

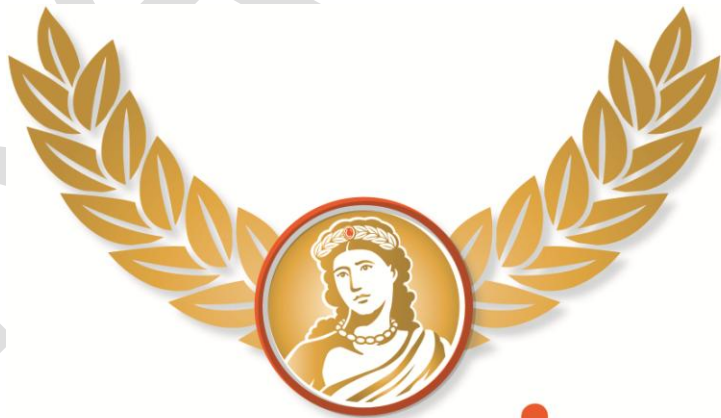
Soteria Strains

Safe Patient Handling and Mobility Program Guide

Section 4 – Special Considerations

Section 4.4 – Cognitive Impairments

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soteria

STRAINS

A provincial strategy for healthcare workplace musculoskeletal injury prevention.

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Section 4 – Special Considerations sub-sections will be expanded and/or modified as required based on input from experience and observations during program implementation.

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4.4 Cognitive Impairment

Changes to cognitive status may be normal for a patient because of their medical history (e.g., early- to late-stage dementia patients) or their medications (e.g., drowsiness from pain meds). Health care workers need to be aware of the patient's cognitive status and anticipated changes/cycles. Please refer to "Section 2.3 – Patient Risk Profile" for information on completing a thorough patient risk profile for all patient populations. Some patient populations require special attention to cognitive status such as patients with brain injury, dementia, and psychiatric co-morbidities.

Health care workers who handle and mobilize patients should either perform or be made aware of the results of regular cognitive screening tests. For areas that have not adopted a standard protocol, two are included in the appendix. Refer to Appendix 4.4.1 – Cognitive Screen: 6CIT Kingshill Version 2000 and Appendix 4.4.2 – The 10-Point Test.

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Appendix 4.4.1 – Cognitive Screen: 6CIT Kingshill Version 2000

6CIT - Kingshill Version 2000	
1. What year is it?	Correct – 0 points Incorrect – 4 points
2. What month is it?	Correct – 0 points Incorrect – 3 points
3. Give the patient an address phrase to remember with five components, e.g., John, Smith, 42, High St., Bedford	
4. About what time is it (within one hour)?	Correct – 0 points Incorrect – 3 points
5. Count backwards from 20 to 1.	Correct – 0 points 1 error – 2 points More than 1 error – 4 points
6. Say the months of the year in reverse.	Correct – 0 points 1 error – 2 points More than 1 error – 4 points
7. Repeat address phrase	

	Correct – 0 points 1 error – 2 points 2 errors – 4 points 3 errors – 6 points 4 errors – 8 points All wrong – 10 points
6CIT score = /28	

- Number of questions: 6
- Time taken to perform: 3-4 minutes
- Score: The 6CIT uses an inverse score, and questions are weighted to produce a total out of 28. Scores of 0-7 are considered normal and 8 or more significant.
- Advantages: The test has high sensitivity without compromising specificity even in mild dementia. It is easy to translate linguistically and culturally. It is also a much newer test than the [Abbreviated Mental Test](#) (AMT).
- Disadvantages: The main disadvantage is in the scoring and weighting of the test, which is initially confusing; however, computer models have simplified this greatly.
- Probability Statistics: At the 7/8 cut off, overall sensitivity is 90% and specificity 100%; in mild dementia, sensitivity = 78% , specificity = 100%

Appendix 4.4.2 –The 10-Point Test

A circle approximately 4.5 inches in diameter is traced. The patient is asked to "put the numbers on the face of a clock" and when the task is completed to "make the clock say 10 minutes after 11." Ten minutes after eleven is the time setting of choice because it forces the patient to attend to both halves of the clock and requires the recoding of the number "10" to the number "2" on the clock.

To score the test, the clock drawing is turned so the number 12 is at the top of the page. The circle is divided into eighths, beginning with a line drawn through the 12 and the middle of the circle. Dividing the circle can be done quickly with any straight edge, but a transparent plastic template of a circle already divided into eighths makes scoring easier. Plastic film used for transparencies can be used and placed over the clock.

One point is given for each of the following numbers that falls in its proper eighth of the circle: 1, 2, 4, 5, 7, 8, 10, and 11. At least half of the numbers must be in the correct segment. Pen marks or words instead of numbers do not count.

One point each is given for a short clock hand pointing at the number "11," and a long hand pointing to the number "2". No points are given for the hands if they are approximately equal in length, for a long hand on the 11 and a short hand on the two, or for hands of any length pointing at other numbers. A score of 10 suggests that cognitive impairment is unlikely. A score of less than eight indicates probable impairment, and a score of less than five indicates prominent impairment.

This system of testing and scoring is simple and requires no special forms or tools. The scoring is more objective than in other versions of clock-drawing tests. Emi Storey, co-author of asked residents at her nursing facility to draw three clocks. None of the clocks took more than six minutes to draw and score.

The clock-drawing test is an excellent screening tool for cognition. It is not stressful and is readily accepted without affronting the patient's dignity. Since analog clocks are familiar to everyone in the developed world, the test can be taken by non-English speaking, multi-ethnic clients with minimal translation, and it will have equal validity.⁶

Figure 1

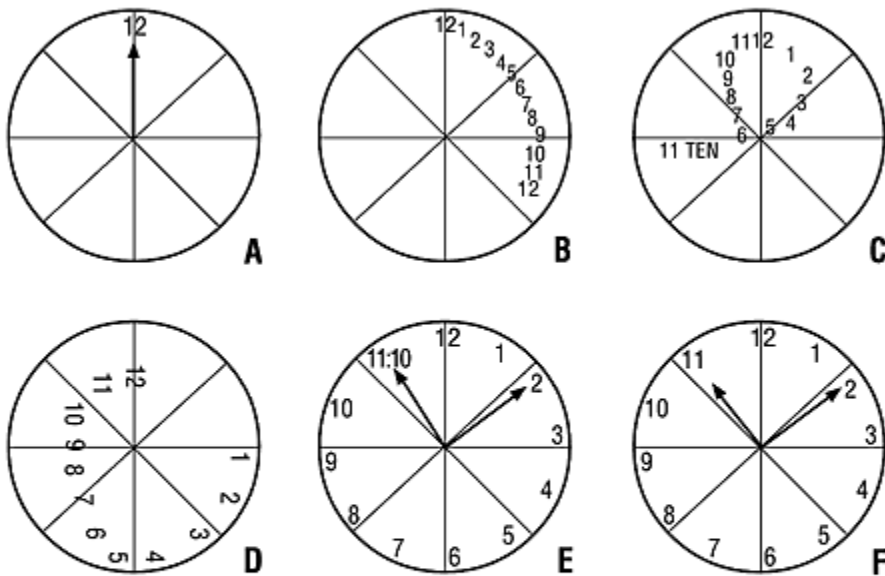


Figure 1. Scoring: **A.** Score = 0. **B.** The number 1 is in the correct position; score = 1. **C.** Numbers 1 and 2 are in the correct positions; score = 2. **D.** Numbers 7, 8, 10, and 11 are in the correct positions; score = 4. **E.** Numbers 1, 2, 4, 5, 7, 8, 10 and 11 are in the correct positions; score = 8. No points for hands of approximately equal length regardless of position. **F.** Numbers 1, 2, 4, 5, 7, 8, 10 and 11 are in correct position for 8 points. The little hand is on the 11 (1 point) and the big hand is on the 2 (1 point); score = 10 points (modified from Manos PJ and Wu, 1994)