Resident Assessment – Best Practices

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Who are you assessing?

- Elders that needing to make a transition in their care
- The resident could be coming from a variety of settings- skilled nursing facility, hospital, home, or other assisted living
- Often these elders have had some amount of physical or cognitive decline in past few months
- Typically current living environment is no longer safe or appropriate for the elder

What do you need to know?

- Medical and Psychological history
- Current mental status
- Current functional status
- Medications/treatments
- Information gathering

Medical history

- Current medical diagnoses
- If in hospital or skilled nursing ,what sent them there
- Allergies
- Previous surgeries
- Recent hospitalizations
- Current medication list
  - Ideally with reason for medication included
- Oxygen use
- Medical professional that has been managing the medical problems

Psychological History

- Known history of any mental illness

  -type of specific mental health diagnosis, if known
- Any hospitalizations for mental illness
- Medications used to address these issues
- Assessment of mood
  - Geriatric Depression Scale
- Alcohol and other substance misuse
  - CAGE- 4-item tool

Mental Status/Dementia Assessment

- Tools to assess mental status
  - Mini Mental Status exam-MMSE
  - Saint Louis University Mental Status-SLUMS
  - **Short Portable Mental Status Questionnaire** (ten questions)
  - **Mini-COG** (clock drawing and 3-item 5 minute recall)

Dementia Assessment Continued

- Important to evaluate for specific dementia related issues to ensure appropriate placement
  - disorientation to time and place
  - visual/spatial issues
  - difficulty with speaking
  - confusion
  - poor judgment
  - wandering
  - attempting to leave current living environment
  - sleep issues
  - combative/aggressive
  - paranoia/suspiciousness
  - hallucinations-visual or auditory
  - yelling/shouting/moaning

Functional Status

- Activities of Daily Living
  - Katz Index

    Bathing, Dressing, Toileting, Transfers, Continence, and Feeding
- Mobility
  - Using any assistive device
  - Falls/history of falls
  - Pain
- Sensory
  - Hearing/hearing aids
  - Vision-cataracts/glaucoma, glasses
- Mouth/teeth
  - Dentures
- Swallowing problems
- Respiratory
  - Oxygen use
- Bladder/bowel
  - Continence
  - Urinary catheter
  - Ostomy

Medications/Treatments

- Reason for medication use
- Medications for mood/dementia with behaviors
  - as needed orders
- Diabetes
  - Blood sugar checks
  - Insulin
- Anticoagulants
  - Injectables
  - oral
- Skin/wound care
  - Basic first aid only
- Catheter care
  - Support from home health agency

Information Gathering

- Social supports
  - POA/MPOA/Guardian
  - Family
  - Caregivers-formal and informal
- Discharge planners
  - Hospital case managers
  - Skilled nursing facility case managers
  - Director of Nursing at skilled nursing facilities
- Therapy
  - Speak with therapists if available about progress or concerns in functionality
- Chart
  - Therapy notes
  - Nursing notes
  - Medication list
- Primary Care Provider
- Challenges
  - No POA
  - Family not in agreement about patients needs
  - Staff at facilities not available to talk

Case Study

- Rose Brown 88 year old Caucasian female
  - Recently widowed has moderate dementia, hypertension, high cholesterol, osteoarthritis, osteoporosis, abnormal gait, and anxiety/depression
  - Has been living with her daughter and her family for past six months.
  - Has had one hospitalization for a UTI, last month fell in home and found to have compression fracture in back and broke right wrist, now in rehab

Case Study Continued

- Medications-
  - Donepezil 10 mg q day
  - Memantine 10 mg bid
  - Lisinopril 20 mg q day
  - Metoprolol 25 mg bid
  - Simvastatin 40 mg q hs
  - Alendronate 70 mg q week
  - Calicum with vitamin D bid
  - Vitamin D3 50,000 units one cap q month
- Medications-continued
  - Citalopram 20 mg q day
  - Lorazepam 0.5 mg q 6 hrs prn for anxiety
  - Acetominophen 500 mg two tabs q 6 hrs prn for pain

Case Study Continued

- Psychological status- GDS 8/15, wringing her hands, tearful at times during questions
- Mental Status-per rehab chart MMSE 15/30, SPMSQ 5/10, oriented to person and general place, keeps asking you same questions very few minutes
  - Dementia issues-wandering in evenings and at night, has walked out the door, talks to her spouse and asks about him frequently, asking about when her spouse will be home, talks about the children and wondering if they are safe

Case Study Continued

- Functional status-ADLs-dependent with bathing, dressing, toileting, assist with transfers, assist with continence, and independent with feeding
- Uses walker for most ambulation
- Has hearing aids, but difficult to keep in
- Wears glasses for reading
- Has upper plate dentures

Case Study Continued

- What things need to be addressed before admission to your assisted living?
- Is there anything else you would like to know about his potential resident prior to admitting her?
- Any specific concerns or hesitations you have with the potential resident being admitted to your facility?

Resources

- Geriatric Depression Scale –short form
  - http://www.chcr.brown.edu/GDS_SHORT_FORM.PDF
- CAGE –Alcohol use screening tool
  - http://www.valueoptions.com/providers/Education_Center/Provider_Tools/Alcohol_Screening_Tool.pdf
- Mini Mental Status Exam-dementia tool
  - http://www.familyrightsassociation.com/psych/mini.html
- SLUMS evaluation-dementia tool
  - http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf

Resources Continued

- Short Portable Mental Status Questionnaire- dementia tool
  - http://www.npcrc.org/usr_doc/adhoc/psychosocial/SPMSQ.pdf
- Mini-COG – dementia tool
  - http://consultgerirn.org/uploads/File/trythis/try_this_3.pdf
- Katz ADLs Index-function assessment
  - http://consultgerirn.org/uploads/File/trythis/try_this_2.pdf