MDS Alert

Resident Assessment ~ Get The Rest Of The Story From The Resident's Family For Delirium, Sensory Deficits, Mood Indicators And More

Ask not and your MDS, care plan and survey record may end up wanting.

Could your resident's family member hold the clues to creating a care plan without any gaps for these conditions?

Delirium (Section B5). Accurate assessment requires conversations with staff and family who have direct knowledge of residents' behavior over the lookback, notes **Bet Ellis, RN,** a consultant with **LarsonAllen** in Charlotte, NC.

"Residents are unlikely to correctly describe their behaviors or give suggestions on what may trigger" the delirium, says Ellis. Family caregivers will also be able to let you know what interventions have helped manage the person's delirium behaviors in the past, she notes.

Example: Medications sometimes trigger delirium. In one case, an 87-year-old male patient with Lewy Body dementia developed a delirium with severe visual hallucinations for a week during a course of ampicillin, relays **Susan Scanland, MSN, RN,** a geropsychiatric expert in Clarks Summit, PA. Another physician prescribed ampicillin for the patient two years later "and the delirium recurred with vivid visual hallucinations persisting for two weeks," she says.

Lesson learned: Ask the family if the person has become confused when taking any medication, including OTC meds, such as Benadryl or sleep aids, or herbs, advises Scanland. "People with dementia, especially Alzheimer's disease, who have already low levels of acetylcholine in the brain, are at higher risk for developing confusion/delirium" when taking an anticholinergic medication, says Scanland. Also ask family/significant others if the elder had delirium during a UTI, respiratory infection or dehydration, suggests Scanland. "These are the most common non-medication types of delirium in elders," she says. "Has the person become acutely confused during a hospitalization? Knowing the past medical history will assist in detecting the cause of delirium."

Target These Additional Sections

Other MDS sections where family input can give you valuable information that's not available from any other source include:

Sensory deficits (Sections C and D): Ask family members questions to uncover a resident's sensory impairments, which are often undiagnosed, suggests Scanland. "Does the person speak loudly or turn up the volume on the television? Can the person read a newspaper? Does he/she wear glasses or a hearing aid?"

Mood and behaviors (Section E): Family members can provide valuable information for completing the mood and behavior sections, notes Brown. Having a social worker talk to the family at admission can help staff determine the resident's and family's attitude about medication use for behavioral symptoms, says **William Simonson, PharmD,** a consultant in Suffolk, VA. That information can open the door for staff to educate the resident/family about the role of such medications -- and also honor their wishes about avoiding them, heading off disputes between the family and facility.

If the resident does have mood and anxiety indicators, staff should really look at family issues, advises **Francis Battisti,** a social worker and nursing home consultant in Binghamton, NY. "When you admit a resident, you are bringing in the whole family," figuratively speaking, even if they aren't visiting, he points out. And "we need to do an assessment of the family interactions and communications or lack of."

Weight loss issues (Section K): "It's important to get family members' input on weight loss questions," counsels **Reta Underwood,** president, **Consultants for Long Term Care Inc.** in Buckner, KY. You may have a hospital admission weight recorded but no historical information on what the person has normally weighed, she notes.

Activities (Section N): To complete Section N accurately you need input from family members or others who know how a resident with dementia is now and also the person he was back in the day. For example, "a sibling or spouse may be the only person who knows that the person used to love ice-skating or had dogs of a certain breed," says Underwood.

Drill down your assessment: It's not enough to know that the person likes animals, for example, says Underwood. Using "drill down" interviewing practices, you can find out more -- "for example, what breeds did he enjoy and how did the person relate to a particular dog?"

Also, the family may know that the person has always been a bit of a loner and enjoyed watching certain TV programs. "Documenting this information and using it for care planning certainly helps the resident," says Underwood. But it "can help ward off survey citations when surveyors see a resident sitting in his room watching TV instead of participating in a group activity," she adds.

Take it the next step: Care plan the types of TV shows, channels and viewing times the person is known to enjoy watching, suggests Underwood. Or if the person enjoys movies, make sure he has access to the ones he enjoys watching, she adds.

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