CHECKLIST FOR CARE OF THE GERIATRIC PATIENT WITH HEART FAILURE

Nutritional assessment (MNA SF) [Score 0-7 malnutrition, 8-11 at risk, ≥12 normal]

- Has food intake declined over the past three months due to loss of appetite, digestive problems, chewing or swallowing difficulties?

  i. (score =0 (severe decrease), =1 (slight decrease), =2 (no decrease)

- Involuntary weight loss during the last 3 months?

  ii. Score 0 = Weight loss greater than 3 kg (6.6 pounds) 1 = Does not know 2 = Weight loss between 1 and 3 kg (2.2 and 6.6 pounds) 3 = No weight loss]

- Mobility?

  iii. Score 0 = Bed or chair bound 1 = Able to get out of bed/chair, but does not go out 2 = Goes out

- Neuropsychological problems?

  iv. Score 0 = Severe dementia or depression 1 = Mild dementia 2 = No psychological problems

- Body mass index (BMI)? (weight in kg / height in m2)

  v. Score 0 = BMI less than 19, 1 = BMI 19 to less than 21, 2 = BMI 21 to less than 23, 3 = BMI 23 or greater

  vi. If unable to do BMI, Calf circumference (CC) in cm 0 = CC less than 31, 3 = CC 31 or greater

The Mini-Cog (Score 0-2 cognitive impairment, Score 3-5 normal)

- Three-word registration: “Please listen carefully to three words, then say them for me now” (banana, sunrise, chair OR village, kitchen, baby OR leader, season, table)
- Clock draw: Reference a piece of paper having a circle on it, and say, “Next, I want you to draw a clock for me. First, put in all of the numbers where they go.” When that is completed, say: “Now, set the hands to 20 past 8.”

  vii. (Score 0 or 2 points) Normal clock = 2 points. Hand length is not scored. Inability or refusal (abnormal) = 0 points.

- Three-word recall: Ask the person to recall the three words you stated in Step 1. Say: “What were the three words I asked you to remember?”

viii. (Score 0-3 points, one for each word without cueing)

PHQ-2 Depression Screen (Score of 3 or more suggest depression)

- Over the past 2 weeks, how often have you been bothered by the following problems?
    - Little interest or pleasure in doing things
        i. Not at all (0), Several days (1), More than half the days (2), Nearly every day (3)
    - Feeling down hopeless or depressed
        ii. Not at all (0), Several days (1), More than half the days (2), Nearly every day (3)

Basic and Instrumental Activities of Daily Living

Basic (based on Katz' Index):

- Bathing (Independent/Dependent)
- Dressing (Independent/Dependent)
- Toileting (Independent/Dependent)
- Transferring (Independent/Dependent)
- Continence (Independent/Dependent)
- Feeding (Independent/Dependent)

Instrumental (adapted from Lawton and Brody):

- Ability to use telephone (Independent, Able with assistance, Unable to perform)
- Shopping (Independent, Able with assistance, Unable to perform)
- Food preparation (Independent, Able with assistance, Unable to perform)
- Housekeeping (Independent, Able with assistance, Unable to perform)
- Laundry (Independent, Able with assistance, Unable to perform)
- Mode of Transportation (Independent, Able with assistance, Unable to perform)
- Responsibility for own medications (Independent, Able with assistance, Unable to perform)

- Ability to handle finances (Independent, Able with assistance, Unable to perform)
- Driving or using public transportation (Independent, Able with assistance, Unable to perform)

Gait Speed over 5 meters (Measure and mark a standard distance of 5 meters. Instruct patient to "start walking at a comfortable pace" several meters before the starting line, and continue walking though the finish line for several more meters. Derive gait speed by calculating 5 meters divided by seconds, to the nearest 0.1 second. A gait speed of <0.8 m/s typically suggests frailty. Age and sex derived cut-offs have been previously published).

Timed Up and Go test (Begin by having the patient sit back in a standard chair with arm rests. The patient can use the arm rests during sit-stand and stand-sit movements. Time how long it takes the patient to stand up from the chair, walk 3 meters, turn around, walk back, and sit down again in chair. In general an older adult who takes ≥12 seconds to complete the test is at risk for falling, and characterizes frailty. Age derived cut-offs have been previously published).

FRAIL questionnaire (Scoring: Robust [score=0], Prefrail [score=1-2], and Frail [score=3-5]).

- **F**atigue: Are you fatigued?
- **R**esistance: Cannot walk up one flight of stairs?
- **A**erobic: Cannot walk one block?
- **I**llness: Do you have more than 5 illnesses?
- **L**oss of weight: Have you lost more than 5% of your weight in the past 6 months?