Dementia: Inpatient models and practical approaches to care

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4/15/16
Objectives and Outline

- **Objectives:**
  - Distinguish dementia, depression, delirium, and normal age-related changes.
  - Describe the clinical features of the most common types of dementia.
  - Discuss methods to minimize behavioral triggers in persons with dementia.
  - Describe different models of inpatient geriatric care.

- **Outline:**
  - Overview of Dementia
  - Assessment Tools
  - Practice approaches to care
  - Models of care
Dementia: an overview
Facts and Figures about Dementia

Worldwide
47.5 million

Projected increase by 2030
75.6 million

Estimated to triple by 2050
135.5 million

- Early diagnosis improves QOL

2015 Alzheimer’s Disease Facts & Figures
World Health Organization (2015) 10 Facts on Dementia
Dementia: an umbrella term that describes the symptoms including memory loss and mental decline

- Deterioration in cognitive abilities
- Impact:
  - More hospitalizations with an increased LOS
  - More outpatient/ambulatory care needs
# Dementia vs. Normal Aging

<table>
<thead>
<tr>
<th></th>
<th>Normal Aging</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Memory</strong></td>
<td>Not being able to remember conversation details from a year ago</td>
<td>Not being able to recall details of recent conversations</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td>Occasionally have difficulty finding words</td>
<td>Frequent pauses and substitutions when finding words</td>
</tr>
<tr>
<td><strong>Executive</strong></td>
<td>Do not have problems completing everyday tasks. May take more longer to perform complex tasks.</td>
<td>Often find it hard to plan or complete everyday tasks</td>
</tr>
<tr>
<td><strong>Function/</strong></td>
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<td></td>
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<tr>
<td><strong>Completing</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Tasks</strong></td>
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</tr>
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</table>
The 3 D’s: Delirium, Depression, Dementia

- Conditions common in older adults
- Important to know patient baseline
- Appropriate assessment and screening
- May have more than 1 ‘D’ present at the same time and symptoms may overlap
- Can lead to undetected and untreated conditions
The 3 D’s: Delirium, Depression, Dementia

<table>
<thead>
<tr>
<th>Feature</th>
<th>Delirium</th>
<th>Depression</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Acute</td>
<td>Variable</td>
<td>Gradual</td>
</tr>
<tr>
<td>Course</td>
<td>Fluctuating</td>
<td>Recurrent</td>
<td>Progressive</td>
</tr>
<tr>
<td>Progression</td>
<td>Typically abrupt</td>
<td>Variable</td>
<td>Slow, irreversible</td>
</tr>
<tr>
<td>Consciousness</td>
<td>Altered</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Attention</td>
<td>Impaired</td>
<td>May be Impaired</td>
<td>Normal until late</td>
</tr>
<tr>
<td>Orientation</td>
<td>Fluctuating</td>
<td>Normal</td>
<td>Impaired</td>
</tr>
<tr>
<td>Psychomotor</td>
<td>Markedly variable; hypokinetic, hyperkinetic;</td>
<td>Variable; psychomotor agitation or agitation/restlessness</td>
<td>Initially normal, may have apraxia late</td>
</tr>
<tr>
<td>Behavior</td>
<td>psychomotor agitation</td>
<td></td>
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<tr>
<td>Hallucinations</td>
<td>Common</td>
<td>Rare</td>
<td>Rare until late</td>
</tr>
<tr>
<td>Duration</td>
<td>Hours - Months</td>
<td>Weeks - Months</td>
<td>Months – Years</td>
</tr>
</tbody>
</table>
Dementia in Acute Care Settings

- Signs & behaviors not be ‘normal’ for older adult
- Think about other causes:

  - Infection
  - Hypothyroidism
  - Pain
  - Medications
  - Delirium
  - Depression
  - Dehydration
  - Alcohol w/d
  - Hearing/Vision Loss

Rule out other causes before diagnostic evaluation
Types of dementia

- **Alzheimer’s disease** ~ 50-70%
- **Vascular dementia** ~ 20-30%
- **Dementia with Lewy Bodies** ~ 15-25%
- **Parkinson’s dementia** ~ 5%
- **Fronto-temporal dementia** ~ 5%
- Creutzfeldt-Jacob disease
- Huntington’s disease
- Wernicke-Korsokoff syndrome
- HIV associated dementia
- Mixed dementia
Signs of Dementia

- **Dependent on:**
  - Type of dementia
  - Part of the brain affected

National Institute on Aging’s website: www.nia.nih.gov
Alzheimer’s Disease

- 6th leading cause of death in US
- Unknown cause – biomarkers being used in research
  - Age and genetic components increase risk
- Irreversible with gradual progression
  - Mild -> Moderate -> Severe/Advanced
  - As disease progresses -> behavioral changes, confusion, difficulty speaking, swallowing, ambulating

Alzheimer’s Association 2015 Alzheimer’s Disease Facts and Figures
Alzheimer’s Disease & the Brain

Plaques and Tangles: The Hallmarks of AD

- **Beta-amyloid plaques**: dense deposits of protein and cellular material that accumulate outside and around nerve cells

- **Neurofibrillary tangles**: twisted fibers that build up inside the nerve cell
Alzheimer’s Disease & the Brain

- Neuron death
- Brain shrinks

Source: Alzheimer’s Association
Vascular Dementia

- 2nd most common
- Caused by blockage or reduced blood flow in the brain
- Common first signs include impaired judgment or inability to complete tasks
- Symptoms may vary depending on what part of the brain is affected

Alzheimer Association 2015 Vascular Dementia Topic sheet
Vascular Dementia

- Risk factors: smoking, HTN, lack of exercise, elevated lipid levels, CV disease, stroke
- Symptoms may improve in the acute recovery phase post-stroke
- Brain function cannot be restored
- Symptoms may plateau then worsen
Dementia with Lewy Bodies

• 3rd most common
• Abnormal deposits of alpha-synuclein protein (Lewy bodies) in cerebral cortex
• Protein deposits cause brain cell damage over time
• Early symptoms include: sleep problems, visual hallucinations, muscle rigidity
• Lewy bodies also found in Parkinson’s dementia
  - Two distinct diseases
Parkinson’s Disease Dementia

- 50-80% of people with Parkinson’s disease will develop dementia
- Problems with movement early symptom
- As Parkinson’s brain changes spread will have changes in thinking and reasoning
- Lewy bodies are present in people who have Parkinson’s disease
  - Symptoms often similar to dementia with Lewy bodies
Frontotemporal Dementia

- Group of disorders caused by progressive nerve cell loss in the brain’s frontal or temporal lobe
- Nerve cell damage in the frontal or temporal lobe cause a change in:
  - Personality
  - Language
  - Behavior
  - Alterations in muscle or motor functions
- Several variants of Frontotemporal dementia
Cognitive assessment
Cognitive Domains

- **Memory** - ability to learn and recall new information
- **Language** - either comprehension or expression
- **Visuospatial ability** - comprehension and effective manipulation of nonverbal, graphic or geographic information
- **Executive function** - ability to plan, perform abstract reasoning, solve problems, focus despite distractions and shift focus when appropriate

(Alzheimer’s Association, 2016)
Mini-cog

- Brief, validated screen to identify pts with dementia (versus those without)
- 3-item recall + clock draw
- Scored “demented” or “non-demented”
- 76-99% sensitive, 89-93% specific

(Doerflinger, 2007)
Mini-cog: Step 1

3-item repeat
- Say 3 words and ask patient to, “repeat them back to me”
- Allow 3 tries then move on
- Validated word combinations

Version 1
- Banana
- Sunrise
- Chair

Version 2
- Daughter
- Heaven
- Mountain

Version 3
- Village
- Kitchen
- Baby

Version 4
- River
- Nation
- Finger

Version 5
- Captain
- Garden
- Picture

Version 6
- Leader
- Season
- Table
Mini-cog: Step 2

Clock draw
• Ask pt to number the clock face (pre-drawn circle)
• Then ask them to draw hands to read “10 minutes after 11”
• 3 minute max; refusal = fail

• Considered normal if all numbers are present in the correct sequence and position, and the hands readably display the requested time.
Mini-cog

- Normal clock?
Mini-cog

- Normal clock?
Mini-cog

- Normal clock?
Mini-Cog

Normal clock?
Mini-cog

- Normal clock?
Mini-cog: Step 3

3-item recall (from step 1)
• Done after clock drawing
Dementia screen: Mini-cog

Mini Mental Status Exam (MMSE)

- Distinguishes those with cognitive impairment from those without (Kurlowicz & Wallace, 1999)
- Scoring:
  - No cog impairment: ≥24/30
  - Cog impairment: ≤23/30
- If used repeatedly, can determine changes over time
- Less sensitive in those w/ low literacy, ESL, or communication disorders
- Copyright restrictions (Newman & Feldman, 2011).
  - $1.23 per test
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<th>Maximum</th>
<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>5</td>
<td>( )</td>
<td>Orientation</td>
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<tr>
<td></td>
<td></td>
<td>What is the (year) (season) (date) (day) (month)?</td>
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<tr>
<td></td>
<td></td>
<td>Where are we (state) (country) (town) (hospital) (floor)?</td>
</tr>
<tr>
<td>3</td>
<td>( )</td>
<td>Registration</td>
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<tr>
<td></td>
<td></td>
<td>Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _________</td>
</tr>
<tr>
<td>5</td>
<td>( )</td>
<td>Attention and Calculation</td>
</tr>
<tr>
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<td></td>
<td>Serial 7’s. 1 point for each correct answer. Stop after 5 answers. Alternatively spell “world” backward.</td>
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<tr>
<td>3</td>
<td>( )</td>
<td>Recall</td>
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<tr>
<td></td>
<td></td>
<td>Ask for the 3 objects repeated above. Give 1 point for each correct answer.</td>
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<tr>
<td>2</td>
<td>( )</td>
<td>Language</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name a pencil and watch.</td>
</tr>
<tr>
<td>1</td>
<td>( )</td>
<td>Repeat the following “No ifs, ands, or buts”</td>
</tr>
<tr>
<td>3</td>
<td>( )</td>
<td>Follow a 3-stage command: “Take a paper in your hand, fold it in half, and put it on the floor.”</td>
</tr>
<tr>
<td>1</td>
<td>( )</td>
<td>Read and obey the following: CLOSE YOUR EYES</td>
</tr>
<tr>
<td>1</td>
<td>( )</td>
<td>Write a sentence.</td>
</tr>
<tr>
<td>1</td>
<td>( )</td>
<td>Copy the design shown.</td>
</tr>
</tbody>
</table>

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Total Score
MOCA

- Better for MCI or early Alzheimer’s dementia
- Used in a variety of other disorders that affect cognition
- Available in 36 languages
- Blind MOCA for visual impairment
- Scoring:
  - Normal: ≥26/30
  - MCI: 19-25.2/30
  - Alzheimer’s: 11.4-21/30
- 90-100% specific, 87% sensitive
- Can be traumatic for patients!

(Doerflinger, 2012)
Formal Evaluation

- Detailed history
- Lab tests
- Neuroimaging
- In-depth patient interview
- Collaborative info from spouse, friends, relatives
- Standardized neuropsych assessment
  - IQ, academic skills
  - Attention
  - Language comprehension
  - Verbal fluency
  - Recall
  - Visuospatial abilities
  - Motor skills
  - Emotional status

(Michels et al., 2010)
Behavioral Expressions & Triggers
Prevalence of behavioral symptoms in AD (n=435)

- Apathy/indifference (75%)
- Aberrant motor behavior (57%)
- Irritability/lability (55%)
- Appetite/eating disorders (54%)
- Agitation/aggression (52%)
- Depression/dysphoria (45%)
- Anxiety (44%)
- Sleep disorders (42%)
- Delusions (35%)
- Disinhibition (23%)
- Hallucinations (20%)
- Elation/euphoria (14%)

(Craig et al., 2005)
Behavioral Expressions

- Outbursts, agitation, aggression
- Resistance to care
- Refusal to participate
- Wandering, rummaging in room
What causes these behaviors?

• **Biological factors**
  - Neurodegeneration, neurotransmitter disruption, hypometabolism (Barton et al., 2016)

• **Environmental factors**
  - Environmental Vulnerability Model (Cohen-Mansfield, 2000).

• **Psychosocial factors**
Biologic factors

• Loss of neurons and build up of proteins in specific brain regions correlate to some behavior changes
• Disruption of neurotransmitters
  ▪ Dopamine
  ▪ Serotonin
  ▪ Glutamine
  ▪ Acetylcholine
• Hypometabolism of grey matter (Mendez et al., 2011)

(Barton et al., 2016)
Anatomy and Functional Areas of the Brain

**Functional Areas of the Cerebral Cortex**

1. **Visual Area:**
   - Sight
   - Image recognition
   - Image perception

2. **Association Area:**
   - Short-term memory
   - Equilibrium
   - Emotion

3. **Motor Function Area:**
   - Initiation of voluntary muscles

4. **Broca’s Area:**
   - Muscles of speech

5. **Auditory Area:**
   - Hearing

6. **Emotional Area:**
   - Pain
   - Hunger
   - “Fight or flight” response

7. **Sensory Association Area**

8. **Olfactory Area:**
   - Smelling

9. **Sensory Area:**
   - Sensation from muscles and skin

10. **Somatosensory Association Area:**
    - Evaluation of weight, texture, temperature, etc., for object recognition

11. **Wernicke’s Area:**
    - Written and spoken language comprehension

12. **Motor Function Area:**
    - Eye movement and orientation

13. **Higher Mental Functions:**
    - Concentration
    - Planning
    - Judgment
    - Emotional expression
    - Creativity
    - Inhibition

14. **Functional Areas of the Cerebellum**
    - Motor Functions
      - Coordination of movement
      - Balance and equilibrium
      - Posture

**Brain Areas**

- Frontal lobe
- Parietal lobe
- Occipital lobe
- Temporal lobe
- Brain stem
- Cerebellum
- Pituitary gland
- Respiratory centers
- Brain stem
- Sagittal View
- Superior View
- Inferior View

(Mid Brain Power, 2014)
Brain Atrophy in Advanced Alzheimer’s Disease
Environmental Vulnerability Model

- Lower threshold to cope with stress
- May overreact to stimuli in the environment

(Cohen-Mansfield, 2000)
Unmet Needs Model

- Decreased ability to satisfy needs independently
- Decreased ability to effectively communicate needs to caregiver
- Needs get expressed as negative behaviors

*Pain  *Loneliness  *Overstimulation
*Hunger *Illness    *Boredom
*Thirst *Fear      *Uncomfortable environment

(Cohen-Mansfield, 2000)
“Create a world in which the person can function with their level of dementia, as opposed to trying to change the person to fit our normalized world.”

-Kim Warchol

President and Founder of Dementia Care Specialists
Practical approaches
Importance of Approach

- Consistency – every time
- Reduce the likelihood of resistance to care
Approach: Elements & Communication

- Elements of the approach:
  - Greet, say hello
  - Make eye contact, address the person by name
  - Identify yourself
  - Approach from the front
  - To reduce sense of threat, talk first, then touch

- Convey an easygoing manner
- Treat the person with dignity and respect
- Avoid “elderspeak”

Alzheimer’s Association, 2016; Family Caregiver Alliance, 2016
Elderspeak

- Infantilizing communication
  - Speaking slowly or loudly
  - Elevated pitch and volume, using a sing-song voice
  - Uses ‘we’, ‘us’, ‘our’ instead of ‘you’
  - Inappropriate terms of endearment
  - Similar to ‘baby talk’
- Conveys a message of incompetence, perceived as patronizing, assumes frailty and reinforces negative age stereotypes
- Older adults with dementia most frequently react to elderspeak communication by negative vocalizations (screaming/yelling, crying, negative verbalizations)

Grimme et al., 2015; Herman et al., 2009; Williams et al., 2009
Care Techniques

- Communication
- Hand under hand
- Music
- DICE method
- Partnering with caregivers
## Communication: General Tips

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Approaches to Avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use short 1-2 step requests</td>
<td>Avoid lengthy, multi-step requests</td>
</tr>
<tr>
<td></td>
<td>Avoid confusing or vague statements</td>
</tr>
<tr>
<td>Patients with dementia do not need to be grounded in reality. Use “therapeutic fibs”</td>
<td>Avoid criticizing or correcting</td>
</tr>
<tr>
<td>Turn negatives into positives ‘don’t go there,” → “let’s go here.’</td>
<td>Avoid arguing</td>
</tr>
<tr>
<td>Provide options ‘would you like water or tea?’</td>
<td>Avoid quizzing ‘Do you remember me?’ → ‘I’m your nurse _____, we talked yesterday.’</td>
</tr>
</tbody>
</table>

Alzheimer’s Association, 2016; Family Caregiver Alliance, 2016
Communication: General Tips

- Give visual cues
- Write things down
- Making agreements may not work
  - ‘Push your call light for help’ may soon be forgotten
  - Adapt the environment instead
Hand Under Hand Technique

- Developed by Teepa Snow, OT
- Gives patient a feeling of control
- Reduces the risk of resistance
- Acts as a motor cue (especially important with impaired language capability)
- Can be used with bathing, feeding, or taking medications

www.teepasnow.com
Music Therapy

• Chang et al. (2015), meta-analysis of the effects of music therapy on patients with mild to severe dementia
  ▪ Moderate to high effect on improving disruptive behaviors
  ▪ Moderate effect on reducing anxiety levels and depressed mood
  ▪ Small effect on improving cognitive functioning
DICE Method

- **Describe the behavior**
  - Avoid labels like “agitated” which do not provide specific details
- **Investigate potential causes**
- **Create a plan**
- **Evaluate if plan is safe and effective**

(Kales et al. 2014)
Role of the caregiver

- Encourage caregivers to partner with medical staff
- Caregivers are vital to understanding the pt’s routine and providing support during a stressful time
- Key times: when the pt wakes up, when meds are given, procedures are done, early evening hours, or the medical team rounds
Hospitalization Schedule for Family Visitation of the Memory Impaired Patient

**Main Family Contact** (Hospital staff are able to call day or night for concerns/issues)
Name: 
Home number: 
Cell phone: 
Work number: 

**Secondary Family Contact**
Name: 
Home number: 
Cell phone: 
Work number: 

<table>
<thead>
<tr>
<th>Family member</th>
<th>Sun Date/time</th>
<th>Mon Date/time</th>
<th>Tues Date/time</th>
<th>Wed Date/time</th>
<th>Thur Date/time</th>
<th>Fri Date/time</th>
<th>Sat Date/time</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Caregiver resources

• *Family Caregiver Alliance*—https://www.caregiver.org/

• *Alzheimer’s and Dementia Caregiver Center*—https://www.alz.org/care/

Implications for Acute Care

- Consistency in approach
- Plan of care
- Family/caregivers
- Anticipate needs
- Communicate what works and what does not work to other members on the team
Models of geriatric care
Why?

- **Silver tsunami**
  - By 2030, 60% of inpatients will be >65
  - 85+ is fastest growing demographic
  - Biggest risk factor for dementia? AGE!

- Those w/ AD and other dementias are 3x more likely to be hospitalized than those without

(Young and Inouye, 2007)
Current state

- Hospitalization is hazardous for older adults!
  - Functional decline, delirium, falls, urinary incontinence, PUs, adverse drug events
- Delirium is the most common complication of hospitalization for older people
- High rates of delirium among patients with dementia
  - 11-42% of medical pts (likely under-reported)
  - Up to half of surgical pts

(Young and Inouye, 2007)
Acute Care for Elders (ACE)

- Nurse-led, team approach to geriatric care
- Minimizes delirium, functional decline, and hospital-acquired complications
- **Preserves independence**
- Emphasizes home discharge whenever possible

https://www.youtube.com/watch?v=8DXM219HXjI
Components of ACE

- Specialized environment
- Nurse-driven prevention protocols
- Interdisciplinary rounding team
- Geriatric assessment
- Discharge planning on day of admission
Specialized environment

- Non-slip, low-glare floors
- Accessible bathrooms, rails
- Large clocks and calendars in each room
- Common areas for dining & socializing
Nurse-driven prevention protocols

• Identify delirium risk
• Promote non-pharm interventions to minimize delirium
• Maximize physical activity
• Reduce pressure ulcers and falls
• Reduce medication side effects
Interdisciplinary rounding team

- Bedside nurse (leads discussion)
- Social worker & case manager
- Physical & occupational therapists
- Pharmacist
- Geriatrician (synthesizes & makes recs)
Geriatric assessment

- Functional status, gait/mobility
- Cognition, Depression, Mood
- Reduce poly-pharmacy
- Social situation, caregiver stress
Discharge planning on day of admission

• Initial evaluation within 24 hours
• Address changes in living situation
• Family meetings to help caregivers
• Community resources
Acute Care for Elders (ACE)

- **Traditional ACE**
  - Geographically located either on a unit or part of a unit
- **Mobile ACE (MACE)—Mt. Sinai, New York**
  - Multidisciplinary geriatric team that follows patients throughout the hospital
- **Virtual ACE—Aurora Health, Milwaukee WI**
  - “ACE Tracker” software, no geriatricians needed
  - Teach ACE principles
## UAB Ace Tracker

<table>
<thead>
<tr>
<th>Patient</th>
<th>Admission Date</th>
<th>Age</th>
<th>LOS</th>
<th>COG</th>
<th>SIS</th>
<th>Delirium/NSC</th>
<th>Anti-P</th>
<th>Beers</th>
<th>Conley</th>
<th>Hx Falls</th>
<th>BR</th>
<th>PT/OT Therapy</th>
<th>Res</th>
<th>ADL</th>
<th>CATH</th>
<th>Press Ulcer</th>
<th>Wound Care</th>
<th>Braden</th>
<th>Albumin</th>
<th>Soc</th>
<th>Adv Dir</th>
<th>Pain Score</th>
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<td>Patient B</td>
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<td>14/14</td>
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<td>Patient E</td>
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**SIS** - Six-Item Screen score if completed

**COG** - ".*" if Cognitive/Memory, Confusion or Alzheimer's dementia present or diagnosis present, or any of the following meds have been ordered: donepezil, rivastigmine, galantamine, memantine

**Delirium** - Delirium indicator followed by N-Desc score. Delirium = "Y" if any of the following are true: 1) N-Desc greater than or equal to 2, 2) CAM = "Y", 3) Anti-Psychotic medication administered

**Anti-P** - "Y" if any anti-psychotic medication was administered within the last 48 hours

**Beers** - "O" - Order for at least 1 medication on BEERS list, "A" - BEERS list, medication administered within last 48 hours

**Advance Directives** - "L" = Living will, "P" = Power of Attorney, "O" = Other
Does ACE work?

- U. Alabama Birmingham
  - Reduced length of hospital stay
  - Reduced variable direct cost ($371/patient)
  - Fewer 30-day readmissions

- Mt. Sinai (New York City)
  - Fewer restraints, bladder infections, PUs
  - Shorter hospital stay and higher satisfaction

Flood et al. (2013)
Hung et al. (2012)
ACE has also been shown to:

- Reduce health care utilization cost
- Improve patient and provider satisfaction
- Reduce falls
- Reduce hospital-acquired pressure ulcers (HAPU)
- Reduce delirium
- Reduce adverse events
- Reduce high-risk medication use
- Improve nutrition during hospitalization
- Improve functional performance at discharge
- Reduce functional decline
- Improve likelihood of living at home after discharge

(Ahmed & Pearce, 2010)
Geriatric Resource Nurse (GRN) Model

- Developed by Nurses Improving the Care of Healthsystem Elders (NICHE)

Goal:

- Promote aging-sensitive principles across an organization, not only on one specific unit (as in ACE)
  - With growing number of hospitalized older adults, impractical to consider segregating them on specific unit(s)
GRN Model

- Bedside RNs receive extensive geriatric training
  - Standardized curriculum focused on geriatric syndromes, communication, healthcare decision making
  - ANCC gerontology nursing certification encouraged in most programs
- GRNs act as clinical resources to other staff r/t geriatric issues
- GRNs spread geriatric best practices by educating their peers and leading by example
Training

Geriatric Advanced Practice Nurse

Geriatric Resource Nurse (GRN)

Geriatric Patient Care Assistant (GPCA)
Does the GRN Model work?

- (Turner et al., 2001)
  - Unit with GRNs compared to unit w/o GRNs at a tertiary med center

On GRN unit:
- Less restraint use
- Improved mobility
- Less decline in ADL function
- Better managed pain and incontinence

- Other organizations described “culture change” or “improved institutional values re: older adult rights and inclusion in decision making”
PACE Programs

• Programs of All-inclusive Care of the Elderly (On-Lok in the Bay Area)
• Offer a comprehensive health plan and social support
  ▪ Transportation, meds, adult day health programs, DME, meal delivery
• No out-of-pocket costs for those on Medicare and MediCal
• Goal to help frail seniors live at home for as long as possible
  ▪ Prevent unnecessary hospitalization
What does long-term care look like?

- Loss of autonomy
- “Institutionalization”
Elder Villages

- Designed for those with dementia requiring 24hr care
  - 23 apts with themes that capture local culture
- Supermarket, post office, sweet shop, hair salon, theater, and park
- “Residents can roam the streets, sit in the sun, stroll in the rain, or enter each others’ homes—the doors are always unlocked.”
- “Freedom in a protected environment”

(Hans, 2010)
(Hans, 2010)
In Summary

• Dementia is an umbrella term indicating cognitive impairment severe enough to impact function. Alzheimer’s is the most common type.
• Key features help distinguish the 3 D’s, which may occur concomitantly.
• Dementia care strategies aim to reduce environmental stress and give the patient a sense of control.
• Nurses trained in the unique needs of geriatric patients are central to each of the inpatient models of care.
References

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