How To try this

CE 2.5 HOURS Continuing Education

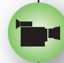
By Katie Maslow, MSW, and Mathy Mezey, EdD, RN, FAAN

Recognition of Dementia in Hospitalized Older Adults

Clinical staff observations and patient and family reports are the keys.

Ed Eckstein

read it | watch it | try it



Web Video

Watch a video demonstrating the use of the four recommended approaches to recognizing dementia in hospitalized older adults at http://links.lww.com/A216.

A Closer Look

Get more information on why increasing the recognition of dementia in hospitals is important.

Try This: Recognition of Dementia in Hospitalized Older Adults

This is the *Try This* page in its original form. See page 45.

Online Only

Unique online material is available for this article. URL citations appear in the printed text; simply type the URL into any Web browser.

Overview: Many hospital patients with dementia have no documented dementia diagnosis. In some cases, this is because they have never been diagnosed. Recognition of Dementia in Hospitalized Older Adults proposes several approaches that hospital nurses can use to increase recognition of dementia. This article describes the *Try This* approaches, how to implement them, and how to incorporate them into a hospital's current admission procedures. For a free online video demonstrating the use of these approaches, go to http://links.lww.com/A216.

Joan Lacy, an RN on a medical–surgical unit, is admitting Betty Raymondi, age 78, who was transferred from the ED with a fracture of the femoral neck sustained in a fall. (This case is a composite based on our experience.) The admitting note indicates that Ms. Raymondi is a widow who has lived in an assisted living facility for two years. Her only daughter lives 60 miles away. Ms. Raymondi's surgery is scheduled for the following day.

As Ms. Lacy examines her, Ms. Raymondi looks agitated, fearful, and confused. She states her name and says she is "in the hospital" but doesn't know the name of the hospital, what day it is, or the name of her assisted living facility. When asked if she is in pain, her response is vague. She has pain in her leg, she says, but can't pinpoint it or rate it on a 1-to-10 scale.

Ms. Lacy calls the assisted living facility for more information. The nurse at the facility says Ms. Raymondi lives in her own apartment and takes three meals a day in the dining room. She says staff members know very little about the fall that led to Ms. Raymondi's hip fracture. A staff member went to her apartment when she didn't come to breakfast and found her on the floor in the bathroom, confused.

When Ms. Lacy asks specifically about confusion, the facility nurse says Ms. Raymondi has no dementia diagnosis noted in her record. The nurse knows, though, that at least 10 times in two months, staff members have had to remind Ms. Raymondi to get her pills from the pharmacy, which they hadn't previously had to do. The facility nurse had also heard from the activities director that Ms. Raymondi had not attended art classes as often as she did previously; once, Ms. Raymondi failed to recognize the activities director. Also, the dining room staff had reported that Ms. Raymondi had come to the dining room several times smelling of urine.

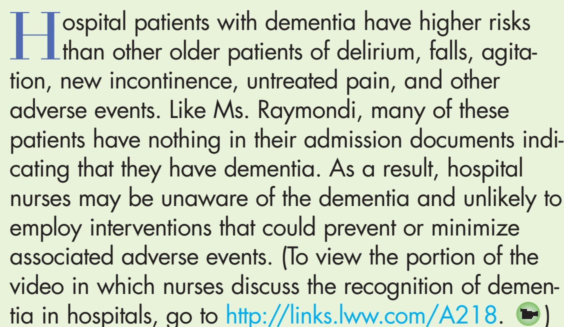
TRY THIS APPROACHES TO RECOGNIZING DEMENTIA

The following four approaches to increasing the recognition of undiagnosed or undocumented dementia can be incorporated into admission procedures quickly and easily.

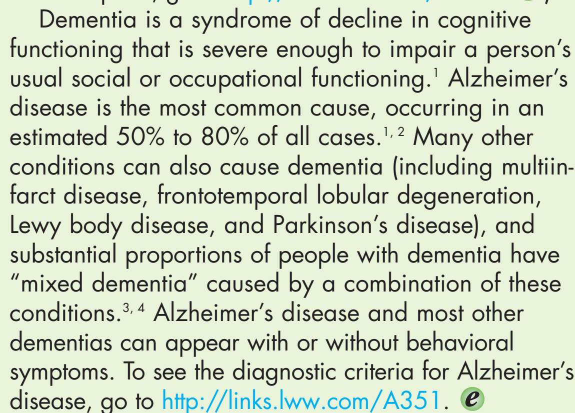
- **Approach 1.** Ask the patient and family members, if any are present, whether the patient has "severe memory problems."
- **Approach 2.** Ask the patient and family members whether a physician has ever said the patient has Alzheimer's disease or dementia.
- **Approach 3.** Ask the patient's family members whether the patient has difficulty with any of the seven specific behaviors listed in the Family Questionnaire (see page 46).
- **Approach 4.** Ask the admitting nurse to look for and document the six specific signs and symptoms of possible dementia listed in the Patient Behavior Triggers for Clinical Staff (see page 46).

The objective with these approaches is not to identify all confusion at the time of hospital admission but rather undiagnosed or undocumented dementia.

Why Increase Recognition of Dementia in Hospitals?



Hospital patients with dementia have higher risks than other older patients of delirium, falls, agitation, new incontinence, untreated pain, and other adverse events. Like Ms. Raymondi, many of these patients have nothing in their admission documents indicating that they have dementia. As a result, hospital nurses may be unaware of the dementia and unlikely to employ interventions that could prevent or minimize associated adverse events. (To view the portion of the video in which nurses discuss the recognition of dementia in hospitals, go to http://links.lww.com/A218.)



Dementia is a syndrome of decline in cognitive functioning that is severe enough to impair a person's usual social or occupational functioning.[1] Alzheimer's disease is the most common cause, occurring in an estimated 50% to 80% of all cases.[1,2] Many other conditions can also cause dementia (including multiinfarct disease, frontotemporal lobular degeneration, Lewy body disease, and Parkinson's disease), and substantial proportions of people with dementia have "mixed dementia" caused by a combination of these conditions.[3,4] Alzheimer's disease and most other dementias can appear with or without behavioral symptoms. To see the diagnostic criteria for Alzheimer's disease, go to http://links.lww.com/A351. *e*

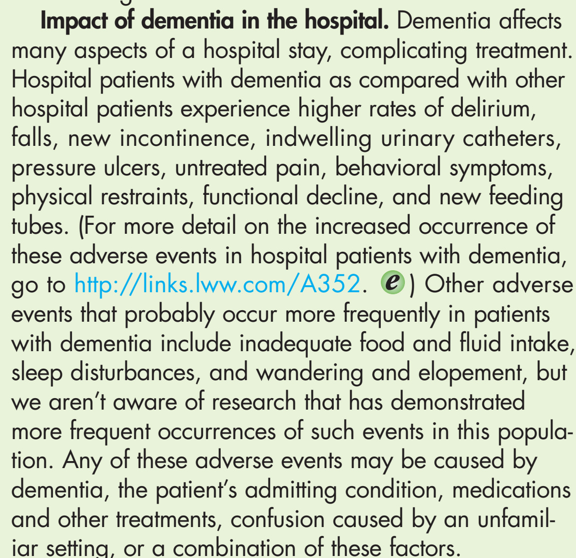
Prevalence. Estimates of the prevalence of dementia in the U.S. population vary. The Alzheimer's Association estimates that in 2007 there were more than 5 million Americans with Alzheimer's disease, 4.9 million of them age 65 and older and 200,000 under age 65.[5]

The prevalence of Alzheimer's disease increases from about 1% of people between the ages of 60 and 64 to 2% of those between 65 and 74 years old and 42% of people age 85 years and older.[2,5] As the baby boomers age and the number of Americans 85 years of age and older increases, the number of people with dementia will also increase rapidly.

People with dementia are more likely than other older people to be hospitalized. No precise figures are available, but it's thought that about 25% of hospitalized patients age 65 and older have dementia.[6] This figure undoubtedly differs from one hospital to another and from day to day in any one hospital.

Many hospital patients with dementia have no documented dementia diagnosis. In some cases, this is because they have never been diagnosed. Studies in primary care settings have shown that only 12% to 41% of people with dementia have a dementia diagnosis or other indication of dementia in their primary care record.[7-11] In other cases, dementia diagnoses were not documented in hospital records. One pilot study of 145 older people admitted to three Philadelphia-area hospitals found that 51 (35%) had cognitive impairment consistent with dementia. Of these, 20 (39%) had nothing in the hospital record to indicate that they had dementia; for nine (18%), a diagnosis of dementia had been recorded; for nine (18%) a diagnosis of delirium had been recorded; and 13 (25%) had a note about confusion and disorientation in their charts but no indication of further assessment.[12]

Most hospital patients with dementia are admitted for treatment of common medical or surgical conditions, such as myocardial infarction, angina, congestive heart failure, and hip and other fractures. Some are admitted for conditions directly related to dementia, such as severe psychiatric or behavioral symptoms; others are admitted for conditions—such as pneumonia, urinary tract infections, and sepsis—that are commonly seen in the late stages of dementia.[12-14]



Impact of dementia in the hospital. Dementia affects many aspects of a hospital stay, complicating treatment. Hospital patients with dementia as compared with other hospital patients experience higher rates of delirium, falls, new incontinence, indwelling urinary catheters, pressure ulcers, untreated pain, behavioral symptoms, physical restraints, functional decline, and new feeding tubes. (For more detail on the increased occurrence of these adverse events in hospital patients with dementia, go to http://links.lww.com/A352. *e*) Other adverse events that probably occur more frequently in patients with dementia include inadequate food and fluid intake, sleep disturbances, and wandering and elopement, but we aren't aware of research that has demonstrated more frequent occurrences of such events in this population. Any of these adverse events may be caused by dementia, the patient's admitting condition, medications and other treatments, confusion caused by an unfamiliar setting, or a combination of these factors.

Ms. Raymondi is at risk for a cascade of problems, including a second fall. Dementia, prior falls, delirium, urinary incontinence, and agitation are all associated with an increased risk of falling in hospitals.[15-20] Physical restraints (often used to prevent falls) and sedative–hypnotic agents (used to decrease agitation) also increase the likelihood of delirium and falls.[15,21-24] The risks can be anticipated and minimized if dementia is recognized and documented on admission, but that often doesn't occur.

Outcomes. Adverse events associated with dementia not only complicate hospitalization for patients, families, and hospital staff, they also result in poor long-term clinical outcomes. Hospital patients with dementia are significantly less likely than other older hospitalized patients to regain their preadmission functional abilities at one month, three months, or one year after discharge.[25-29] Moreover, among older hospital patients admitted from home, those with dementia are two to four times more likely than those without dementia to be discharged directly to a nursing home and three to seven times more likely to be living in a nursing home three months after discharge.[25]

Costs to hospitals. Adverse events associated with dementia, such as delirium and falls, increase the amount of time staff must spend caring for these patients and the average length of the patients' hospital stays, both of which are costly to hospitals. Adverse events and the perceived risk of these events also increase the use of "sitters," also known as companions, resulting in high costs often charged to nursing budgets. Although hospitals use sitters for various purposes, one study using data from 29 hospitals found that patients' confusion, agitation, risk of falling, wandering, and elopement account for most sitter use.[30]

Accreditation and quality of care. Adverse events associated with dementia may also have effects on hospital accreditation, reimbursement, and quality. The Joint Commission's patient safety goals specifically address falls and pressure ulcers (see www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals). The Joint Commission also requires a face-to-face assessment and documentation for all patients in physical restraints, and inappropriate use of restraints can result in loss of accreditation and Medicare reimbursement. The National Quality Forum consensus standards for nursing-sensitive care address falls, pressure ulcers, and physical restraints, and the National Database of Nursing Quality Indicators includes falls and pressure ulcers.[31, 32]

Although it's unlikely that the underlying disease or condition that causes a patient's dementia will be changed substantially in a short hospitalization, dementia-related adverse events can be targeted and prevented or minimized. That can occur, however, only if dementia is recognized early in a patient's hospital stay. (To see an algorithm showing when to use each of four tools for assessing mental status in older adults, go to http://links.lww.com/A334.)

ADMINISTERING THE TRY THIS APPROACHES

Recognition of Dementia in Hospitalized Older Adults (page 45) recommends using the four approaches with all patients age 75 and older. (To see the video segment showing a nurse using these approaches with a patient, go to http://links.lww.com/A217.) This recommendation reflects the relatively low prevalence of dementia in people younger than 75. Other age cutoffs—for example, age 65 and older or age 70 and older—could also be used. In deciding whether to use a lower age, hospitals should weigh the impact of failing to recognize dementia in patients younger than 75 against the staff time required to implement the four approaches.

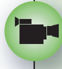
Approaches 1 and 2. The admitting nurse asks the patient and family members, if any are present, whether the patient has "severe memory problems" and whether a physician has ever said the patient has Alzheimer's disease or dementia. These questions can be added to the checklist routinely used at admission. Hospitals that have a printed form listing diseases and conditions, which patients or their families are asked to complete before or at the time of admission, could also add "severe memory problems," "Alzheimer's disease," and "dementia," to the list.

Ms. Raymondi. Ms. Lacy has determined that Ms. Raymondi's assisted living facility has no record of a physician having diagnosed dementia. She calls the daughter, who says that she doesn't think Ms. Raymondi's physician has ever said she has dementia but that Ms. Raymondi's memory problems have certainly become more severe in the past six months.

Approach 3. The admitting nurse asks members of the patient's family, if any are present at the time of admission or soon afterward, to complete the seven-item family questionnaire shown in Recognition of Dementia in Hospitalized Older Adults (see page 46). The nurse should say to the patient, "Is it okay with you if I ask your [husband, wife, daughter, for example] to fill out this questionnaire?" The nurse should show it to the patient if she or he is interested in seeing it. If the patient does not object, the nurse should ask the family member to complete the questionnaire, saying that the responses will "help us provide better care." Alternatively, the nurse can ask the family member the questions. If the patient objects, the nurse should not use the questionnaire and should rely instead on the three other approaches.

Ms. Raymondi's daughter completes the family questionnaire when she comes to see her mother later on the day of admission. The completed questionnaire shows that Ms. Raymondi has frequent problems with four of the seven items listed. The daughter writes on the form that Ms. Raymondi is

How To try this



Watch It!

Go to http://links.lww.com/A216 to watch a nurse use the Family Questionnaire and the Patient Behavior Triggers for Clinical Staff to screen for possible dementia in a hospital patient and discuss how to administer them and interpret results. Then watch the health care team plan strategies to prevent or minimize dementia-related adverse events.

View this video in its entirety and then apply for CE credit at www.nursingcenter.com/AJNolderadults; click on the How to Try This series link. All videos are free and in a downloadable format (not streaming video) that requires Windows Media Player.

not able to perform any of the other three activities at all because of her memory problems.

Approach 4. The admitting nurse watches for the six behaviors listed in Recognition of Dementia in Hospitalized Older Adults (page 46). Many people with dementia exhibit these behaviors in hospitals and other settings. The triggers can be printed on a card or other form, which can be laminated, to remind nurses to look for and document them.

Ms. Raymondi. Ms. Lacy has already noted the patient's disorientation and the fact that she is a "poor historian." Using the list of patient behavior triggers, she also notes that Ms. Raymondi has difficulty finding the right words, using appropriate words, and following conversations.

SCORING AND INTERPRETING RESPONSES

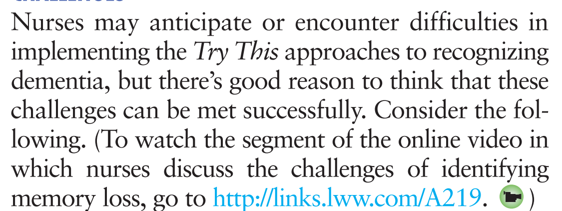
No scoring is needed for a patient's or family's responses to the questions about an existing diagnosis or "severe memory problems" or for the nurse's observation of behavior triggers. That information will help nurses develop the patient's plan of care and work with the patient throughout the hospitalization. Ms. Lacy's observations that Ms. Raymondi is disoriented, for example, will make her cautious about accepting Ms. Raymondi's statements as accurate. In particular, the observation that Ms. Raymondi cannot pinpoint the source of her pain or rate its severity will alert her to the possibility that Ms. Raymondi will not be able to report pain and is therefore at risk for untreated pain.

The family questionnaire can be answered and scored according to a 3-point Likert-like scale: "not at all" = 0, "sometimes" = 1, and "frequently" = 2. Possible scores on the questionnaire range from 0 to 14. A score of 7 or more indicates probable dementia. A score of 3 to 6 indicates possible dementia; any score of 3 or more suggests the need for further evaluation. Ms. Raymondi's score on the family questionnaire would have been 8 if only the four areas in which she still has some ability were evaluated.

Use of the four *Try This* approaches does not result in a new diagnosis of dementia. Approach 2 may reveal an existing diagnosis known to the patient or family but not documented in the hospital record. The other three approaches reveal signs and symptoms of dementia that indicate a need for further assessment. When this occurs, it's feasible but not necessarily ideal for a diagnostic evaluation to be arranged while the patient is hospitalized. More important than an immediate diagnostic evaluation, however, is the identification of nursing procedures to prevent or minimize adverse health events during the hospitalization.

If a diagnostic evaluation doesn't take place while the patient is in the hospital, she or he should be referred to the primary care physician, a geriatrician or geriatric psychiatrist, or a specialized diagnostic center for a postdischarge diagnostic evaluation.

CHALLENGES



Nurses may anticipate or encounter difficulties in implementing the *Try This* approaches to recognizing dementia, but there's good reason to think that these challenges can be met successfully. Consider the following. (To watch the segment of the online video in which nurses discuss the challenges of identifying memory loss, go to http://links.lww.com/A219.)

Concerns about offending the patient or family members or both. Alzheimer's disease and other dementias are still highly stigmatized, and some nurses may be reluctant to ask patients and their families about these conditions. However, in clinical experience with the *Try This* approaches, patients and families have not become upset by the questions. In fact, nurses often report that families express appreciation, saying that no one has ever asked them about this before and that they are relieved to be asked about it.

Absence of a family member to respond to questions. Some hospital patients with dementia do not have a family, or family members may not be present at the time of admission or early in the hospital stay when information is needed. In this case, the nurse has several options. One is to try to identify a close friend who can provide information. It may also be possible to telephone a family member or close friend who can provide information at the time of admission. If that isn't feasible, recognition of possible dementia will have to be based on the nurse's observations of the patient behaviors listed in the Patient Behavior Triggers for Clinical Staff and the patient's responses to the questions about memory problems and a previous diagnosis of dementia.

try this: Best Practices in Nursing Care for Hospitalized Older Adults with dementia
alzheimer's association
from The John A. Hartford Institute for Geriatric Nursing and the Alzheimer's Association

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Recognition of Dementia in Hospitalized Older Adults

By: Mathy Mezey, EdD, RN, FAAN, New York University College of Nursing and Katie Maslow, MSW, The Alzheimer's Association

WHY: About one fourth of older hospital patients have dementia.[i] Their dementia may never have been formally diagnosed, and even if it has been diagnosed, the diagnosis may not be noted in their hospital record. Because of stress caused by acute illness and being in an unfamiliar setting, some older patients show symptoms of dementia for the first time in the hospital.Older hospital patients with dementia are at much higher risk than other older hospital patients for delirium, falls, dehydration, inadequate nutrition, untreated pain, and medication-related problems. They are more likely to wander, to exhibit agitated and aggressive behaviors, to be physically restrained, and to experience functional decline that does not resolve following discharge.This *Try This* document suggests ways hospitals can increase recognition of dementia in their older patients, to lessen or avoid any of these problems.

TARGET POPULATION: Dementia should be considered a possibility in every hospital patient age 75 and over and can be present in younger patients as well. People with dementia usually come into a hospital for treatment of their other medical conditions, although some come in because of complications of their dementia. Of older people with dementia, 30% also have coronary artery disease; 28% congestive heart failure (CHF); 21% diabetes; and 17% chronic obstructive pulmonary disease (COPD).[ii]

BEST PRACTICES: Several approaches can be used to increase recognition of dementia in older hospital patients. One approach is to ask the person and family if the person has "severe memory problems."[iii] Another approach is to ask if a doctor has ever said that the person has Alzheimer's disease or dementia.[iv] The easiest way to do this is to add the items "severe memory problems," "Alzheimer's disease," and "dementia" to the list of diseases and conditions patients and families are routinely asked about on intake forms and in intake interviews.

Two instruments on the second page can also be used to alert staff to the possibility of dementia. The approaches exemplified in these instruments identify "triggers" that indicate a possible problem and need for further assessment. It should be noted that reliability for these instruments has not been established. Hospitals should consider which approach(es) will work best within their existing admission procedures. A combination of approaches may be most effective.

When no prior diagnosis of dementia is reported:

1. ***Family Questionnaire:*** A family member or friend who accompanies the patient to the hospital can be handed a print copy of the 7-item Family Questionnaire.[v] This questionnaire is intended to identify memory problems that interfere with day to day activities – a hallmark sign of possible dementia. As an alternative to the print questionnaire, the intake interviewer or other hospital staff can ask the family member or friend the seven questions. Responses can be scored by staff.
2. ***Patient Behavior Triggers for Clinical Staff:***[vi] This tool includes signs and symptoms that suggest the need to consider dementia. The intake interviewer and other hospital staff can be asked to record or report their own observations of these signs and symptoms.[vii]

Note: At the time of hospital intake, it is very difficult to differentiate dementia from delirium, and many older patients with dementia also have delirium.[vi] None of the approaches above rule out delirium. Further assessment is needed for this purpose.

REFERENCES:

i Maslow, K. (2006). How Many People with Dementia are Hospitalized?" In N.M.Silverstein, & K. Maslow (Eds.). *Improving hospital care for persons with dementia* (pp 3-21). NY: Springer Publishing Co, Inc.
ii Bynum, J.P.W, Rabins, P.V., Weller, W., Niefeld, M., Anderson, G.F., & Wu, A.W. (2004). The relationship between a dementia diagnosis, chronic illness, Medicare expenditures, and hospital use. *JAGS*, *52*(2), 187-194.
iii One of 18 conditions listed in Kaiser Permanente's health risk assessment instrument for Medicare beneficiaries.
iv Question from the Medicare Current Beneficiary Survey.
v Adapted from a family questionnaire developed for the Chronic Care Networks for Alzheimer's Disease project, a joint project of the Alzheimer's Association and the National Chronic Care Consortium.
vi Adapted from a similar tool developed for the Chronic Care Networks for Alzheimer's Disease project, a joint project of the Alzheimer's Association and the National Chronic Care Consortium.
vii Mion, L.C., Palmer, R.M., Anetzberger, G.J., & Meldon, S.W. (2001) Establishing a case-finding and referral system for at-risk older individuals in the emergency department setting: The SIGNET model. *JAGS*, *49*(10), 1379-1386.
viii Fick, D, & Foreman, M. (2000). Consequences of not recognizing delirium superimposed on dementia in hospitalized elderly individuals. *Journal of Gerontological Nursing*, *26*(1), 30-40.

Best practice information on care of older adults: www.ConsultGeriRN.org.

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BEST TOOLS:
Family Questionnaire [v]

Please answer the following questions. This information will help us provide better care for your family member or friend. Thinking back over the past six months, before hospitalization, would you say your family member or friend has experienced or had problems with any of the following? Please circle the answer.

1. Repeating or asking the same thing over and over.	Not at all	Sometimes	Frequently	N/A
2. Forgetting appointments, family occasions, holidays?	Not at all	Sometimes	Frequently	N/A
3. Writing checks, paying bills, balancing the checkbook?	Not at all	Sometimes	Frequently	N/A
4. Shopping independently for clothing or groceries?	Not at all	Sometimes	Frequently	N/A
5. Taking medications according to instructions?	Not at all	Sometimes	Frequently	N/A
6. Getting lost while walking or driving in familiar places?	Not at all	Sometimes	Frequently	N/A
7. Making decisions that arise in everyday living?	Not at all	Sometimes	Frequently	N/A

Relationship to patient ______________________________*(spouse, son, daughter, brother, sister, grandchild, friend, etc.)*
This information will be given to the patient's primary health care provider. Thank you for your help.

How to Use the Family Questionnaire:
If a family member or friend is with the patient, tell the patient you have a few questions for his or her family member or friend that will help you find out if the patient has trouble remembering or thinking clearly. Explain that this information may not come to the hospital's attention unless you ask about it and that the information will help you take better care of the patient. Show the questionnaire to the patient if he or she asks to see it. Ask the patient for their consent, then hand the questionnaire to the family member or friend. Once it is completed, score the questionnaire, and attach it to the patient's chart.

Scoring:
Not at all or N/A = 0
Sometimes = 1
Frequently = 2

Total Score: __________

Score Interpretation: *A score of 3 or more should prompt further assessment. A score of 3-6 indicates possible dementia. A score of 7-10 indicates probable dementia.*

Adapted from a family questionnaire developed for the Chronic Care Networks for Alzheimer's Disease project, a joint project of the Alzheimer's Association and the National Chronic Care Consortium.

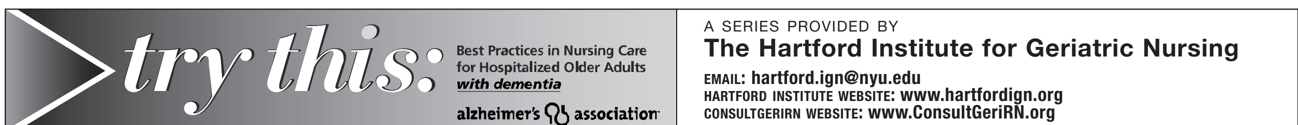
Patient Behavior Triggers for Clinical Staff [vi]
Individuals with undiagnosed dementia may exhibit behaviors or symptoms that offer a clue to the presence of dementia, for example, if the patient:

• Seems disoriented
• Is a *"poor historian"*
• Defers to a family member to answer questions directed to the patient
• Repeatedly and apparently unintentionally fails to follow instructions
• Has difficulty finding the right words or uses inappropriate or incomprehensible words
• Has difficulty following conversations

How to use the patient behavior triggers:
These triggers can be used on a laminated card or other convenient form to remind staff of signs and symptoms that indicate a need for dementia assessment.

Adapted from a similar tool developed for the Chronic Care Networks for Alzheimer's Disease project, a joint project of the Alzheimer's Association and the National Chronic Care Consortium.

When the results of any of these approaches indicate possible dementia, further assessment is needed to measure the level of cognitive impairment and identify delirium, depression, and other conditions that can cause cognitive impairment. For assessment instruments that are useful for this purpose, see *Try This:* Mental Status Assessment of Older Adults: The Mini Cog; *Try This:* Confusion Assessment Method (CAM); *Try This:* Brief Evaluation of Executive Dysfunction; and *Try This:* The Geriatric Depression Scale (GDS), all available at www.hartfordign.org.



Online Resources

For more information on the Recognition of Dementia in Hospitalized Older Adults and other geriatric assessment tools and best practices for people with dementia, go to www.hartfordign.org, the Web site of the John A. Hartford Foundation–funded Hartford Institute for Geriatric Nursing at New York University College of Nursing. The institute focuses on improving the quality of care provided to older adults by promoting excellence in geriatric nursing practice, education, research, and policy.

For more information on best practices in the care of older adults go to www.ConsultGeriRN.org. The site lists many related resources and offers continuing education opportunities.

Go to www.nursingcenter.com/AJNolderadults and click on the *How to Try This* link to access all articles and videos in this series.

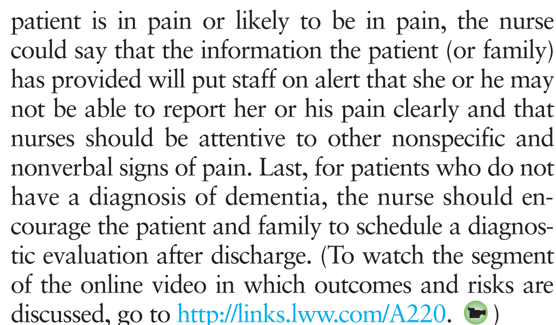
Concerns about the need to obtain a patient's consent to ask a family member questions and complete the family questionnaire. Some hospital patients with dementia are not capable of giving informed consent because of their cognitive impairment, and nurses may be reluctant to proceed without consent. In such cases, nurses can discuss their concerns with their supervisor; it may also be possible to present such concerns to the hospital's legal advisors. With respect to the Family Questionnaire, family members' responses are likely to be most helpful when patients have mild or moderate dementia and are still capable of providing verbal consent.

Concerns about the time required to implement the four approaches. Hospital nurses are extremely busy and may resist these new tasks. The objective of the *Try This* approaches is to allow nurses to identify most patients with undiagnosed or undocumented dementia without making the process so long or complicated that nurses won't want to use it.

COMMUNICATING THE FINDINGS

Findings obtained through the four *Try This* approaches, including an existing diagnosis and any signs and symptoms of possible dementia, should be documented in nursing notes and hospital records and on discharge forms. The information should also be communicated verbally to staff members who interact with the patient but do not have access to or are not likely to see nursing notes or other hospital records, such as laboratory technicians and food service personnel.

In communicating with patients and family members about findings from the four *Try This* approaches, it's important for nurses not to overstate or exaggerate the findings. Except for the question about whether a physician has ever given the patient a diagnosis of Alzheimer's disease or dementia, the other approaches identify signs and symptoms of dementia, not a dementia diagnosis. When the patient has signs and symptoms of dementia, the nurse should tell the patient and family that it's important for the hospital to have that information so that the best care can be provided. If possible, the nurse should give a patient-specific example of what that means. If the patient has mild or moderate dementia, the nurse could point out that the hospital can be a confusing place (or that surgery or other treatments the patient will receive may make her or him temporarily more confused) and that the information the patient (or family) has provided about memory problems or related symptoms will help hospital staff make sure that everything possible is done to avoid greater confusion and help the patient remember where she or he is and what treatments are being provided. If the patient is in pain or likely to be in pain, the nurse could say that the information the patient (or family) has provided will put staff on alert that she or he may not be able to report her or his pain clearly and that nurses should be attentive to other nonspecific and nonverbal signs of pain. Last, for patients who do not have a diagnosis of dementia, the nurse should encourage the patient and family to schedule a diagnostic evaluation after discharge. (To watch the segment of the online video in which outcomes and risks are discussed, go to http://links.lww.com/A220.)



CONSIDER THIS

The approaches discussed here can be integrated easily into a facility's admissions process.

What evidence supports using the approaches described? The overall validity and reliability of the *Try This* approaches have not been established, but each of the approaches has support in the literature and strong face validity.

Approach 1, asking the patient and family whether the person has "severe memory problems," comes from a questionnaire that Kaiser Permanente has used since 1996 for new enrollees. An analysis of completed questionnaires for 320,000 Kaiser enrollees 65 years old and older showed that 4% had a positive response to the question.[33] This proportion is lower than the probable true prevalence of dementia in this population (approximately 12% to 13%). Thus, the question likely identifies people with dementia with few false positives, but it may miss a substantial number of other people who also have dementia.

Approach 2, asking the patient and family whether a physician has ever given the patient a diagnosis of Alzheimer's disease or dementia, comes from the Medicare Current Beneficiary Survey, a survey of Medicare beneficiaries conducted by the Centers for Medicare and Medicaid Services (see www.cms.hhs.gov/mcbs). The question is asked of the beneficiary or a proxy. Results vary by year, but in general

about 5% of older Medicare beneficiaries have a positive response to the question, including about 3% of those living in the community and 40% of those in nursing homes (according to an unpublished Alzheimer's Association analysis conducted

It's important for nurses not to overstate or exaggerate the findings.

by one of us, KM). This question identifies people who have dementia, with few false positives, but misses a substantial number of those whose dementia is undiagnosed or who are (or whose families are) unaware of the diagnosis.

Approach 3. The Family Questionnaire was adapted for use in hospitals from a similar questionnaire used in a multisite Alzheimer's disease demonstration project.[34] Numerous studies have shown that family members' responses to questions such as those in the family questionnaire are accurate in identifying dementia.[35-38]

Approach 4. The list of patient behaviors was adapted for use in hospitals from a similar instrument developed for a multisite demonstration project. A study conducted in hospital EDs found that nurses are fully capable of noticing and documenting such signs and that their observations are generally accurate and helpful in identifying dementia.[39] ▼

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Routine use of a Try This *tool may require formal review and approval by your employer.*

REFERENCES

1. Holsinger T, et al. Does this patient have dementia? *JAMA* 2007;297(21):2391-404.
2. Cummings JL, Cole G. Alzheimer disease. *JAMA* 2002; 287(18):2335-8.
3. Langa KM, et al. Mixed dementia: emerging concepts and therapeutic implications. *JAMA* 2004;292(23):2901-8.
4. Schneider JA, et al. Mixed brain pathologies account for most dementia cases in community-dwelling older persons. *Neurology* 2007.
5. Alzheimer's Association. *Alzheimer's Disease Facts and Figures 2007*. Chicago, IL: The Association; 2007. http://www.alz.org/national/documents/Report_2007FactsAndFigures.pdf.
6. Maslow K. How many hospital patients have dementia? In: Silverstein NM, Maslow K, editors. *Improving hospital care for persons with dementia*. New York: Springer Publishing Company; 2006. p. 1-22.
7. Boise L, et al. Dementia assessment in primary care: results from a study in three managed care systems. *J Gerontol A Biol Sci Med Sci* 2004;59(6):M621-M626.
8. Borson S, et al. Improving identification of cognitive impairment in primary care. *Int J Geriatr Psychiatry* 2006;21(4): 349-55.
9. Callahan CM, et al. Documentation and evaluation of cognitive impairment in elderly primary care patients. *Ann Intern Med* 1995;122(6):422-9.
10. Ganguli M, et al. Detection and management of cognitive impairment in primary care: The Steel Valley Seniors Survey. *J Am Geriatr Soc* 2004;52(10):1668-75.
11. Valcour VG, et al. The detection of dementia in the primary care setting. *Arch Intern Med* 2000;160(19):2964-8.
12. Naylor MD, et al. Cognitively impaired older adults: from hospital to home. *Am J Nurs* 2005;105(2):52-61.
13. Lyketsos CG, et al. Dementia in elderly persons in a general hospital. *Am J Psychiatry* 2000;157(5):704-7.
14. Torian L, et al. The effect of dementia on acute care in a geriatric medical unit. *Int Psychogeriatr* 1992;4(2):231-9.
15. Krauss MJ, et al. A case–control study of patient, medication, and care-related risk factors for inpatient falls. *J Gen Intern Med* 2005;20(2):116-22.
16. Ash KL, et al. A case control study of falls in the hospital setting. *J Gerontol Nurs* 1998;24(12):7-15.
17. McCarter-Bayer A, et al. Preventing falls in acute care: an innovative approach. *J Gerontol Nurs* 2005;31(3):25-33.
18. Miceli DG. Falls associated with dementia: how can you tell? *Geriatr Nurs* 2005;26(2):106-10.
19. Oliver D, et al. Development and evaluation of evidence based risk assessment tool (STRATIFY) to predict which elderly inpatients will fall: case–control and cohort studies. *BMJ* 1997;315(7115):1049-53.
20. Oliver D, et al. Risk factors and risk assessment tools for falls in hospital in-patients: a systematic review. *Age Ageing* 2004;33(2):122-30.
21. Inouye SK, Charpentier PA. Precipitating factors for delirium in hospitalized elderly persons. Predictive model and interrelationship with baseline vulnerability. *JAMA* 1996; 275(11):852-7.
22. Capezuti E, et al. The relationship between physical restraint removal and falls and injuries among nursing home residents. *J Gerontol A Biol Sci Med Sci* 1998;53(1):M47-M52.
23. Oliver D, et al. Do hospital fall prevention programs work? A systematic review. *J Am Geriatr Soc* 2000;48(12):1679-89.
24. Hitcho EB, et al. Characteristics and circumstances of falls in a hospital setting: a prospective analysis. *J Gen Intern Med* 2004;19(7):732-9.

25. Sands LP, et al. Cognitive screening predicts magnitude of functional recovery from admission to 3 months after discharge in hospitalized elders. *J Gerontol A Biol Sci Med Sci 2003;58(1):37-45.*
26. Gill TM, et al. The combined effects of baseline vulnerability and acute hospital events on the development of functional dependence among community-living older persons. *J Gerontol A Biol Sci Med Sci* 1999;54(7):M377-M383.
27. Hansen K, et al. Risk factors for lack of recovery of ADL independence after hospital discharge. *J Am Geriatr Soc* 1999;47(3):360-5.
28. Sager MA, Rudberg MA. Functional decline associated with hospitalization for acute illness. *Clin Geriatr Med* 1998; 14(4):669-79.
29. Sands LP, et al. The effects of acute illness on ADL decline over 1 year in frail older adults with and without cognitive impairment. *J Gerontol A Biol Sci Med Sci* 2002;57(7): M449-M454.
30. Worley LL, et al. Constant observation practices in the general hospital setting: a national survey. *Psychosomatics* 2000; 41(4):301-10.
31. National Quality Forum. *National voluntary consensus standards for nursing-sensitive care: an initial performance measure set.* Washington, D.C.: The Forum; 2004 Oct. NQFCR-08-04. http://www.qualityforum.org/pdf/reports/nsc.pdf.
32. American Nurses Association. *The national database of nursing quality indicators (NDNQI).* The Association. 2007. http://nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/PatientSafetyQuality/NDNQI/NDNQI_1.aspx.
33. Brody KK, et al. Usefulness of a single item in a mail survey to identify persons with possible dementia: a new strategy for finding high-risk elders. *Dis Manag* 2005;8(2):59-72.
34. Maslow K, Selstad J. Chronic care networks for Alzheimer's Disease: approaches for involving and supporting family caregivers in an innovative model of dementia care. *Alzheimer's Care Quarterly* 2001;2(1):33-46.
35. Galvin JE, et al. The AD8: a brief informant interview to detect dementia. *Neurology* 2005;65(4):559-64.
36. Jorm AF. Methods of screening for dementia: a meta-analysis of studies comparing an informant questionnaire with a brief cognitive test. *Alzheimer Dis Assoc Disord* 1997;11(3):158-62.
37. Kemp NM, et al. Diagnosing dementia in primary care: the accuracy of informant reports. *Alzheimer Dis Assoc Disord* 2002;16(3):171-6.
38. Mulligan R, et al. A comparison of alternative methods of screening for dementia in clinical settings. *Arch Neurol* 1996;53(6):532-6.
39. Mion LC, et al. Establishing a case-finding and referral system for at-risk older individuals in the emergency department setting: the SIGNET model. *J Am Geriatr Soc* 2001; 49(10):1379-86.

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