Long-Term Care Survey Alert

RESIDENT ASSESSMENT: These Best Practices Will Help You Evaluate, Care Plan A Resident Triggering On The Cognitive Impairment QI

Identify what's wrong so you can help.

If you don't assess and care plan each resident triggering on the cognitive impairment QI, you may miss the window for detecting and correcting reversible causes of cognitive problems. And if the resident is showing signs of the early stages of dementia, you need to update the medical and nursing care plan to identify and address the problem and related outcomes.

Rule out delirium: An acute infection, recent hospitalization, serious pain or new medication can cause delirium, which mimics signs of dementia. But the onset of delirium is acute compared to dementia, which occurs more slowly, according to **Susan Scanland, MSN, APRN, BC-GNP**, in a presentation, "Assessment of Delirium, Depression and Dementia," at the March 2006 **American Association of Nurse Assessment Coordinators** conference in Las Vegas. You may also see "marked fluctuations and day/night cycle changes."

Assessment tool: Use the Confusion Assessment Method (CAM) to quickly ferret out whether a resident may have delirium. For details on the test, read the article at www.hartfordign.org/publications/trythis/issue13.pdf.

Look For Other Causes

"Sometimes a medication that doesn't really cause delirium can still affect short-term memory--for example, the benzodiazepenes," says **Marilyn Mines, RN, BC**, director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. "Or a psychoactive medication could affect how involved the person is in making decisions and being involved in the facility," she says. If you suspect that's the case, ask for a pharmacy consult.

"People under significant stress may show problems with short-term memory or decision-making," says Mines. How is the resident sleeping? Chronic insomnia can affect a person's cognitive functioning.

Another possibility: The person may have had a pre-existing mild dementia that staff didn't detect on the prior assessment. Mines notes that "someone might test as OK on memory and cognitive skills for decision-making initially because he has has learned how to cover up his problem. But by the time the next assessment rolls around, the staff realize the person has an issue with cognition."

A dementia medical work-up includes a CT or MRI of the person's brain, complete blood count and full chemistry profile, TSH, vitamin B-12 levels, an EKG and urinalysis, according to Scanland's AANAC presentation. Optional testing might include the person's "folate level, a toxicology screen, HIV and syphilis testing for endemic areas or high-risk patients, a chest x-ray and lumbar puncture."

Tip: Don't forget to check the person for anemia, which can cause cognitive decline over time.

In addition to lab and diagnostic neuroimaging and a physical exam, a dementia evaluation also includes formal mental status testing, and a history of the person's memory, mood, behavioral changes, medications and medication history--and a look at the person's changes in functional status, Scanland relayed.

Take a Holistic Approach to Care Planning

For example, if the resident with worsening cognition also has incontinence and depression indicators, is there a

relationship among those outcomes? "Probably," says **Steven Littlehale, MSN, RN**, chief clinical officer for **LTCQ Inc**. in Lexington, MA. Depression can worsen cognition and might also cause or worsen incontinence, if the person lacks the motivation to use the toilet on his own. Or the worsening cognitive impairment could play a role in the depression and incontinence, Littlehale says.

Determining which came first--the depression, incontinence or cognitive loss--gets tricky, says **Jennifer Gross, RN, BSN**, a consultant with LTCQ.

The way out of the maze: Address each of the problems and see what happens, suggests Littlehale. For example, the interdisciplinary team can get to the bottom of the person's depression and treat that--and see if his cognition and continence improves.

"An effective incontinence care plan might take into account the person's cognition, possible medication side effects, physical functioning, mobility, activity and dietary preferences, etc.," adds Gross.

If the resident receives a diagnosis of dementia, "don't just say you're going to write a care plan for cognitive impairment," Gross emphasizes. "Look at how the cognitive impairment affects the person's fall risk, continence, ADLs, etc."

Tip: Provide therapeutic activities with a goal of cognitively stimulating people with dementia, adds **Roberta Reed, MSN, RN,** clinical care manager at **Legacy Health Services**. "If you don't stimulate people cognitively, their decline will be even more rapid," she cautions.

Don't Give Up

As a resident's dementia progresses, evaluate your care plan options to help the person maintain or improve related outcomes.

For example, "when you look at the QI for [low-risk] incontinence, anyone who is coded as B4 = 3 [severely impaired in cognitive skills for daily decision-making] and B2a = 1 for a short term memory problem--or totally dependent in mobility ADLs--will be excluded from the denominator," says **Rena Shephard, RN, MHA, FACDONA**, president of **RRS Healthcare Consulting** in San Diego. "And someone that severely impaired cognitively will probably be difficult or impossible to train to be continent again," she adds.

"But that doesn't mean staff shouldn't try to put the person on an individualized schedule for toileting" to keep him as continent as possible, says Shephard.