Guidance for Assessment of Cognitive Impairment in Old Age Psychiatry (Central Manchester).

In most circumstances it is probably most appropriate that they are assessed in their home environment (taking into consideration safety risks to staff and local lone worker protocol). It is important to have a collateral history from someone who is familiar with the person, however at times there may be some difference of views making it more appropriate that the person be interviewed separate from the person being assessed.

1. Firstly establish the onset of cognitive impairment. How long have problems been present? Did they start suddenly or gradually? How have they progressed; gradually, stepwise or with fluctuations on a week to week/day to day or throughout the day basis? Was the onset correlated with any physical health problem or psychosocial stressor? Is it just short-term memory that is affected or long-term memory?

2. Language (normally left side brain): - Are there problems with expression or understanding? Are there word finding difficulties or signs of making up words? Do they use filling-in words e.g. thingy, wotsit, doodah, more than they used to? A good way to test language on the mini mental state examination is to ask if people are able to name a winder on a watch and a nib or clip on a pen. Do they have problems with comprehension? If you are not sure you could ask the following "if the lion killed the tiger, which animal is dead" or ask the person to point to a source of illumination in the room. Do they use the telephone normally still? Ask the person if they are able to read and write and if there is any change (e.g. not able to read books now but can read newspapers, unable to write letters but can do Christmas cards), reckon change in shops and calculate.

3. Recognition (right temporal):- Can the person recognise faces or objects? Do they misidentify faces and objects? Can they distinguish between recognition and naming?

4. Visuospatial problems (right parietal): - Do they get lost in familiar or unfamiliar environments? Do they lose things in the house more than they used to? Can they put clothing on correctly (arms in arms holes etc)? **Do they drive and are there any concerns about there driving, have there been any accidents, near misses, impulsivity and poor judgement when driving or episodes of getting lost, do they limit their driving?**

5. Are there any signs of apraxia or agnosia? Are there any things they are unable to do but have normal motor skills e.g. operating a television/remote control or dressing? Are they unable to visually recognise things despite reasonable vision?

6. Ask about changes in personality/character. Has there been any personal or social misconduct/disinhibited behaviour? Has there been a change in choice of language e.g. swearing, saucy comments? Have they become more selfish? Have they developed a sweet tooth? Do they have any obsessional or ritualistic behaviour? Are there any signs of apathy/lack of motivation?

7. Is there any change in their activities of daily living? What is their self-care like? Are they able to cook, make a hot drink, shop, clean the house, dress, wash, do their laundry or deal with their finances?

8. Are there any specific risk issues e.g. wandering, falls, verbal or physical aggression, compliance with medication, safety with appliances (e.g. gas cooker/fire), vulnerability through exploitation or abuse by others, leaving the front door open? Is their nutrition neglected?

9. Ask about symptoms and change in mood (either lowered or elated, including biological, cognitive and somatic symptoms of depression, anxiety and screen for suicidal ideas). For each ask about onset, intensity, duration.

10. Ask about psychotic experiences (e.g. hallucinations and delusions). "Do you ever see/hear things that others cannot?"

11. Ask about neurological symptoms including headache, visual/auditory impairment, dysarthria, weakness of the limbs, falls/dizziness/loss of balance, incontinence, sensory problems, seizures, abnormal movements or recent head injuries.

12. Past Medical History: - Screen for vascular risk factors, including hypertension, heart disease, raised lipids, diabetes, history of stroke/TIAs, history of smoking and alcohol intake (current and past). Screen for any history of head injuries including heavy footballs and boxing. Any other life history of cerebral damage.

13. Medication: - Ask about any allergies or drug sensitivities. Make sure you check what medication people should be taking and what they are taking. You will need to look at their medication and see if there is any evidence of poor compliance. Also ask about any other over the counter type preparations or non-prescribed drugs taken (including illegal).

14. Family History: - Enquire about deaths of family members (parents, siblings, and children), the age and cause of death. Ask if there is any family history of memory or psychiatric problems.

15. Personal History: - Ask about where the person was born and brought up. Ask about childhood experiences and parenting. Ask about ability at school and whether there were any subjects they were particularly good or poor at. Were they able to read and write? Enquire about their occupational history, what jobs have they done, roughly for how long and what was the main reason for leaving? What age did they retire and was this on health grounds? Consider industrial poisons/chemicals. What marriages or significant relationships have they had and what children do they have? Any head injuries that caused unconsciousness? Boxing?

16. Social History: - Where does the person currently live and with whom. What aids and adaptations do they have in their home environment e.g. walking stick/zimmer frame/wheelchair/stair lift/stair rails or other rails/bathroom aids? What informal support do they have from family, friends and neighbours (type and frequency, would help be available in a crisis)? What formal service support do they have e.g. home care, Meals on Wheels, day care, respite care? Do they have a pendant alarm and understand how to use it? Do they have a gas cooker/gas fire? Do they have a smoke alarm? Does it work? Do they understand what it is?

17. Mental State Examination: - To include routine categories but also pay particular attention to any fluctuating level of consciousness, (distractibility, sensitivity to noise) signs of intoxication, walking abnormalities (feet wider apart than normal, dragging feet, shuffling), other crude neurological signs, signs of self-neglect, disinhibited, apathetic or aggressive behaviour, signs of self neglect (hair, teeth, clothes, odour) and assessment of capacity with regard to the assessment for further investigations, information sharing and future management plan.

18. Further Investigations from this baseline may then include physical examination, and check blood screen has been done although this is the role and responsibility of primary care and should include: full blood count, ESR/CRP, B12 and folate, U&Es, profile, calcium/phosphate, liver function tests, thyroid functions tests, glucose, lipids and if indicated flammatory markers/ auto-antibodies. We usually arrange a CT brain scan, ECG, MSSU and in certain circumstances an EEG. A small number of people may require further specialist and neurological investigations e.g. lumbar puncture. Specific consideration should be given to whether there is any indication for screening for sexually transmitted diseases or evidence of malignancy (e.g. PSA in a man with weight loss). Neuropsychology testing may be indicated in some people for more specific assessment where the diagnosis appears unclear. Further specialist assessments could include nursing, occupational therapy and social work.

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