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Guidelines for Safe Management of the Demented Resident in the Assisted Living Facility Setting

*A Handbook for Owners, Operators, and Managers of
Assisted Living Facilities*

This book contains a brief synopsis of management strategies for common problems encountered in the care for dementia residents that can be used in conjunction with the DETA Care Series, the DETA Brain Series, and the Behavioral Management Handbook. Operators of SCALFs are expected to have procedures in place to address basic health and behavior problems within the facility. This handbook outlines common problems, suggestions, and interventions for SCALF managers.

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1.

Basic Principles Of Management For Assisted Living Facilities With Demented Residents

The safe, profitable operation of an assisted living facility for demented residents requires specific clinical and management skills. The management team is responsible for the clinical environment of the facility, as well as the financial viability of the enterprise. Family caregivers are more likely to place demented residents in facilities with trained, motivated compassionate staff.

A successful program for persons with dementia includes, 1) an appropriate physical structure, 2) adequate staffing, and 3) basic management programs that fully utilize available personnel. The SCALF management team must assure that consultants are appropriately utilized. Family involvement in the facility is essential to maintaining quality of care and reducing the risk of liability actions. Each facility must have a method of dealing with basic quality of care issues such as weight loss, falls, assaults, etc. Although each facility will have a medical consultant, many residents will retain their primary care physician. These doctors may not understand basic dementia care and your facility will need to provide appropriate liaison to reduce the risk of excessive medication or unrecognized health problems that produce in-house complications like falls, weight loss, etc. This handbook is designed for upper management within each assisted living facility. This book contains brief descriptions for the role of key personnel, e.g., medical consultant, nurse, coordinator, etc., within your facility. This text discusses key issues in maintaining a patient population that is appropriate to your staffing and physical structure. The text outlines management actions for specific types of problems encountered within your resident population. The educational segment describes basic and advanced learning programs for your workers that culminate in recognition as experts in dementia care.

2.

Comprehensive Assessment and Management of Behavioral Problems in the Regular Assisted Living Facility Setting

1. Overview

The assisted living residents may exhibit symptoms of a broad range of psychiatric and behavioral problems associated with dementia. The assisted living staff must understand and deal with abnormal behaviors. The ALF management team must determine whether a behavior represents a medical emergency or an issue for discussion with the resident's family. The ALF staff must know how to deal with emergencies such as elopement and recognize medical problems in persons with limited abilities to communicate. The staff of facilities that specialize in dementia care, i.e., SCALFs, require expertise beyond that expected for persons who operate regular assisted living facilities.

The resident who ages in place differs from that of an individual transferred to the facility. Residents who age in place have previously learned the routine and the physical structure for the assisted living facility. A new individual with dementia may be unable to learn that routine and structure. The new admission may require several months to accommodate to the new environment. During the transition phase, the new resident may manifest transient behavioral abnormalities.

A comprehensive dementia program within an assisted living requires a four-step approach: 1) promote intellectual wellness, 2) identify and treat dementia as early as possible, 3) reduce behavioral complications produced by dementia and slow the loss of function, and 4) recognize patients who need different services.

2. Epidemiology Of Psychiatric Problems In Alf Residents

The assisted living operator will be required to manage dementia, mental health problems or abnormal behaviors. At the national level, all residents have high rates of psychotropic medication usage to include antipsychotics, antidepressants, and benzodiazepines. The types of behavioral problems encountered in the ALF will resemble those seen in nursing homes with almost half of residents (42%) having one or more behaviors in the last two weeks with up to 1/5 of residents demonstrating physical aggression and 13% manifesting non-compliance with treatment programs. The use of psychotropic medications exceeds half (53%) and includes neuroleptics (21%), antidepressants (33%), and benzodiazepines (24%). ALF residents can demonstrate many behaviors, similar to those experienced by nursing home residents including pacing (13%), hoarding (9%), disrobing (5%),

and restlessness (10%). Smaller facilities are more likely to have residents with more intense behavioral problems.

Simply stated, the assisted living facility residents require structured living for specific reasons. In many instances, the ALF admission was precipitated by cognitive decline, psychiatric problems, or complex psychosocial needs. The ALF resident will also demonstrate multiple medical problems that complicate the behavioral management.

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3.

Maintaining Cognitive Health in the Regular ALF Resident

1. Promotion of Successful Aging and Dementia Prevention

Intellectual wellness is part of a comprehensive wellness program that every assisted living facility should develop. Although genetics accounts for about 1/3 of aging, life choices determine about 2/3 of how well we age. Residents within your facility will benefit from an aggressive, successful aging program (See Handout on Successful Aging) that defines simple, direct interventions to promote physical, mental, and spiritual wellness.

Clinical trials do not provide a specific program for successful aging. An accurate study to determine the impact of successful aging program on health outcomes for elders would require about 30 years of research using thousands of research subjects in multiple centers through the country. This scientific endeavor would be expensive, tedious, and difficult to quantitate. Such research will never occur and clinicians are left with interpretation of longitudinal studies such as the Framingham, Honolulu, Rotterdam, or Baltimore longitudinal studies. These multi-decades studies of thousands of older subjects describe health and behavioral patterns that are associated with successful aging. Many problems or interventions defined by these studies are important to the assisted living operator.

- A. Exercise:** Physical, intellectual, and spiritual exercises are key components to successful aging. The assisted living facility should have an active program that promotes regular age and disease appropriate exercises for residents. Residents should be encouraged to engage in intellectually stimulating activities such as reading, crossword puzzles or learning new skills. Novel learning is more protective against dementia than repeating intellectual processes that use “old” knowledge. Spiritual exercise is also important and the facility should facilitate participation in the spiritual activity choice for the residents. Studies demonstrate that individuals with active spiritual life have less morbidity associated with disease and quicker recovery from surgery.
- B. Hypertension and Cardiovascular** Hypertension and cardiovascular disease are both associated with cognitive decline. ALF staff should

**Disease
Prevention:**

encourage ALF residents to monitor blood pressure, consult with physician, and comply with protocols to lower blood pressures. Even mild elevations of systolic and diastolic blood pressures, e.g., 160/90, can be associated with increased heart disease and risk for dementia. Every longitudinal study that has examined the effect of high blood pressure on brain function show that people with untreated or under-treated hypertension are at greater risk for developing cognitive decline as they grow older. The ALF staff should educate residents on the benefits of hypertension and vascular control for overall cognition.

**C. Recognize
and Treat
Depression:**

Depression is a common disorder in all older individuals and studies demonstrate that up to 33% of assisted living residents manifest evidence of depression based on symptoms or therapy. Depression is a serious health problem that significantly increases the risk of medical problems such as heart attack, stroke, and disability from those events. Depressed patients recuperate from surgery slower and have more complications. A depressed, assisted living resident is probably less likely to remain in your facility and more likely to require more services. Depression is easily treated with non-addictive antidepressant medications (**See Depression Handout**). The assisted living staff is encouraged to promote depression screening and identify early warning signs for depression in the ALF resident. Those individuals should be encouraged to seek a proper evaluation and fill prescriptions provided by the physician. Depression also occurs in dementia and Parkinson's disease.

D. Avoid Delirium:

Delirium is a common problem in all elderly patients and this condition is particularly problematic in persons with dementia or neurological diseases, e.g., stroke, multiple sclerosis. Abrupt changes of behavior or intellectual function suggests delirium in the older patient. Older persons admitted to the hospital are at increased risk for developing delirium and subsequent placement in a nursing home.

The assisted living operator and staff should be aware of the symptoms of delirium. Dementia does not produce abrupt changes of intellectual function or

behaviors. Sudden loss of intellectual ability or new onset behavioral problems suggests a new medical problem that requires evaluation by a physician with expertise in treating older persons.

Residents may return from the hospital dramatically different than when transferred for a medical or surgical problem. Post-hospitalization confusion is common and the assisted living staff should encourage the patient or family to seek assistance for their resident **(See Delirium Handout)**.

E. Avoid Medication Mistakes:

Medication mistakes are common in the elderly and about 10% of drugs written for all older people are written in error. Medication problems are particularly common in persons residing in the assisted living facility regardless of whether they self-administer drugs or the facility administers the medication. Both under-treatment and over-prescription occur in the ALF setting. Residents are commonly under-treated for serious health problems, like congestive heart failure (62%) or osteoporosis (60-70%).

Persons with dementia or other neurological problems are at high risk for adverse consequences of medication mistakes. The facility should encourage residents to investigate their medications, comply with written instruction, or ask doctors important questions. Treatment with more than one drug from the same class, e.g., high blood pressure, diabetic, deserve an explanation from the doctor at a routine visit. Sleeping and nerve pills should be prescribed with great care as they can cause confusion and accidents. Powerful tranquilizing medications, such as antipsychotic medications, should be used for very specific purposes. Over-the-counter preparations, such as sleeping aids, antihistamines, etc., can produce significant problems in the ALF resident.

F. Avoid Complications During Hospitalization:

Safe, hospital visits are an essential component to any wellness program. Hospital safety is a major concern that involves the resident, their family, and the assisted living staff. Staff should alert the families to the three

deadly D's of hospitalization – delirium, decubiti, and debilitation. Debilitation includes dehydration, demobilization, and diminished oral intake. Persons with dementia are particularly prone to serious avoidable complications during hospitalization and families should discuss this issue with the anesthesiologist, the surgeon, and the hospital treatment team.

4.

Early Recognition And Treatment Of Dementia

1. Detection Or Early Intervention For Dementia

Persons with dementia often go unrecognized by family, friends, and their primary care doctor. The assisted living facility staff may observe slow deterioration of function over time. Many medical problems, neurological diseases, and psychiatric disorders can produce deterioration of intellectual function. Dementia screening is safe, effective, and reliable. No clinical evidence suggests that individuals are harmed or distressed by the screening process and early identification affords an opportunity for aggressive therapy and slowing the progression of the disease. Many screening instruments are available that use as little as seven minutes. Individuals who screen positive should be referred to a local physician with expertise in assessment and management of dementia such as neurologists, psychiatrists, or family practice doctors with expertise in geriatrics.

Persons diagnosed with Alzheimer's disease should be encouraged to use available medications to slow the progress of the disease. Available medications, including Aricept, Exelon, Reminyl and Namenda are proven to slow the progression of the disease and maintain the patient outside of a nursing home for an additional two years. Early recognition and treatment may reduce the likelihood of developing behavioral complications or avoidable complications such as delirium. Everyone benefits when the patient is screened for dementia and their life management plan is adjusted to reduce risks for avoidable complications such as mistakes in self-administration of drugs, vehicular accidents, or accidental injuries.

The DETA program provides support to all ALF operators in Alabama who care for person with dementia, regardless of whether these facilities are regular ALF's or SCALF's. Please visit our web-site www.alzbrain.org for our printed materials that are available to each of you.

5.

Management Organization for SCALFs

Specific members of the management team provide essential leadership in the SCALF. Each member must understand their responsibilities and execute these duties with professionalism and devotion. A trained, motivated, compassionate staff is a powerful marketing advantage for the facility.

Unit Coordinator

The unit coordinator is an essential leader in the facility and this person should know the residents, staff, and operating programs. The unit coordinator is the liaison between the staff and the medical team to assure that proper communication occurs between PCA's and the consulting nurse or physician. The unit coordinator should master all the material in the DETA Brain Series and demonstrate the capability to oversee behavioral management of demented residents. This individual should assess quality parameters such as weight monitoring, hydration monitoring, patient care plans, and nutrition. The unit coordinator must oversee the falls prevention program to assure that recommendations made by the treatment team are executed by the staff. The unit coordinator is responsible to assure that appropriate staff training occurs. The unit coordinator is also responsible to assure that basic health and safety measures such as unit cleanliness, fire evacuation plans, physical plant, etc. are appropriate to the resident's needs.

Nurse Consultant

Control of medical and neuropsychiatric symptoms is the cornerstone of a safe cost-efficient facility. The consulting nurse is responsible to assure that proper assessments are made on each resident and that appropriate care plans are executed. The consulting nurse should formulate a reassessment when a major change occurs in a resident, e.g., return following rehabilitation for stroke or hip fracture. The resident nurse should communicate with the physician and sponsor when specific significant events occur, i.e., weight loss, behavioral change, adverse drug reactions, elopement, accidental injury or two or more falls within 30-days.

The nurse consultant should master material in the DETA Brain Series. The basic prevention programs for falls, weight loss, and behavioral alterations are outlined in DETA handouts entitled "*Prevention of Falls in the Dementia Resident*", "*Weight Loss in the Dementia Patient*", and "*Management for Aggression in the Nursing Home*". The registered nurse should have executed these protocols as a minimal when the significant occurrences are detected. Regulations do not specify

the specific format for resident assessment or reassessment, however, these protocols should be complete and information should be timely.

Medical Director

The medical director serves in an important role in quality assurance, program development, and problem solving for staff. Residents may retain their original physician; however, primary care doctors may not understand the specific requirements for regulations in Specialized Care Assisted Living Facilities (SCALF's). The consulting physician should assist SCALF management in addressing key medical quality indicators, such as falls, weight loss, polypharmacy, and wellness programs within the facility. The medical director should communicate with other physicians when problems exist with the resident. For example, a delirious patient requires immediate evaluation and the primary care physician should be encouraged to evaluate acutely confused patients either in the office or emergency room. The medical consultant can oversee the registered nurse, nurse consultant, and the pharmacist to assure that their services are appropriate to the facility. Although the medical director would be the best person to provide primary medical care services to each resident, families do have the choice of continuing use with their own primary care doctor. The medical consultant can confer with staff at the Alabama Department of Public Health or the DETA with questions about management issues.

6.

Managing The Environment Of Care

Managing the Resident Population

The features of the resident community are partially determined by the management's admission policy. The facility admission policy is impacted by many issues, including financial considerations, occupancy rate, family wishes, and resident's suitability. The management must match resident's needs and family expectations to the resources of the assisted living facility. Staffing ratio will be higher in facilities that admit larger numbers of more cognitively impaired residents. Residents with severe behavioral disturbances require well-trained, organized staff and facilities with sufficient room to prevent over-crowding. Units with larger numbers of behavioral problems should have strong collaborative relationships with neuropsychiatric treatment programs to allow transfer of residents who become too disturbed for the facility.

Staff Selection

The selection of staff is an essential component to high quality care. Recruitment of compassionate, thoughtful individuals is a cornerstone to quality care. Retention is an essential part of recruitment and high staff turnover often produces poor care. Staff requires about six months to learn residents and procedures within any facility.

Good staffing enhances care and reduces the likelihood of abuse or neglect. Studies in nursing homes show that abuse increases when poorly trained staff are placed on undermanned units with poor supervision and oversight. Education, motivation, and management will diminish the likelihood of staff abuse or neglect. Although age and education may not predict staff performance, intellect and motivation are essential to good care. Past experiences with elder care such as nursing home or home health can be beneficial. High-quality staff should have a solid sense of responsibility. Individuals who demonstrated good parenting skills may have better attitudes towards managing helpless individuals.

Many families visit on weekends or in the evening when licensed staff are not available to supervise workers and inform family members. Management must carefully control the quality of information from workers to family in order to avoid misinformation that produces anxiety and misunderstanding among family members. A structured, available leadership chain-of-command is essential for staff management after hours or on the weekend. Responsible, thoughtful individuals should be designated to interact with family members.

Environment

Management of the SCALF environment is essential to managing residents. Noisy, chaotic units produce anxiety and stress in residents that translates into abnormal behaviors. The environment should be free of as many hazards for falls or accidents as possible, e.g., open stairwells, floor cords, throw rugs, slippery floors, uneven floors, etc. Lighting should always be adequate for individuals with low vision. Sound levels should be diminished, as many elderly persons are hearing impaired and high background noises diminishes their capacity to understand verbal directions. Each resident's room should be customized and familiar objects should be placed. Staff should not play loud, inappropriate music. All television programming should be appropriate to the resident's cognitive levels, e.g., avoid talk shows with aphasic residents. Many basic, inexpensive environmental interventions, e.g., memory books, pictures on door of family, etc., can enhance resident's quality of life and reassure anxious residents. The environment must be managed 24-hours per day, especially after hours or on the weekend. Loud noise agitates residents. Family visits should be managed to assure that large numbers of concerned family members do not disrupt the environment for other residents.

Family Education

The family plays a vital role in care of demented residents, as well as in maintaining morale of staff. Angry, hostile family members disrupt the therapeutic environment and demoralize staff, producing staff turnover. All family caregivers benefit from educational materials on the symptoms and natural history of dementia. Educational materials, such as those provided via the DETA Family Series can offer helpful insights to family about resident behaviors and resident's needs. Families need careful education about the causes of dementia and the natural history of the disease. Although many family members have a sophisticated understanding of Alzheimer's disease and other dementias, some family members may lack basic knowledge that prevents misinterpretation of resident behaviors or false accusations, e.g., "they have me locked up", "they are not feeding me", etc. All involved family members need education, especially those who visit episodically. Angry, out-of-town family members may create anxiety and distress for in-town family members who are providing the best support possible for the demented individual. Family members must understand the biological causes of intellectual and psychiatric problems, as well as the progressive natural history of the disease. The DETA Program can provide materials via our web-site (www.alzbrain.org) to family members throughout the United States.

Survey Process

Surveyors will monitor many aspects of care within your facility. The primary concern for surveyors is safety and quality of life. Surveyors become alarmed when they perceive problems with resident safety, security, or dignity. Adequate numbers of motivated, trained staff who are attending to the residents send a positive message to the survey team. Educated family members who understand complications associated with dementia are less likely to file complaints with the surveyors. Calm, safe, controlled environments assure surveyors and family that the facility has a successful comprehensive behavioral management program. Specific types of problems such as hip fractures, falls, and resident's health problems can be unavoidable in either the assisted living facility or at home. The facility will be judged on its ability to minimize the risk for such occurrences and to manage these problems.

Activity Programs in the SCALF

Bored residents become disruptive residents. The SCALF is encouraged to have active structured programming that is appropriate to the cognitive level of the patient. Staff can learn basic recreational programming and use basic interventions such as music, television, exercise, and crafts to expend as much resident time as possible per day. Structured, predictable, appropriate activities lower resident anxiety and enhance everyone's quality of life. Families are very appreciative of active, appropriate, dignified activities in the facility. Please refer to the DETA guideline for recommended activities and the DETA web-site for additional references for suggested activities in dementia.

Liability Management

Long-term care facilities are becoming the frequent target of liability actions. The assisted living facility is liable for bad resident outcomes when the quality of care falls below the community standard. Falls, injuries, health catastrophies, etc., can occur in the best facilities. The key feature for liability is whether appropriate interventions were employed to minimize the risk or manage the event.

Plaintiffs' attorneys know that the four essential elements to a successful lawsuit include: 1) a poor outcome for a resident, 2) an angry resident family, 3) an angry former employee who testifies on behalf of the plaintiff, and 4) a proven record of providing poor care as documented by adverse findings on the survey process. Effective respectful communication with all segments of the family is essential to lowering family anger in the event of an adverse event. The facility should encourage communication with all involved family members including those who reside out of the community. The effective use of standard management strategies

to deal with common problems such as weight loss, falls, injuries, and elopement demonstrates the facility's compliance with community standard of care.

Most litigation occurs many months or years following the event. The only facts available at trial are the adverse resident outcome, the documentation that the facility develops, and the documentation in the survey findings. The best legal defense against liability actions is documentation of good resident care and sound facility policies.

Staff Development

The workforce in the assisted living facility industry will expand at 2 or 3 times the national growth over the next 10 years. The assisted living facility manager will struggle to recruit and retain adequate numbers of high-quality staff. Managers should develop linkages with high schools, trade schools, technical schools, and other health professional organizations within the community or region to attract part-time or full-time employees to the workforce. The DETA School Series provides educational programs that ALF management can use in local high schools to attract graduating students into the workforce.

7.

Behavioral Management in ALFs and SCALFs

Overview

1. Maintaining Function In The Dementia ALF Resident

The demented ALF resident will manifest psychiatric and behavioral symptoms in the middle or latter stage of the disease. The management strategy must be adjusted to meet the specific needs of the resident. Individuals who live alone may require continuous sitter service. Staff may need to educate family caregivers who reside with the resident. All caregivers within your facility should be encouraged to join Alzheimer's support groups and obtain basic information via the DETA website or by calling the DETA office. Caregivers should prepare for the possibility that kind, redirectable residents may eventually develop significant behavioral problems. The assisted living staff must monitor cohabitating caregivers for excessive stress or physical exhaustion. Death or disability of the caregiver may produce a catastrophic event for the demented person. Assisted living staff should encourage caregivers to break from caregiving responsibilities for at least one-half day per week.

The assisted living facility staff should encourage caregivers to take appropriate legal measures to protect their loved one from exploitation for bad business decisions. The resident's financial resources need to be protected in order to provide support for the individual and their spouse. Demented residents should not be allowed to retain access to check accounts, bank accounts, stock transactions, etc. These individuals should not be allowed to execute contracts without review by the family caregiver.

Behavior Management

Behavior problems occur in approximately 75 percent of demented residents in the middle or late stages of the disease. Management must have an effective program to prevent behavioral problems or minimize disturbance produced by the symptoms. Prevention is the first step in a behavior management program. Staff must recognize potential behavioral problems as well as residents that are at greatest risks for specific types of behavior problems. Staff must have access to information on how to deal with common behavioral symptoms. The facility must have a procedure to manage situations that become behavioral emergencies.

Management must facilitate communication between shifts to assure that staff can track developing behavioral problems. Management must assure that adequate staff is present to manage common behavioral problems encountered in the assisted

living facility. The aftermath of poor nurse supervision of residents include resident injury, diminish quality of life, enhanced facility liability, and increased expenses to the facility resulting for additional care needs or transfers to nursing homes.

Management must monitor the types of residents admitted to the facility to avoid large numbers of severely, behaviorally disturbed residents. The admission of large numbers of residents with behavioral problems requires a facility with sufficient space to prevent crowding and sufficient numbers of staff to monitor residents and avoid resident-on-resident assault or injury to staff (For additional information, See the DETA booklet entitled, “Managing Behavioral Symptoms of Dementia”).

Psychotropic Medications

Psychotropic medications are significant because these drugs can produce weight loss, falls, and other problems. The appropriate use of psychotropic medications is outlined in the DETA handbook entitled, “A Short-Practical Guide for Psychotropic Medications in Dementia Patients”. Dose reductions and other nursing home interventions are not required by statute; however, smart clinicians attempt to minimize psychotropic medications as these drugs produce serious complications. The facility must work with treating physicians to optimize the use of psychoactive medications. Staff should recognize the common complications of psychotropic medications to avoid excessive reliance on drugs for behavioral management. Management should communicate through family with doctors about the need to adjust psychotropic medications or refer the resident to a specialist in geriatric psychiatry.

2. Common Behavioral Problems

The assisted living resident may manifest a broad range of behavioral problems based on the type of dementia, kind of facility, sensory impairment, health problems and other variables. Aggression, resistiveness, screaming, non-aggressive disruptive behaviors, and others can pose significant problems to the assisted living staff. One-third of the residents will have at least one behavioral manifestation on a weekly basis. Thirteen percent will demonstrate some form of aggression including cursing (12%), physical striking (6%), grabbing (5%), and others.

The assisted living has limited resources to manage the aggressive patient. These individuals should be admitted to a local psychiatric facility for assessment and stabilization (**See Aggression Handout**). Verbal aggression can be distressing and

staff may need to perform a basic assessment to determine the cause of this type of behavior.

Complaining (10%), screaming (6%), and repetitive questions (11%) are common verbal behaviors that can produce difficulties for the resident and staff. These behaviors require simple behavioral interventions (**See Behavior Checklist**) for proper assessment and management.

3. Resisting ADL's

Wandering (13%), hoarding (9%), and disrobing (5%) are also common problems seen in this resident population. Each behavior requires a specific intervention (**See Behavior Checklist**). A significant number will begin to resist or avoid basic ADL's as the disease progresses in the middle stages. Patients begin to refuse to bathe, change clothing, toilet or groom. Medications are only helpful for refusal of ADLs when the patient is preoccupied with psychotic beliefs or suffers from depression. Depressed individuals may refuse to get out of bed or participate in activities. Psychotic patients may be concerned that the staff will harm them during the ADL process. For depression or psychosis, medications may be beneficial. Most other problems with ADLs result from difficulties in communication, forgetting how to perform the basic function, and fear over intrusive interventions such as disrobing. Staff should be familiar with material taught in the DETA Care Series tapes and supervisors should be familiar with printed materials regarding dressing, bathing, and feeding.

Weight loss is a common problem in the mid- to latter-stages of dementia. Patients may forget how to use utensils or in the later stages, forget how to chew and swallow. Late-stage patients with swallowing dyspraxias or apraxias may be inappropriate for assisted living care, as there are great risks for choking. Middle-stage patients often require some assistance with feeding and accommodation of diet to meet their specific needs. Staff is referred to the handout entitled, "Weight Loss in the Demented Resident" for further information about this matter. The medical director should be involved with planning for these patients.

Patients often develop falls towards the middle- or latter-stages of the disease. The facility should consult with the medical director for proper assessment of the patient's gait and possible medical causes of the gait instability. The management staff is referred to the handouts entitled "Prevention of Falls in the Demented Resident".

4. Falls

Older persons are at high risks for falls and the SCALF manager should have a program to minimize resident risk. Falls can occur in any long-term care setting and some residents will sustain injuries and fractures. The SCALF is expected to

have programs in place that minimize the frequency of falls and reduce the likelihood that a resident will sustain injury.

Staff must understand the frequency and risks of falls. All staff must recognize those residents who are at high risks for falling. Prevention is the best way to reduce injuries and risks for litigation. Nursing homes are now sued on a regular basis over injuries sustained during a fall. This problem will occur in the ALF industry as well. Staff should be trained to sustain a low-risk environment by maintaining adequate lighting, clean floors, and dry surfaces. The facility must use furniture that is stable and will not collapse under resident's weight. The management must maintain a safe environment. Structural risks such as open stairway, unlit steps, etc., should be modified to prevent accidental falls.

Residents with repeated falls should be evaluated by their physician, and the resident's family should be consulted about the possibility of physical therapy to strengthen the resident or develop a safe ambulation program.

Staff must be trained to manage basic emergencies associated with falls. Staff must know basic, prudent steps such as summoning help, assessing the resident prior to moving, and calling for EMS when unsure about the severity of a resident's injury. Emergency numbers must be available and local EMS personnel should be familiar with the facility and the resident population (See DETA handout "Prevention of Falls in the Dementia Patient" for additional information).

5. Elopement

Elopement is a serious risk for any facility that manages large numbers of demented residents. Staff must be trained to react automatically in the event of an elopement. The slower the response time to an elopement, the higher the likelihood that a resident will be injured or lost. Prevention is the basis of any elopement program. All staff must know which residents have the potential for escaping from the facility. Resident accountability must be carefully monitored. During an elopement emergency, staff must be trained to execute a protocol that begins with a resident-count and securing of the perimeter, followed by a systematic search or request for outside assistance. Staff should notify supervisors about all suspected elopements, and supervisors should respond to the facility in a prompt manner. The supervisor should manage the search and the evaluation of the recovered resident. Family should be immediately notified about the event (See DETA handout "Wandering and the Dementia Patient" for additional information).

6. Assaultive Behavior

Assaultive behavior can occur in any demented resident and this complication occurs in approximately 25% of these individuals. Assaultive behaviors include verbal, physical or sexual aggression. Most aggressive behavior is aimed at staff -- usually during redirection or ADL function. Assaultiveness is more common in mid-stage dementia.

Prevention is the best management option for assaultive behavior. Staff must recognize all residents with a past history of aggressive behavior. Supervisors must train staff on management techniques that include distraction and redirection. Staff should recognize the early warning signs of hostile behaviors. The facility should have an established plan to handle residents who escalate to the point where they are no longer manageable within the facility. This plan should be implemented at any time of day or night, e.g., call paramedics and have resident transported to local general hospital (See DETA handout "Pharmacological Management for Aggression in the Nursing Home" for additional information).

7. Medical Emergencies

Older residents have many medical problems that may require acute medical intervention. Demented residents depend upon ALF workers to summon the appropriate level of care. Common health problems such as chest pain, shortness of breath, diabetic reactions, seizures, vomiting, and loss of consciousness may signal serious health problem that requires immediate medical intervention. Staff must be able to render immediate first aide and then summon the appropriate assistance.

Management must assure that staff can locate key medical information for ER staff or paramedics. Staff should be familiar with residents who have unique medical needs, e.g., diabetics, epileptics, etc. Staff should be trained to recognize the importance of common health changes, e.g., loss of consciousness, severe persistent chest pain. The facility should have a standard operating procedure to deal with these health problems, e.g., call the family and ask for directions, dispatch paramedics, etc.

8. Weight Loss

Weight loss is a common preventable problem in persons with dementia. Weight loss contributes to injuries and behavioral abnormalities. The facility management is responsible to assure that excessive weight loss is recognized in resident populations. Inaccurate weights are a common cause of "weight loss" and management must assure that admission weights are accurate.

The most common reason that residents lose weight is because they are not fed sufficient amounts of food. Management must assure that appropriately prepared, nutritionally balanced food is available for residents within the facility. Staff must understand the types of feeding problems encountered in residents with dementia. Management must keep sufficient staff in the building during mealtime to assure that all residents can be fed. Management must provide sufficient snacks or other nutritious supplements for calorie-wasting residents. The facility must have an active system for weighing residents and a standard procedure for referral when residents continue to lose weight (See DETA handout “Comprehensive Multidisciplinary Assessment of the Demented Nursing Home Resident with Weight Loss” for additional information).

9. Hydration

Many demented residents have difficulties maintaining adequate fluid intake. Dehydration is a common cause of behavioral disturbance and medical complications. The facility should have appropriate hydration programs that prevent dehydration.

Staff must be educated on problems experienced by demented residents in maintaining adequate hydration. Staff should be trained to continuously offer fluids to residents and recognize those individuals at greatest risk for dehydration. Staff should be familiar with early symptoms of dehydration and the facility should have a standard procedure for managing residents who appear dehydrated (See DETA Fact Sheet on Hydration” for additional information).

10. Sex And The Demented ALF Resident

Sex is an issue that provokes strong response from residents, staff, and family members. Humans are sexual beings and older people retain active sex lives.

Healthy, intellectually intact elders often continue to have a healthy sex life with intercourse at a regular interval. Certain physiological changes occur in the aging resident that may affect their ability to perform sexually. Men often develop erectile dysfunction produced by alcohol, medications, diabetes, and vascular disease. Women often develop atrophy of the vaginal covering, and thinning of the labial tissue along with loss of lubricating fluid that diminish pleasure and increase discomfort. Sexually transmitted diseases can occur in the elderly resident. The typical mode of spread is from male to female when men engage in sexual activity with prostitutes. Sexually active, single elders should be encouraged to use reasonable measures to reduce the risk of sexually transmitted diseases.

Mildly demented persons are capable of providing informed consent to engage in sexual relations with a partner or spouse. Moderate to severely demented persons

probably lack the capacity to give informed consent. Sex between a caregiver and a severely demented person raises specific ethical issues that require clarification on a case-by-case basis. A sexually active, demented person who desires sex with an intact spouse or partner can elect to engage in intercourse. A sexually motivated, cognitively intact caregiver seeking to have sex with a demented person is unclear.

Sexual aggression in the demented patient requires a specific evaluation and management strategy regardless of whether the patient resides in a nursing home or assisted living facility (See Handout).

Wandering behavior is common in persons with dementia – especially in the middle to latter stages. Wandering can produce risk to the resident by several mechanisms including: 1) assault by other residents, 2) accidental injury, and 3) elopement. Wandering in the long-term care setting requires a specific intervention regardless of whether the patient is in the nursing home or assisted living facility.

8.

Work Force Training

Overview

The DETA Care Series is a videotape based learning program that contains two basic elements, (1) The DETA core curriculum and (2) the DETA advanced curriculum. This program is appropriate for both certified nursing assistants and resident care attendants in assisted living facilities. The core curriculum provides workers with basic knowledge necessary for safe resident management regardless of their past experience in dementia care. Each video segment is twenty to thirty minutes in duration. The program includes a teacher's guide, student's guide, videotape, and posttest. Materials are prepared for individuals with a high school education or GED. The direct teaching style limits terminology but emphasizes principles of safe management and staff empathy for residents.

The videotape program includes a basic science segment that focuses on brain alterations followed by a description of practical management techniques. Most segments contain one or two vignettes that allow the worker to imagine common daily problems experienced by a demented resident. A post-test is presented at the back of each segment to test knowledge and attitude. Some segments also contain examples of poor resident management that allows students to contrast basic common mistakes made by poorly trained staff against well-trained professional.

The teacher's guide contains multiple segments for both the instructor and the student. The instructor is provided teaching objectives and a brief synopsis of important material. The teacher is referred back to other DETA resources for more detailed information. Teachers should master the material in the DETA Brain Series prior to training with the DETA Care tapes. The DETA Behavior Management Series can be used in addition to the DETA Brain Series tapes.

The DETA Care Advanced Series includes eight tapes covering more sophisticated knowledge for the ALF employee. Staff who have worked for over six months in an assisted living facility or nursing home are eligible to complete tapes 13-20 and achieve recognition as a dementia specialist. The educational coordinator should document that they have observed the worker successfully and independently completing the list of assigned tasks. Upon completion of the written test and the task certification, this individual is recognized as a dementia specialist.

9.

Checklist For Dementia Specialists

1. Feeding

- a. Assist a mildly demented person to eat.
- b. Feed a moderately demented resident.
- c. Accurately weigh and record resident's weight.
- d. Understand complications from poor nutrition or feeding problems.

2. Hydration

- a. Direct a mildly demented resident to drink.
- b. Assist a moderately demented resident to drink.
- c. Accurately assess the hydrational status of a resident.
- d. Understand complication of poor hydration.

3. Fall Prevention

- a. Successfully identify environmental hazards for falls.
- b. Demonstrate preventive attitudes towards at-risk residents.
- c. Intervene to prevent a resident's fall.

4. Transfer

- a. Assist an unsteady resident to the standing position.
- b. Assist a resident to sit comfortably.
- c. Assist with the movement of a resident to the wheelchair, to the bed.
- d. Identify hazardous situations during the transfer of a resident.

5. Redirection

- a. Demonstrate ability to verbally redirect.
- b. Demonstrate ability to deal with agitated resident using redirection and distraction.
- c. Successfully manage a potentially dangerous situation with resident so that emergency is safely concluded.

6. Elopement

- a. Identify residents at risk for elopement.
- b. Demonstrate basic elopement prevention attitude and knowledge
- c. Know location of emergency numbers in the event of an elopement.
- d. Demonstrate an understanding of basic elopement management procedures.

7. Wandering

- a. Identify residents with wandering problems.
- b. Use behavioral interventions to deal with the wandering behaviors.
- c. Successfully redirect a resident involved with rummaging behavior or explain the management technique.

8. Managing an Aggressive Situation

- a. Monitor the SCALF environment for potential aggression.
- b. Intervene with residents prior to aggressive episode.
- c. Effectively manage an aggression emergency or explain management.

9. Family Interaction

- a. Demonstrate the ability to explain a resident's condition to the family.
- b. Answer questions asked by the family about behavioral symptoms of the resident.
- c. Explain educational resources available to family members through the SCALF.
- d. Encourage visiting family members to view dementia education programs.

10. Dressing

- a. Demonstrate the ability remind or verbally direct a resident during dressing.
- b. Successfully dress a resident who needs total assistance.
- c. Demonstrate the ability to dress a resistive resident.

11. Toileting

- a. Explain toileting schedules and problems encountered by demented residents during toileting.
- b. Successfully toilet a male and/or female using verbal direction.
- c. Successfully toilet a male and/or female who needs complete assistance with toileting.
- d. Demonstrate the ability to change adult continence products.
- e. Toilet a resistive resident.

12. Management of Health Emergencies

- a. Demonstrate knowledge of how to summon emergency medical services.
- b. Explain facility protocol for bringing EMS into the facility.
- c. Explain basic criteria to determine when a possible medical emergency is occurring.
- d. Explain or demonstrate the sequence of interventions necessary to deal with a medical emergency in the ALF.

13. Prevention of Elopement

- a. Explain which residents are at high risks for elopement.
- b. Understand the basic security features of the facility and ability to monitor and operate warning devices.
- c. Explain or demonstrate the management method employed for a possible resident elopement.
- d. Demonstrate the ability to summon emergency assistance when a resident is gone.

14. Prevention of Abuse and Neglect

- a. Always demonstrate a respectful, supportive attitude towards residents and families.
- b. Respect the privacy of each individual at all times.
- c. Demonstrate professional self control when a resident says or does provocative things.
- d. Understand the three common types of abuse.
- e. Explain the consequences of abuse or neglect to the resident, family, and abuser.

- f. Demonstrate the ability to mentor a new employee on the proper attitude towards older persons with dementia.

15. Working Nights and Weekends

- a. Demonstrate the ability to assess and manage a person with nocturnal agitation, i.e., sundowning.
- b. Demonstrate the ability to follow nighttime procedures for patient accountability and behavior management.
- c. Demonstrate knowledge about after-hours or weekend emergency medical services.

10.

Safe Hospitals Program

Hospitals are an integral part of care for persons with dementia. Demented patients may require medical or surgical care during the course of their illness. High quality hospital care is essential to maintaining quality of life for patients and American has one of the best hospital care systems in the country. Studies show that more than 2 million Americans will develop complications that may be avoided by simple, low-tech interventions (HospitalElderLife@yale.edu). Some hospitals struggle with care for persons with dementia. Physicians, nursing staff, dietary staff, and support personnel can misunderstand the special needs of an Alzheimer patient. This program alerts families to common problems encountered during hospital stay referred to as the “seven deadly sins” of hospitalization. Family caregivers should be aware of these complications and discuss specific potential problems with nurses and physicians at the hospital. Hospital administrators and patients advocates should be aware of this issue. The seven deadly sins of hospital care include delirium, dehydration, demobilization, diminished nutrition, diagnostic confusion, drug reactions, and decubiti.

7 Deadly Sins Of Hospital Care

1. **Delirium**: Delirium is a common avoidable problem that occurs during hospitalization, i.e., abrupt worsening of confusion. Many demented patients are admitted with delirium. Many individuals develop delirium from treatable causes like medication side effects, dehydration, sensory overload, etc. A specific handout is available to physicians and families on protection against delirium.
2. **Decubiti**: Decubiti are bed sores that are produced by the pressure of a human body on a bony point. Decubiti can begin in a period of hours if patients are not turned properly. Any bed-bound patient needs a skin protection plan during the hospital stay that includes skin care, skin inspection, and turning the patient on a regular basis. Each hospital has different plans for protecting the skin of patients; however, the families are encouraged to discuss skin care on admission. Some patients may be restrained to prevent problems with medical devices such as breathing tubes, chest tubes, etc. Hospitals should be attentive to the skin care needs of the immobile Alzheimer patient and make reasonable efforts to reduce the risks for skin breakdown. The development of a decubitus during a hospital stay does not necessarily indicate poor care if the hospital made reasonable efforts to protect the patient’s skin based on national standards of care.

3. **Dehydration:** Dehydration is a common problem during hospitalization and patients often drink inadequate amounts of fluid to sustain adequate body-water content. Families should discuss appropriate hydration and determine whether the staff is monitoring the daily amounts of oral intake. The federal nursing home guidelines suggest that a 150lb. person requires about 2,000cc or 2 quarts of water per day. Patients who develop dry mouth, dry eyes, dry skin, poor urinary output, and skin that is doughy rather than plump are potentially dehydrated. Oral hydration is usually the preferred method to maintain body fluids.

4. **Diminished Nutrition:** Diminished nutrition is a major problem for frail, hospitalized older patient with dementia. Many self-sufficient patients are no longer able to manage in the hospital because of disorientation and confusion. The family caregiver and the nursing staff should discuss the need for assistance with feeding. Patients should not have dramatic weight loss during hospitalization.

Each scale weighs a patient differently and patients may have significant weight gain or weight loss identified during the admission process. Patients should be weighed on the same scale, at the same time of day, with the same clothing to assure accurate estimates of weight. Starting with the baseline admission weight, the patient should not lose considerable amounts of weight. Abrupt loss of weight suggests either malnutrition or dehydration. Abrupt increases of weight suggests excessive fluid intake, e.g., IV hydration.

5. **Demobilization:** Demobilization is a serious problem in frail elders. Demented patients are sometimes allowed to lie in bed for prolonged periods of time. Confusion associated with medical problems or disorientation from hospital stay may worsen the walking ability of a patient. Ambulation has many benefits to the demented patient; first, the movement of the leg diminishes the risk of blood clots; second, constant practice of walking reduces the likelihood that the patient will forget how to walk during the course of the hospitalization; third, walking helps expand airway and reduce the likelihood of lung infections; fourth, walking eliminates pressure from skin and diminishes the risk for decubiti. Families should discuss with the hospital staff the plan to walk the patient based on the patient's ability. Moderate to severely demented patients who remain bed-bound for many days or weeks are less likely to resume ambulation after they return home or return to the nursing home. Walking is a "use it" or "lose it" skill in many demented patients. Although ambulation does carry the risk of falls with injury, confinement to bed also carries significant risks.

6. **Drug Reactions:** Demented patients are unable to ask questions and monitor medications administered to themselves. The family is entitled to ask about specific medications and the benefit provided to the patient through those medications. Pain pills, tranquilizers and other medications that alter brain function require careful review and consideration. Confusion about medications is possible when multiple physicians are caring for the patient.

7. **Diagnostic and Therapeutic Confusion:** Moderate or severely demented patients react differently to health problems than intellectually normal individuals. Patients are unable to explain pain or physical symptoms. Demented patients respond differently to infections than cognitively intact persons. Diseases such as coronary artery disease or heart failure have different manifestations in the older patient as compared to younger individuals. Persons with dementia respond differently to infections and demonstrate less elevation of temperature. Healthcare providers should be aware of clinical differences in care for persons with dementia as opposed to individuals with normal brains.

*Physician guidance and information is available through
the DETA Program*

1-800-457-5679

CAREGIVER BILL OF RIGHTS

Family caregivers must speak for patients who lose the ability to comprehend healthcare issues. These family caregivers have certain rights including:

1. The right to receive complete, unbiased information about every procedure proposed for their patient.
2. A complete description of short-term and long-term complications for every intervention.
3. The right to seek a second opinion about diagnosis and treatment.
4. The right to insist that healthcare professionals obey the patients' written advanced directives.
5. The right to assume the role as the expert on the patient's unwritten wishes about end-of-life issues.
6. The right to respectfully disagree with the medical team.
7. The authority to have the wishes of the patient honored.

For more information or inquiries, call the Dementia Education & Training Program at 1-800-457-5679.

1. Delirium

Delirium is temporary confusion produced by medical problems or confusing medications. Delirium is common in all hospitalized elders; especially those with dementia. Hospitals should take necessary steps to lower the risk of producing delirium in older patients. Excessive use of sedatives, tranquilizers, and pain pills are a very common cause of delirium.

Patients who become acutely confused during a hospitalization need a careful evaluation to understand the cause of the confusion. Confusion is to the brain the same as heart failure is to the heart. Brain failure needs an aggressive evaluation and treatment of every potential cause. The risk for nursing home placement rises dramatically in the confused patient in the hospital. The longer the patient remains confused, the more likely the patient will have a poor outcome. Hospital acquired delirium; i.e., confusion is a hospital complication that should be addressed by the hospital staff prior to discharge.

Things To Do If The Patient Becomes Confused

1. Call the confusion to the staff's attention.
2. Ask about why the patient is confused.
3. Do not accept the assurance that all old people become confused.
4. Ask the physician to conduct a confusion assessment.
5. Ask for a neurology or a psychiatry consultation to examine the cause of confusion.
6. Ask the doctor to explain all the potential risk factors for confusion and how they are treating each risk factor.
7. Avoid restraints with confusion.
8. Use sitters to protect the patient.
9. Beware of dehydration or malnutrition in the confused patient.
10. Do not accept a transfer to the nursing home unless the doctor can explain how it will help your patient's confusion.

The DETA Hospital Program is designed to forge a therapeutic alliance between the hospital that treats older patients and family caregiver who assist with their care after discharge from the facility. The program is designed to promote communication between patient, family caregiver, and the hospital

treatment team, which is responsible for care. This program defines for consumers expected community standard of care for hospitalized elders.

2. Decubiti (Bed Sores)

Patients with dementia are often less mobile when they are sick and in the hospital. Skin problems can occur in as little 12 hours with continuous pressure on a bony point. Sick older people with poor nutrition are at greater risk for developing skin breakdown. Skin problems can lead to infections and other complications. Families should monitor the position of the patient in the hospital to determine whether these individuals are being moved to redistribute weight. Patients lying flat on their back need protection for certain body areas such as the heels or the elbows.

Nurses should check skin on a regular basis and the immobile patient should be turned on a regular basis. The nursing staff and the doctor should explain to the family how they will avoid skin breakdown in these individuals. Families should be allowed to see the schedule for turning the patient and signatures indicating that the patient has been turned. Special mattresses, heel protectors, and other devices can be used to reduce the risk of skin problems.

A skin problem does not necessarily mean that the patient is receiving poor care. If a patient develops a pressure sore in the hospital, it is the responsibility of the hospital to assess the problem and develop a plan to correct the ulcer. The wound specialist for the hospital should examine the patient and help the nursing staff to manage the problem. Skin problems cannot wait for the patient to be transferred to another facility such as rehab hospital or a nursing home. Hospitals have the responsibility to treat the skin problem and avoid complications such as infection.

Things To Do To Prevent Skin Problems

1. Watch your patient to see if staff is turning them or moving them in bed.
2. Ask the nurse about how they will protect the patient's skin.
3. Ask to see areas such as the back of heel, hip bones, back, and shoulder blades.
4. Insist that the nursing staff inform you about any skin breakdown.
5. Insist that the nursing staff explain the treatment strategy for any skin breakdown.
6. Ask for the hospital wound specialist to examine your patient.

7. Ask for a conference with the doctor and the hospital wound specialist to discuss any new pressure ulcers.
8. Insist that a plan be developed prior to discharge that deals with the skin problem.

3. Dehydration (Fluid Loss)

Many Alzheimer's patients are admitted to the hospital with dehydration. Studies show that up to one-third of persons admitted from nursing homes to hospital are dehydrated. Dehydration is defined as a significant deficit of water in the body. Patients with dehydration have dry mouth, dry eyes, waxy skin, diminished urine production, and low blood pressure that cause dizziness on standing.

The doctor in the hospital should be aware of your patient's fluid status at all times. Too much fluid causes heart problems and too little fluid causes dehydration. An IV does not mean that the patient is receiving adequate fluid. The doctor must determine how much fluid the patient is missing and how much fluid the patient needs on a daily basis and add the two together to correct the fluid imbalance. Your doctor should be willing to discuss the fluid status of your patient.

Patients require at least six glasses of water per day to maintain adequate fluid balance. Patients who do not receive intravenous fluids must be drinking fluids throughout the hospital stay. If your patient is not taking fluids by mouth and does not have an IV, then you should discuss fluid problems with the doctor.

Patients who are discharged from the hospital with dehydration are more difficult to manage and likely to develop worsening of dehydration in the nursing home or assisted living facility.

Things To Do If Your Patient Is Dehydrated

1. Ask the doctor about dehydration.
2. Ask the doctor to describe how he will fix the dehydration.
3. Monitor the fluid intake of the patient.
4. Ask the nurse about I. and O. (intake and output).
5. Ask the doctor if a laboratory value suggests serious dehydration.

6. Do not allow the patient to be discharged without discussing the correction of continued dehydration.

4. Malnutrition (Diminished Nutrition)

Many older people are malnourished upon entering the hospital. Sick older persons often stop eating or become so confused during the hospitalization that they forget how to feed themselves. Patients should eat at least 75% of their tray on a daily basis. Hospitals have dieticians who can alter a diet to enhance eating by the patient. Poor nutrition produces slow recoveries and poor wound healing. If your patient is not eating in the hospital, you should discuss nutritional problem with the doctor. Even a few days of poor nutrition creates problems for the patient. Patients who are not eating food are often not drinking water and these patients are at risk for dehydration. Hospital acquired malnutrition is a hospital-based complication that should be addressed prior to discharge.

Things To Do For Diminished Nutrition

1. Watch the staff feed the patient.
2. Assist with feeding yourself.
3. Ask the nurse about snack supplements.
4. Ask to speak with the dietician about your patient's nutritional status.
5. Discuss nutrition with the doctor.

5. Demobilization

Many older patients with dementia remain in bed while they are hospitalized. Patients often have restraints or bed rails to prevent them from getting out of bed. Hospitals are concerned about falls and react to the risks by limiting activity.

Prolonged bed rest is bad for old people. Extended periods in bed increase the risk for blood clots, lung infections, skin breakdown, decreased appetite, and many other problems. Patients who walk into the hospital are expected to walk out of the hospital. Patients stop walking for many reasons including delirium and generalized weakness.

Family and staff can walk patient with assistance. Physical therapy can visit the patient and assist with ambulation. Patient's who walk into the hospital should not be discharged from the hospital until the doctors and nurses explain how the patient will begin to walk again. This ambulation plan should be communicated from the hospital to the rehab hospital or nursing home that is receiving the patient.

Some patients stop walking because of stroke, heart failure, broken bones, or other identifiable. The doctor should be able to explain the specific reason why your loved one has stopped walking and why they do not expect them to walk again. Hospital acquired problems with ambulation are hospital-based complication. Patients should not be discharged from the hospital until a plan is developed to assist the patient to regain their strength and ability to walk.

Things To Do About Demobilization

1. Discuss plans to continue walking with the doctor prior to surgery or on admission.
2. Discuss your willingness to accept the risk of falls from walking with assistance as opposed to lying in bed.
3. Determine that the patient will get up and walk after surgery as quickly as possible.
4. Avoid restraints.
5. Ask for a sitter.
6. Request a physical therapy consult.
7. Request an evaluation by a rehabilitation specialist.
8. Ask that doctors to limit the number of pain pills, tranquilizers, and sedatives given to the patient.

6. Drug Reactions (Adverse Drug Reactions)

Patients receive many drugs while in the hospital. Frequently, a patient will have a primary doctor plus several consultants who may all order medications. In general, two of the same medications should raise concerns about communication among the doctors. Families should monitor the medications received by the patient and inquire about the reason for the prescription of each drug. Pain pills, tranquilizers, and sleep pills can produce significant complications in the frail older person. Dosages of medications should be adjusted for the special needs of the older patient; especially those with kidney or heart problems.

Patients can have reactions to drugs termed “adverse drug reaction”. An adverse drug reaction does not suggest poor care or lack of attention by the doctor. Drugs can interact with other drugs to increase or decrease their concentration in the body. Many hospitals have consulting pharmacists who can advise doctors on specific dosing ranges for older patients and warn about potential drug-drug interaction.

Ways To Understand Medications

1. Ask what drugs the patient is receiving.
2. Determine which doctor is ordering the drugs.
3. Inquire if any of the drugs do the same thing.
4. Inquire why your patient is receiving two drugs that do the same thing.
5. Ask whether dosages have been adjusted for older patients.
6. Ask about any mind altering drug termed “psychotropic medications”.
7. Inquire about why the patient is receiving psychotropic medication and what the expected side effects are.
8. If a patient appears to have adverse reaction to medications, ask for consultation by the hospital Pharm-D to assess the drug program.

7. Diagnostic And Therapeutic Confusion

Persons with dementia respond differently to health problems than younger patients. Demented persons are less able to explain symptoms and follow directions during diagnostic procedures. Patients may have lower baseline temperatures that mock temperature elevation. The clinician should have familiarity with demented patients. Treatment complications should be measured against possible benefit. Diagnostic examinations should be employed when results will be used to determine treatment that is appropriate for the patient’s stage of dementia. Hospitals or geriatricians can be consulted for complicated cases.

1. Expect that all doctors will ask you about symptoms, problems, and medical history.
2. Ask the doctor about their experience in treating persons with dementia.
3. Ask how each test will help you patient.
4. Inquire about how a positive test can find a treatable illness.

5. If the doctor seems unsure about your patient, inquire about availability of hospitalist or geriatrician.
6. Go online to learn more about specific diseases and treatment.
7. Remember your caregiver's bill of rights.

11.

The DETA Prescriptive Safety Program

Doctors and their patients share responsibility for safe use of prescription medications. The prescription safety team includes the doctor, pharmacist, and patient who receive the medication or family caregiver who assists with the administration of medications. Each member of the team shares professional and ethical responsibilities to reduce the risk of prescription errors or injuries produced by medication side effects.

Some medications side effects are unavoidable. Many drug related complications can be prevented with good communication and proper education. The prescriptive safety program focuses on reducing avoidable complications for medications. The program includes communications with doctors, pharmacists, and residents. Patients are provided specific guidelines to measure their risk level for having an adverse drug reaction. Consumers are provided a list of responsible actions that reduce communication problems. Pharmacists and doctors are alerted to potential problems associated with medication problems. Prescription safety is everyone's responsibility. Good medication compliance by educated patients who accurately report symptoms to the doctor is the cornerstone of prescription safety.

Risk Factors For Prescriptive Problems

1. More than five medications
 2. More than two doctors
 3. Memory troubles
 4. Problems with depression
 5. Not taking medications as prescribed
 6. Taking other folks medication
 7. Receiving more than one medication in the same family of drugs
- The more risk factors present produces a greater risk for medication malfunction***

Prescriptive Bill Of Rights

1. Patients are entitled to an explanation of the reason why each drug is prescribed by the doctor.
2. Doctors should explain potential side effects in lay person terms.
3. Pharmacist should be willing to advise patients on taking the medication, using face-to-face, verbal explanations.
4. Pharmacists should be willing to review over-the-counter medications and prescriptions to assess for interactions with prescribed medications.
5. Patients are entitled to enough time from their doctor and their pharmacist to reduce the risk of hospitalization from drug interactions.

Patient's Prescriptive Responsibility

1. Patients must bring all medications to every doctor's office visit.
2. Patients should ask their doctor about the reason for medications and common side effects.
3. Patients should ask pharmacist to explain medications and common or dangerous side effects.
4. Patients must take medications exactly as prescribed by their doctor.
5. Patients should avoid taking other people's prescriptions.
6. Patients should honestly inform doctors when they fail to follow instructions.
7. Patients should consider changing doctors or pharmacist when professionals refuse to explain medications.
8. Patients are responsible to safeguard their medication safety.

For Doctor

This patient has been provided the DETA Prescriptive Advisory that alerts individuals when they may be at risk for adverse drug reactions. Studies show that about 10% of elders in all clinical settings are exposed to potential medication errors including wrong drugs, wrong dose, drug-drug interactions or duplicate therapy. Adverse drug reactions contribute to 10 to 20% of hospital admissions for older persons. Patient compliance is a national problem with 1/3 patients not taking medications, 1/3 taking some medications, and 1/3 fully compliant.

Patients and pharmacists have both been provided with guidelines to assist with their prescriptive medical care. Patients are advised as to their responsibilities in managing their own health care including compliance, accurate reporting, and avoiding the use of unreported medications. Information about this program and the clinical data that support the recommendations provided to your patient can found on www.alzbrain.org.

For Pharmacist

This patient participated in the DETA Safety Pharmacy Program. We educate our caregivers and family members about the safe, effective use of prescription drugs and over-the counter preparations. Patients have received the fact sheets that describe medication risk factors. The caregivers are instructed to keep your advice when multiple psychotropic medications are present.

This program focuses on the national health problem of mis-prescription and non-compliance. Studies show that about 10% of medications consumed by older people involve some type of medication error. About one-half to two-thirds of elders have some level of medication non-compliance. These medications mistakes produce significant morbidity and mortality as well as excessive expense related to hospitalization produced by adverse drug reactions.

This customer has been instructed to inquire about their medication and possible adverse drug reactions. They have been told to ask for verbal explanation rather than small print, complex written explanations that provide no meaningful benefit to the older, sensory-impaired citizen.

We hope that you will participate in this program and safeguard the safety of your customer and patient. Individuals have been instructed to change pharmacist if their local pharmacist is unwilling to help with patient safety.

12.

Guide For The Assisted Living Facility Operator On Delirium

Recognition of Delirium

Delirium is temporary confusion produced by medical problems, medications, or other causes. Delirium is common in people over the age of 65; especially those with brain damage such as Alzheimer's disease, strokes, Parkinson's disease, etc. These groups, such as Alzheimer's patients, are at high risk for delirium as up to 92% of Alzheimer's patients develop delirium following repair of hip fracture. The assisted living facility operator should be concerned about delirium because the one-month mortality is high, i.e., up to 15%, and the six-month institutionalization rate is substantial, i.e., up to 43%. Delirious residents wind up in nursing homes and unable to return to the assisted living facility.

The ALF operator can reduce the risk of delirium by encouraging the family to discuss this common complication with the surgeon or the hospital. Delirium information sheets are available for the surgeon, nursing staff, and anesthesia team. The acronym "**MESS**" can be used to explain common causes of delirium. The acronym stands for *Medical* (as in medical causes of delirium such as infection or metabolic problems), *Environmental* (such as noisy, disruptive hospital units), *Sensory* (as in sensory impairments), and *Scripts* (as in prescriptions that produce confusion in elders).

Delirium is a dangerous, avoidable complication for frail elders or those with brain diseases. The assisted living facility operator can encourage patients and family caregivers to discuss management strategies with doctors or surgeons that reduce the likelihood this dangerous and sometimes lethal disease.

Enclosed is an information packet on delirium and surgery for your residents. The family information packet alerts caregivers to potential problems. These consumers can provide professional materials to surgeons, nurse anesthetists and other hospital staff. The information provides valuable tips to reduce hospital-based complications.

13.

Assessing The Need To Discharge Your Transfer Resident

Regular ALF and SCALF residents may sometimes manifest dangerous or aggressive behaviors that exceed the facility's capacity to safely manage. Facility operators and clinical staff should have an established policy to determine which clinical circumstances require sitters, transfer to psychiatric units, or discharge from the facility. The cause of the behavioral problems will be the major determinant in whether a facility is capable of continued management of the resident.

Abrupt onset behavioral problems are more likely to result from reversible complications like delirium or depression that can be effectively treated. Hostility, aggression, attempts at elopement or other dangerous behaviors should be evaluated on a case-by-case basis. Delirious residents should revert to normal behaviors and these individuals require continuous supervision until they have a sustained period of normalcy, i.e., days to several weeks. Depressed or bereaved individuals may require somewhat longer observation; however, these persons may be appropriate for continued stay in the facility based on a professional assessment by psychiatrist, neurologist or some other expert in dementia.

Persistent dangerous behaviors often begin with middle stage dementia and persist for months or years. Dangerous wandering that produces confrontations with other residents, explosive aggressive behavior, or treatment refractory delusions that drive elopement may require discharge from a regular ALF to a SCALF. The typical SCALF should be able to manage elopement, wandering, and impulsive or aggressive behavior precipitated by environmental stressors. Residents who attack staff or other residents without provocation in a dangerous manner require admission to a psychiatric unit that can properly assess cause and adjust medications. In the event that this behavior persists, these residents may not be appropriate for replacement in the SCALF. Most residents are managed through a combination of behavioral interventions and appropriate psychotropic medication. Residents with complex medical and psychiatric needs may require transfer to a nursing home with the capacity to manage behavioral problems. Residents with dangerous behaviors produced by dementia in the middle stages of their illness may have persistent symptoms for months or several years. These individuals may require outplacement to more appropriate facilities.

Sitters who remain with dangerous residents in either ALFs or SCALFs should have adequate training on the management of dangerous behaviors. The DETA Care Series includes sufficient material to educate these individuals on redirection and anticipation of dangerous behaviors. Untrained staff members are at greater risk for being injured or allowing the residents to engage in dangerous behaviors within the facility. Family sitters require similar levels of knowledge to protect other residents from this behavior.

Residents who begin to manifest dangerous behaviors require an immediate careful evaluation by the treatment team and management team to reduce the likelihood of a violent or dangerous crime. Environmental stressors, potential weapons, elopements scenarios and other potential risk factors should be assessed on an individual-by-individual and facility-by-facility basis to reduce the relative risk to the resident, other inhabitants, staff, and visitors.

BEHAVIORAL CHECKLIST FOR DEMENTIA PATIENTS

	SYMPTOMS	CAUSES	INTERVENTIONS / TREATMENT
(1)	WANDERING	Disorientation Anxiety/Boredom Urinary/Fecal Urgency Hunger Rectal Impaction	Recreational Activities Recreational Activities Toileting Schedule Frequent Feedings Remove Impaction
(2)	YELLING	Boredom Fear Pain Depression Psychosis Anxiety Hunger Fatigue Sensory Impairment Delirium Rectal Impaction	Recreational Activities Reassurance Analgesic SEE DEPRESSION FACT SHEET SEE PSYCHOSIS FACT SHEET Recreational Activities Feedings Naps Check Vision and Hearing SEE DELIRIUM FACT SHEET Remove Impaction
(3)	VERBAL OR PHYSICAL THREATS	Fear Disorientation Fatigue Hunger Pain Delusion Aphasia Rectal Impaction Delirium Sensory Impairment	Reassurance Reorientation and Reassurance Naps Feed Patient Analgesics SEE PSYCHOSIS FACT SHEET Non-verbal Communication Remove Impaction SEE DELIRIUM FACT SHEET Check Vision and Hearing
(4)	INCONTINENCE	Disorientation UTI Medication GU Problem Delirium Rectal Impaction	Toileting Schedule Treat UTI Change Medication Urology Consultation SEE DELIRIUM FACT SHEET Remove Impaction
(5)	STEALING	Disorientation Delusions	Recreational Activities SEE PSYCHOSIS FACT SHEET

	SYMPTOMS	CAUSES	INTERVENTIONS / TREATMENT
(6)	DISROBING	Amnesia Apraxia Anxiety Delirium	Recreational Activities Jumpsuits Recreational Activities SEE DELIRIUM FACT SHEET
(7)	WEIGHT LOSS		SEE WEIGHT LOSS HANDOUT
(8)	AGITATION		SEE AGITATION HANDOUT
(9)	REPETITIVE QUESTIONS	Amnesia Boredom Aphasia	Recreational Activities Recreational Activities Non-verbal Communication
(10)	POOR HYGIENE	Apraxia Aphasia Psychosis	SEE BATHING HANDOUT Non-verbal Communication SEE PSYCHOSIS FACT SHEET
(11)	FALLS		SEE FALLS FACT SHEET AND HANDOUT
(12)	MISIDENTIFICATION OF CAREGIVER	Agnosia Delusions	Tolerance SEE PSYCHOSIS FACT SHEET