scores can be affected by the way an individual scores the tool. Also, any tool is just one part of the information and does not provide a diagnosis or answer by itself. In other words, all tools must be considered in the context of the rest of the assessment data.

In order to assist you with what tools should be used, refer to the Assessment Guides and Tools in the Resource section of the P.I.E.C.E.S. Guide. There is a reference chart that provides an overview and description for each of the tools. More information follows with greater detail of each of the tools. By using the tools often, you will gain a sense of which tools fit the clinical picture of your resident. So try to use them often.

In general, the Cognitive Assessment Measure (CAM) and I WATCH DEATH are tools that assist in determining delirium. These can be used regardless of cognitive status. The Folstein MMSE and The Clock Drawing Test assess for cognitive status. There is a floor and ceiling effect for both with regards to cognitive status. Clinicians gain valuable knowledge on the resident's cognitive status as long as they take into consideration the rest of the assessment data. Also, you can observe the person in terms of the 7As to better understand cognition. The Cornell Scale for Depression, and SIG E CAPS both screen for depression and can be used in spite of cognitive status, as they utilize our observations of the client. The Geriatric Depression Scale (GDS) is also a screening tool for depression, but for use with the less cognitively impaired. The Cohen-Mansfield Agitation Inventory (CMAI) is used whenever you want to pinpoint actual behaviours, frequency and associated caregiver perceptions. The Dementia Observation Scale (DOS) can be used with many situations and gives an excellent report on when behaviours actually occur. Both of these are independent of cognitive status. The Disorders of Logic is used to assess the status of delusional thinking. Because these questions require meaningful dialogue and self-assessment, cognitive status cannot be too impaired.

There are drawbacks to all assessment tools. We can list all the negative aspects of each, as well as the positive. The Tools section of the manual reports on reliability issues in more detail. In all cases, the clinician is responsible for administering and interpreting the tool appropriately, thus maximizing its reliability.

The degree of cognition can affect the ability to participate in any of these assessment tools. It is important that the clinician take into consideration cognitive status and the rest of the assessment data when interpreting the results of the tools. The more you administer these tools, the more you will have a sense of normal and abnormal test results. It will help you in learning that "common language" which is one of the P.I.E.C.E.S. goals. Using the tools can be fascinating as you try to understand what the residents are trying to tell you through their behaviour, so that you can develop customized care strategies.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*