Assessment Module

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About this Module:

Assessment is a key component of nursing practice, required for planning and the provision of resident and family centered care. Information that is obtained from an accurate assessment serves as the foundation for age-appropriate nursing care, enhancing the residents' quality of life and independence. The LVN must have a specific set of skills in order to adequately and effectively assess the resident, including:

- a physical assessment;
- a functional assessment; and
- any additional information about the resident that would be used to develop the care plan.

This module will provide you with all of the information necessary to ensure adequate assessments are completed for each resident in the facility, meeting the state and federal requirements for resident assessment.

Overview:

Conditions such as functional impairment and dementia are common in nursing home residents. A thorough assessment that identifies these conditions can help facility staff manage these conditions and prevent or delay any potential complications. A comprehensive assessment is defined as a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of the older residents in order to develop a coordinated plan to maximize their overall health. In the State of Texas the comprehensive assessment must be performed by the RN. The health care of the older residents extends past the traditional medical management of their illnesses. It may require evaluation of multiple issues including physical, cognitive, affective, social, financial, environmental, and spiritual components that influence an older resident's health.

Objectives:

The objectives for this module include:

a. Identify the differences between a Comprehensive and Focused Nursing Assessment
b. Identify the types of nursing data necessary to determine the health needs of a resident
c. Discuss the differences related to normal aging that may be seen when conducting a physical assessment on an elderly resident
d. Discuss the Federal resident assessment requirements.

Pretest:

1. Gathering historical information about the resident is part of the comprehensive assessment.

◯ True ◯ False

2. The resident's ability to perform tasks required for living is part of the functional assessment.

◯ True ◯ False

3. Assessing for polypharmacy in a newly admitted resident is the responsibility of only the doctor.

◯ True ◯ False

4. It is important to assess a resident with dementia for any challenging behaviors that they may exhibit.

◯ True ◯ False

5. It is not important to assess for the potential causes for challenging behaviors in a resident with dementia. .

◯ True ◯ False

6. When completing your assessment on a newly admitted resident, it is important to get information from family members and loved ones.

◯ True ◯ False

7. Subjective data is data that the nurse gathers from the observing and assessing the resident.

◯ True ◯ False

8. Prior to assessing a resident, the nurse should obtain consent from the resident.

◯ True ◯ False

9. When a resident is displaying a challenging behavior, the nurse should assess for pain as one of the underlying causes.

◯ True ◯ False

10. There are no federal requirements that dictate the use of assessments for residents in nursing homes.

◯ True ◯ False

Answers:			
1. T	2. T	3. F	4. T
5. F	6. T	7. F	8. T
9. T	10. F		

Chapter 1:

Overview:

In an effort to provide as comprehensive care as possible, it is imperative that the LVN understands the importance of an assessment. In a nursing home, the assessment is the basis for the care that the individual resident will receive on a daily basis. For residents in a nursing home, the assessment is about more than just the physical assessment; it includes many other components that may impact a number of areas of care for the resident. The LVN should be familiar with all of the components of an effective assessment and understand how best to obtain the information needed in each area.

Focused Assessment vs. Comprehensive Assessment:

A focused assessment is a detailed nursing assessment of specific body system (s) related to the presenting problem or other current concern(s). Depending on the resident, there may be more than one body system that is assessed; during a focused assessment the resident may complain of a specific symptom, in a specific body system that requires additional investigation. The LVN may implement a pneumonic to effectively assess the area of complaint, such as the PQRSTU:

1. **P**rovocation: What brings it on? What was the individual doing when he/she noticed it? What makes it better? Worse?
2. **Q**uality or Quantity: How does it feel (sharp, dull, throbbing, cramping)?
3. **R**adiating: Does it spread anywhere else in the body?
4. **S**everity: How bad is it on a scale of 0-10? Is it getting better, worse, or staying the same?
5. **T**iming: When did it first occur? How long did it last? How often does it occur?
6. **U**nderstanding of the resident's perception of the problem: What does the resident think it means?

This pneumonic may not be effective for every resident during every assessment; however, it is one of many tools that can be used during the assessment to ensure accurate information is collected.

A comprehensive assessment is an assessment that is generally done upon admission to a healthcare setting by the RN. This assessment usually includes:

1. Health history
2. General survey
3. Measuring vital signs
4. Assessing body systems
5. Psychosocial information

A comprehensive assessment is often times referred to as an admissions assessment or initial assessment. The LVN, while not responsible for performing this type of assessment on a resident should be fully aware of the components of the assessment in order to understand what the resident is receiving care for and how best to provide that care. The data in a comprehensive assessment is what ultimately influences the care plan that is put into place.

Considerations in preparing for a physical assessment[1]:

When the LVN is ready to do a focused assessment on a resident, there are several things that he/she should take into consideration, especially when working with the residents in the facility. These include:

1. Establishing a positive rapport with the resident, as this will decrease the amount of stress that the resident may have in anticipation of what is about to be done.
2. Explaining the purpose of the assessment. The LVN should remember that the nursing home is the resident's home, and it may seem intrusive when the LVN enters the room unannounced to perform an assessment. The LVN should reassure the resident that the assessment is only to gather information about him/her so an individualized care plan can be put into place.
3. Obtaining and documenting informed verbal consent for the assessment. If the resident can verbally give consent, the LVN should obtain it, since the resident will generally be the main source of the information for the assessment.
4. Ensuring all data collected is maintained in confidence. The LVN should explain to the resident what information is needed and how that information will be used.
5. Providing privacy from unnecessary exposure. The LVN must assure as much privacy as possible, using drapes or curtains in the room and closing doors.
6. Communicating special instructions to the resident. As the LVN does the assessment, he/she should inform the resident of what will be done and if the resident can assist in any way. This is especially important, as many of the tasks that are done during an assessment can be embarrassing or uncomfortable.

The LVN should remember when performing a focused assessment on an elderly resident the resident may quickly become fatigued; therefore the assessment may need to be broken into several sections that can be done at different times. It is also important for the LVN to understand that the resident may be a poor historian or unable to verbally provide information, therefore completing the assessment may have to wait until a family member or loved one is able to assist with providing the information. This may mean the LVN will need to schedule a time to meet with the family to facilitate completion of a timely assessment.

[1] Army Publications. Medical Reference and Training Manuals: Considerations in Preparing for a Physical Assessment – Nursing Fundamentals II. http://armymedical.tpub.com/MD0906/MD09060107.htm

Comprehensive Geriatric Assessment:

Regardless of the type of assessment that is being conducted, several important components need to be taken in to consideration in order to provide adequate care for the resident. A comprehensive geriatric assessment performed by an RN will provide the LVN with all of the information needed to provide the highest quality of care to the resident.

The comprehensive geriatric assessment is a thorough assessment that is designed to collect data that will be required for use in the care plan. The nursing components of a geriatric assessment[2] include:

1. History: This should include the resident's past medical and surgical history and provides the background information that is necessary to understand the resident as a whole. This should include any and all childhood illnesses, immunizations, allergies, hospitalizations and serious illnesses, accidents, and injuries.
2. Functional capacity: The functional capacity refers to the ability of the resident to perform activities necessary or desirable in daily life. It is directly influenced by health conditions, particularly in the context of a resident's environment and social support network. Changes in functional status (e.g., not being able to bathe independently) should prompt further diagnostic evaluation and intervention. Measurement of functional status can be valuable in monitoring response to treatment and can provide information that assists in long-term care planning.
   a. Activities of daily living (ADLs): An older resident's functional capacity in the facility should be assessed at the level of ability to perform the basic ADLs (BADLs). These include:
      i. Bathing
      ii. Dressing
      iii. Toileting
      iv. Maintaining continence
      v. Grooming
      vi. Feeding
      vii. Transferring
   b. Gait speed: In addition to measuring the resident's ability to perform BADLs, gait speed should also be assessed, as it can predict functional decline and early mortality in the older resident.
3. Falls/imbalance: Approximately one-third of persons over age 65 and one-half of those residents over 80 fall each year. Residents who have fallen or have a gait or balance problem are at higher risk of having a subsequent fall and losing what independence they may have

[2] Ward, K., Reuben, D., Schmader, K., & Sokol, H. (2015). Comprehensive Geriatric Assessment. http://www.uptodate.com/contents/comprehensive-geriatric-assessment.

left. A falls risk assessment should be conducted during every initial assessment and after any significant changes in health status. The LVN should know the facility's policies/procedures on how to identify these individuals so that additional assessments can be performed as necessary.

4. Cognition: The incidence of dementia increases with age, particularly among those over 85, yet many patients with cognitive impairment remain undiagnosed. The value of making an early diagnosis includes the possibility of uncovering treatable conditions. Assessing the cognition of a resident can be done by simply observing the resident and having conversations with them.
5. Mood: Depression is the most common psychogenic problem identified in elderly residents. Since the symptoms may span a wide range of things, it should be considered as a possibility in any resident. Depression may appear as any changes in behavior (apathy, anger, self-depreciation); changes in thought processes (confusion, disorientation, poor judgement); and somatic complaints (appetite loss, constipation, insomnia). All of these symptoms are ones that you can easily assess in your resident and if noted, they should prompt a call to the physician for follow-up.
6. Polypharmacy: Older residents are often prescribed multiple medications by different health care providers and are taking over-the-counter medications, thus putting them at increased risk for drug-drug interactions and adverse drug events. The LVN should review the resident's medications at admission and any time a new medication is ordered. The LVN should also assess over-the-counter medication usage. Any PRN medications that the resident has an order for, but that haven't been used in a designated timeframe (per facility policy/procedure), should be reviewed for need. If it is determined that the resident no longer needs the medication, the LVN should inform the prescriber to have the order discontinued.
7. Social support: It should be determined on admission, if there is a strong social support network in existence for the resident. If there is not a strong support system in place for the resident, the LVN must determine if there is anyone who is legally responsible for the resident (if they are unable to make their own decisions) and if there is, the extent of their decision making abilities. It is also important for the LVN to determine who the support system is and the resident's attitude toward members of the support system. The resident's marital status should be noted. Additionally, it is imperative that the LVN obtain additional information about the resident such as: educational level, jobs held, and financial issues, existence of an advanced directive (or views on prolonging life if no advanced directive is available), and individualized goals. All this information should be documented as it may be vital information in the future.

Considerations in Elderly Residents:

When assessing an elderly resident, the LVN must understand that there are some physical differences in this resident population, due in part to the normal aging process that has to be taken into consideration. These include[3]:

1. Skin, hair, and nails: Skin color and texture commonly change as a person ages. The resident may report that his/her skin seems thinner and looser, less elastic, than before. The resident also perspires less. The hair thins grays and becomes coarser. Distribution of the hair on the scalp, face and body may also change. The resident may disclose that their scalp feels dry. The fingernails may thicken and change color slightly. The **LVN** should assess whether or not the resident can take care of his or her own nails.
2. Eyes and vision: It is known that up to 57% of individuals living[4] in a long term care setting have visual impairments. The resident may report increased tearing. He/she may also exhibit presbyopia (diminished near vision due to normal decrease in lens elasticity). The LVN should be sure to assess if the resident has experienced any changes in his vision, especially night vision.
3. Ears and hearing: The resident's hearing may be affected by gradual irreversible hearing loss of no specific pathologic origin, a symptom that is common among older residents.
4. Respiratory system: The LVN should be sure to remember that shortness of breath during physical activity could be normal, even if the shortness of breath has increased recently. A warning sign of respiratory problems could be if the shortness of breath has come on suddenly. If the resident has trouble breathing, the LVN should assess for the precipitating circumstances. Does he or she cough excessively? Does the cough produce much sputum, perhaps blood in the sputum? Aging can also affect the nose. The resident may report sneezing, a runny nose, and a decreased sense of smell or bleeding from mucous membranes, all which can be normal but could also be a sign/symptom of something abnormal.
5. Cardiovascular system: More than half of all elderly people suffer from some degree of congestive heart failure. The LVN should assess whether the resident has gained weight recently and if his/her belts or rings feel tight. In addition, find out if he/she tires more easily now than previously. Ask if he/she has trouble breathing or if he/she becomes dizzy when rising from bed or from a chair.
6. Gastrointestinal system: An elderly resident may complain about problems related to his or her mouth and sense of taste. For example, he/she may experience a foul taste in his mouth because saliva production has decreased and mucous membranes have atrophied. If he/she has dentures, the LVN should assess how comfortable they are and how well they work. Their sense of taste decreases gradually as well. This may be why the resident reports that his/her appetite has decreased, or that he/she craves sweeter or spicier foods. The resident

[3] Geriatric Nursing Principles: Chapter III Physical Assessment and Recording the Findings Geriatric Review of Systems. http://www.nurseslearning.com/courses/nrp/NRP1612-30/Section%203/index.htm.

[4] Boltz, M., Capezuti, E., Fulmer, T., & Zwicker, D. (2016). *Evidence-Based Geriatric Nursing Protocols for Best Practice.* New York: Springer Publishing Company.

may also have nonspecific difficulty in swallowing. The LVN should carefully assess the possible causes of regurgitation or heartburn. Additionally, the LVN should ask the resident is he/she has the same degree of difficulty swallowing solids and liquids, if food lodges in his/her throat upon swallowing, and does he or she experience pain after eating, or while lying flat. The LVN should be sure to also ask questions related to the residents bowel habits, to determine if there have been any significant changes.

7. Nervous system: The LVN should inquire about changes in coordination, strength or sensory perception. Does the resident have any headaches or seizures or any temporary losses of consciousness? Has he or she had any issues with incontinence of the bowel or bladder?

In addition to the physical differences that the elderly resident displays, there are significant psychological differences as well. These include:

1. Organic Brain Syndrome: Organic Brain Syndrome is the most common form of mental illness in the elderly population. It occurs in both an acute form (reversible cerebral destruction) and a chronic form (irreversible cerebral cellular destruction). Characteristics of both types include impaired memory (especially recent memory), disorientation, confusion and poor comprehension. In the elderly resident, acute organic brain syndrome may result from malnutrition, cerebrovascular accident and drugs, alcohol or head trauma. Restlessness and a fluctuating level of awareness, ranging from mild confusion to stupor, may signal this condition. The cause of chronic organic brain syndrome is unknown. The major signs of this disorder include impaired intellectual functioning, poor attention span, memory loss using confabulation and varying moods.
2. Depression: Depression is the most common psychogenic problem found in the elderly population. Since the symptoms of depression span a wide range, the LVN should definitely consider it as a possibility if he/she observes any of these signs, and question the resident in detail about recent losses. The LVN should also find out the coping mechanisms that the resident is using to deal with any recent loss.
3. Adverse Drug Reactions: When the LVN performs an assessment of an elderly resident, he/she should consider that the psychological problems may result from undetected adverse drug reactions. The incidence of these reactions increases in older people because they are frequently on multiple medications. Physiologic changes related to the aging process also may alter a resident's reaction to drugs. Such routinely prescribed medications as tranquilizers and barbiturates can cause or increase depression. Other medications, including anticholinergics and diuretics, may cause confusion in elderly patients.
4. Paranoia in the Elderly: Paranoia is defined as an unreasonable fear that they are in danger. Paranoia may be one symptom of psychosis, depression or dementia. It can also be a discreet illness, characterized by a slow, gradual development of a rigid delusional system in a resident who otherwise has clear thought processes. If the LVN detects signs of paranoia during the mental status examination, he/she should try to determine whether the signs are a

result of sensory-loss problems (which may be corrected by glasses or a hearing aid), psychological problems or a realistic fear of attack or robbery.

5. The Effects of Anxiety: In an elderly resident, the need to adjust to physical, emotional and socioeconomic changes of being placed in a nursing facility can cause an acute anxiety reaction. These changes may raise the anxiety level to the point of temporary confusion and disorientation. Often an elderly person's condition can be mislabeled as senility or as organic brain syndrome. The LVN should assess for this in the resident and report it to the physician in order to ensure adequate treatment.
6. Dementia: Dementia is the loss of intellectual abilities, especially those higher order functions measured by memory, judgment, abstract thinking and visual-spatial relations, in the context of preserved alertness. Dementia is different from delirium, which is a clouding of consciousness with decreased awareness of both external and internal environment and a decrease in the ability to sustain attention manifested by disordered thinking and agitation. The LVN should assess for any of the signs/symptoms of dementia, and report any abnormal findings to the physician in an effort to ensure that the resident receives the proper treatment and that there are care plans in place for all treatments.

Chapter 2:

Root Causes of Behavior[5]:

There's been a rapid increase in the number of nursing home residents who are affected by Alzheimer's disease or other dementia related conditions, so behavioral symptoms may be exhibited. It is the responsibility of the LVN working with these residents to be able to assess these challenging behaviors and determine their root cause with the assistance of the RN. Whether a behavior is problematic depends upon the environment and the capacity of those working with the resident and their ability to address the causes and consequences of the behavior.

The needs-driven behavior model suggests that disruptive, agitated, and aggressive behaviors are the result of unmet needs. Behavior, in this model is related to both individual characteristics and environmental triggers (physiological, psychosocial, environmental, and social).

i. Individual Characteristics: those relatively stable individual and health-related issues that predispose someone with dementia to engage in certain disruptive behaviors. There are four individual and health-related characteristics that may affect a person's behavior:
   a. Dementia-related functioning (such as language and memory impairment)
   b. Overall health status and level of dementia
   c. Demographic variables (such as marital status and number of children)

[5] Alzheimer's and Related Dementias: Behavior Management of AD/Dementia Patients. https://www.atrainceu.com/course-module/1473200-55_alzheimer-s-and-related-dementias-module-03.

d. Psychosocial variables (such as personality traits and coping mechanisms)

ii. Environmental Triggers: those things within the environment that may drive or cause disruptive behavior. The environmental triggers include:
   a. Physiologic need (hunger, thirst, pain, or fear)
   b. Psychosocial needs (such as contact with family)
   c. Environmental issues (such as cold room or an uncomfortable chair)
   d. Social surroundings (such as too many people or too much noise)

Another model of understanding behaviors is the ABC model. This is a problem solving model that identifies critical points for intervention of the behavior based on observing the antecedent, behavior, and consequence (A, B, C).

1. Antecedent: what precipitated or caused the behavior
2. Behavior: what is the behavior
3. Consequence: what are the consequences of the behavior

This model is effective when successful strategies are regularly communicated to staff and they understand what triggers a challenging behavior. The ABE model can assist the LVN to understand what the behaviors are and modify the environment and interaction accordingly.

The LVN should understand the specific behavior that the resident is displaying, assess what may have caused it, and work with the care team to change the behavior. The challenging behaviors that are most often displayed by a resident with dementia include: aggression, confusion, anxiety or agitation, repetition, suspicion, wandering, and trouble sleeping[6].

1. Aggression: this behavior may be verbal (shouting, name calling) or physical (hitting, pushing). It is important to try to understand what is causing the anger, as it can occur suddenly with no apparent reason or can result from a frustrating situation.
   a. The LVN should assess the resident for pain, as in a resident with dementia; pain can cause the resident to act aggressively.
   b. The Pain and Unmet needs document can be used by educators to discuss the consequences of pain as an unmet need. This document can be found in Appendix A
2. Confusion: The resident with dementia may not recognize familiar people, places, or things. He or she may forget relationships, call family members by other names or become confused as to where home is. The resident may also forget how to use common items.

   The LVN must assess for the underlying cause of the confusion. This can be something as simple as a change in living arrangements or something more serious such as an infection (such as a UTI).

[6] Alzheimer's Association: behaviors. https://www.alz.org/national/documents/brochure_behaviors.pdf.

3. Anxiety or Agitation: Residents can become anxious or agitated for many reasons. It is important that the LVN observe the resident to determine what triggers this behavior.

   The LVN should observe the resident's surroundings, the time of day, what, if anything has just occurred, and assess the resident for the possibility of pain, hunger, need for sleep, and any sudden changes.

4. Repetition: A resident with Alzheimer's may do or say something over and over. In many cases the resident may just be looking for comfort, security, or familiarity.

   The LVN should assess the resident who is using repetitive words or actions to determine if he/she is trying to express a concern, ask for help, or cope with frustration, anxiety, or insecurity.

5. Suspicion: The memory loss and confusion that comes with dementia may cause a resident to perceive things in a new and unusual way. The resident may become suspicious of those around them, even accusing others of theft, infidelity, or other improper behavior. The resident may misinterpret what he or she sees and hears.

   The LVN must understand that this is a part of the disease process in a resident with dementia. The LVN does have a responsibility to the resident to assess the situation, anytime that a resident makes any claim of theft, as it may actually be occurring.

6. Wandering: It is very common for a resident with dementia to wander. As the disease progresses, the individual no longer remembers that the nursing facility is home, so he/she may try to go home, or even try to create a familiar routine like going to work or picking up children from school.

   In this instance, the LVN must be very aware of the warning signs of someone who may wander. These may include (not an all-inclusive list): requests to "go home", restlessness or pacing, and appearing to be lost in a new or changed environment.

7. Trouble sleeping: Residents who have dementia may have problems sleeping or experience changes in their sleep schedule.

   Assessing the resident who is having trouble sleeping is important. The LVN may need to review the resident's history to determine if there is a reason for the sleep disturbances, for example if the individual worked nights and slept during the day, he/she may not be able to make that change.

It is of the utmost importance that the LVN understands that he/she is responsible for assessing and reassessing an individual any time that there is a change in condition. The different

challenging behaviors that can be seen in these residents require a significant amount of assessment and follow up to ensure that the needs of the resident are being met. It is not enough to simply do an initial assessment and not pay particular attention to these issues. In addition to the assessment, the LVN should also ensure that the information that is discovered during the assessment is properly documented so that other care staff who working with this resident is knowledgeable about the challenging behaviors that he/she may exhibit.

Chapter 3:

Risk Assessment:

As individuals age, there are many physical changes that occur; those that didn't present as a problem previously, may begin to pose a risk to the resident's well-being as he/she gets older . When conducting assessments, the LVN must be sure to evaluate these 'risk' areas to ensure any issues that arise are included in the care plan. These include:

1. Eyes: All of the eye structures change with aging. Due to these changes, the LVN should be sure to do a risk assessment for the following: falls due to a reduction in the residents visual acuity; reduced activity due to a reduction in the resident's peripheral vision; and the inability to get around as they used to due to their inability to tolerate glare and trouble adapting to darkness or bright light. The resident should be assessed for more than just their visual acuity, as it may not be enough to identify their risks for injuries.
2. Ears: As an individual age there are several changes that one might experience with their ears. The ear is not only responsible for picking up sound; it is also responsible for maintaining the balance. As one ages, the structures inside the ear also start to change and their functions decline. Since these changes can be quite drastic for an individual, the LVN must be aware of the risks that are associated with changes to a resident's ears. The resident may no longer be able to distinguish high-frequency sounds and may also have trouble carrying on a conversation in the presence of background noise. This poses a risk to the resident as they may not fully hear what is going on and may not be able to actively participate in their care, increasing frustration and agitation. In addition to risks caused by hearing loss, there are risks associated with changes in the resident's balance. These risks include the resident being unable to maintain their balance while sitting, standing, or walking, which will put them at high risk for falls.
3. Hemiparesis: An LVN may have residents who have suffered from a multitude of different illnesses or injuries. Among the most common are those residents who have experienced a stroke. Hemiparesis is the most frequent neurological deficit after a stroke, so the LVN would need to assess for the risk for falls due balance impairments. The LVN should assess the resident with hemiparesis for muscle strength, range of movement, muscle tone, motor coordination, sensory issues, and cognition on admission and on an on-going basis to

determine any changes in the resident's abilities. It is important that the LVN works with the interdisciplinary team as well, when making determinations about the resident's abilities.

4. Paraplegia: Those residents who have impairment in the motor and/or sensory function of their lower extremities are diagnosed with paraplegia. These residents are at risk for falls if they aren't educated on their condition. The LVN must be sure to fully assess for the resident's abilities and educate them about the risks that they face. In addition to fall risks, these residents are at a significant risk for pressure ulcers due to their inability to easily move themselves. The LVN must understand this risk factor and perform a thorough skin assessment of the resident at least every shift and work with the nurse aides to ensure that they report any signs/symptoms of skin breakdown as soon as they are discovered. Residents with paraplegia are also at risk for developing venous thromboembolisms which can lead to deep vein thrombosis and pulmonary embolisms. The LVN should be aware of the risk to the resident as well as what signs/symptoms to look for. The signs and symptoms of a DVT include (but are not limited to): edema, warmth, and erythema to the affected extremity. Signs and symptoms of a Pulmonary Embolism include (but are not limited to): cough, syncope, and tachycardia.

As part of the risk assessment, there are several different forms that can be used to determine the level of issues such as falls and skin breakdown. See Appendix B for these forms.

Where to place a resident in the room:

Once the LVN assesses the resident for any additional risks based on their medical conditions, he/she should work with the administration to ensure the best placement in the room that will provide the resident and the staff with the most safety. The bed of a resident who has paraplegia should be placed against the wall of the affected side, if at all possible. This will keep the resident from trying to get out of bed without assistance, especially if there are concerns related to cognition or a diagnosis of dementia. As the LVN works with the high risk resident (s) he/she should be sure to continually assess the environment, inclusive of the room, to ensure the resident's safety on a daily basis.

Chapter 4:

Texas Board of Nursing and Assessments:

The Texas BON, through the Nurse Practice Act (NPA) dictates all of the LVN's responsibilities, as mentioned in the role of the nurse in the assessments section. Below are the specific BON rule sections, position statements, and links for easier access to the information:

1. Texas Administrative Code, Title 22, Part 11, Chapter 217, Rule §217.11 Standards of Nursing Practice. http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=11&ch=217&rl=11

2. Texas Occupations Code, Title 3, Subtitle E, Chapter 301 Nurses, Subchapter A General Provisions, Sec. 301.002 Definitions. http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.301.htm
3. TX BON Differentiated Essential Competencies of Graduates of Texas Nursing Programs. http://www.bon.texas.gov/pdfs/publication_pdfs/delc-2010.pdf
4. TX BON Frequently Asked Questions – Nursing Practice. LVNs Performing Initial Assessments. http://www.bon.texas.gov/faq_nursing_practice.asp#t13.

The LVN should have a full understanding of their scope of practice, knowing what he/she is allowed to do with regards to assessing residents in the facility. The NPA details that an LVN is not allowed to perform a comprehensive assessment, as this is the responsibility of the RN.

Federal Nursing Facility Regulations:

The LVN should be aware that there are rules and regulations by which they must practice. With regards to assessments, the federal regulations require the completion of an assessment, and that the assessment is used in the creation of the care plan. The F-Tags that are specific to assessments are F272, F273, F274, F275, and F276.

A. F272[7]: The facility must conduct a resident assessment upon admission and periodically in order to develop a care plan, to provide the appropriate care and services for the resident, and to modify the care plan and care/services that are being received, based on any changes in the resident's status. Additionally, the facility must ensure that a comprehensive assessment is performed on all of the residents. This assessment must include the following components:

i. Identification and demographic information
ii. Customary routine.
iii. Cognitive patterns.
iv. Communication.
v. Vision.
vi. Mood and behavior patterns.
vii. Psychological well-being.
viii. Physical functioning and structural problems.
ix. Continence.
x. Disease diagnosis and health conditions.
xi. Dental and nutritional status.
xii. Skin Conditions.
xiii. Activity pursuit.
xiv. Medications.
xv. Special treatments and procedures.
xvi. Discharge planning.
xvii. Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

[7] Centers for Medicare and Medicaid Services (CMS) State Operations Manual Appendix PP. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

xviii. Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

While the LVN isn't directly responsible for performing the comprehensive assessment, he/she should understand that it is a requirement for the facility to gather the assessment information. In addition, the LVN should know where to find the information in the assessment so that the care being provided to the resident is in line with the assessment.

B. F273[5]: CMS requires that a comprehensive assessment be completed, when required, within 14 calendar days after the resident is admitted to the facility. The LVN should be aware of the timing requirements in order to ensure that he/she is providing care based on the most up-to-date assessment.

C. F274[5]: This regulation requires that a resident who is readmitted to a facility after a significant change in condition receive a comprehensive assessment within the same 14 calendar day timeframe as the new admission requirement. The change in condition can be either for the better or worse of the resident; either way there must be a comprehensive assessment performed.

D. F275[5]: In this requirement, CMS dictates that for those residents requiring an assessment, a new comprehensive assessment must be completed at least once every 12 months. This assessment must be done within 366 days after the most recent annual review date (ARD) of the most recent comprehensive assessment.

E. F276[5]: The last CMS requirement related to assessments is that the facility must assess a resident using the quarterly review instrument specified by the state and approved by CMS with a frequency of no less than once every 3 months. This requirement is for a review of, at a minimum, all the items contained in the standards quarterly review form.

As mentioned before, the LVN is not responsible for any of the comprehensive assessments that are required to be completed for the resident. The LVN however should be aware of the findings in the comprehensive assessment in order to ensure that all of the care that is being provided to the resident is based on the most current assessment.

Chapter 5:

Resources:

There are many different versions of a booklet that tell a resident's story, and can be used to provide a facility with the information that they need to provide person-centered care to that resident. The following are two different examples of these booklets:

A. **"This is Me"[8]:** The Alzheimer's Society's booklet "This is Me", is a leaflet that will help support an individual who is being cared for in an unfamiliar place. It enables health and social care professionals to see the person as an individual and deliver person-centered care that is tailored specifically to the person's needs. That information can help reduce distress for the person with dementia, and help to prevent issues with communication, or even more serious conditions such as malnutrition and dehydration. A sample of this booklet can be found in Appendix C.

B. **"A Passport Into My Life: Understanding My Journey Will Help You Understand Me"[9]:** After reviewing documents from several sources, including the Alzheimer's Society and the Alzheimer's Association, the Behavior Management Task Force created the Passport. This booklet provides information about the person and paints a picture of who the person really is. Passport information includes interests, accomplishments, daily routines, familiar names, traumatic life events, and a number of expressions of needs. A sample of this booklet can be found in Appendix D.

C. **Alternative Communication Boards:** There are many different ways to communicate with the residents in a nursing facility that are unable to verbalize their wishes and the care that they would like receive. The inability to communicate with the healthcare provider in long-term care can often result in a decrease in the quality of life that the resident experiences. Successful communication with a resident who is unable to communicate effectively is an essential component of caring for them. Several examples of the different types of alternate communication devices are available in Appendix E.

D. **Jennifer Wills' Pain, Pain Go Away Presentation** is also available to use to instruct the students on assessing for a patient's pain. This is available as an additional attachment to this tool kit**.**

[8] Alzheimer's Society. "This is Me". https://www.alzheimers.org.uk/thisisme.
[9] A Passport to Better Care. http://www.providermagazine.com/archives/2014_Archives/Pages/0814/A-Passport-To-Better-Care.aspx.

Appendix A

Pain and Unmet Needs

Assessing for Pain as an Unmet Need

Individuals with dementia often experience unmet needs such as pain, hunger, boredom, toileting, etc. Of all of the unmet needs that may be experienced, pain is the most common one that is experienced by individuals with dementia.

Pain often leads to behavioral issues, as these individuals are unable to express the pain that they experience. Pain is frequently underdiagnosed in individuals with dementia and warrants a high degree of suspicion when behavior changes are exhibited. Due to deficits in language and cognition that occur with dementia, an individual with dementia may often have a reduced ability to express pain normally. Pain is likely to manifest itself as a behavioral expression, but can also lead to sleep disturbances, decreased socialization, malnutrition, impaired immune function, and impaired ambulation just to name a few. The resident should be observed for their body language and other nonverbal cues that may indicate the presence of pain, such as resistance to care, striking out, and other aggressive expressions during care.

Successful pain management programs include processes for completing a pain assessment, along with re-evaluations to determine the effectiveness of any treatment provided. Standardized, evidence-based assessment tools are an important component of any pain management program. A variety of valid and reliable assessment tools are available, including tools developed specifically for evaluating residents with dementia or other cognitive impairments, as assessing for pain in individuals with dementia can often times be very difficult due to the loss of ability to communicate. In individuals who are in the beginning stages of dementia, it may be possible to get accurate information from them regarding their pain level, using one of several self-reporting scales, such as the Numerical Rating Scale and the Faces Pain Scale (FPS). In those individuals who are in the more advanced stages of dementia, the Pain Assessment in Advanced Dementia Scale (PAINAD) is recommended. The Behavioral Pain Assessment Scale can also be used for an individual who may not be able to communicate effectively. Each resident should have a pain assessment completed on admission, quarterly thereafter and whenever there are changes in condition. The pain assessment serves as the baseline from which care planning will be initiated and measurable goals established.

Resources to assess for Pain:

The following are links to where examples of the different pain assessment scales can be accessed:

Numerical Rating Scale:
http://www.geriatricpain.org/Content/Assessment/Intact/Pages/NRScale.aspx.

Faces Pain Scale (FPS):
http://www.geriatricpain.org/Content/Assessment/Intact/Pages/FACESPainScale.aspx.

Pain Assessment in Advanced Dementia Scale (PAINAD):
Instructions:
http://www.geriatricpain.org/Content/Assessment/Impaired/Pages/PAINADToolInstructions.aspx.
Form: http://www.geriatricpain.org/Content/Assessment/Impaired/Pages/PAIDADTool.aspx.

Behavioral Pain Assessment Scale:
http://dc67k423myy0n.cloudfront.net/content/intqhc/16/1/59/F2.large.jpg.

For additional resources related to pain management in those with dementia, you can visit:

- http://www.leadingage.org/How_to_Assess_Reduce_and_Manage_Pain.aspx.
- http://www.tmfqin.org/Resource-Center.

References:

Pain management in patients with dementia:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3817007/.

Understanding and Responding to Behavioral Symptoms in Dementia:
http://webcache.googleusercontent.com/search?q=cache:C1QHxNSaZsgJ:www.nursing.uiowa.edu/sites/default/files/documents/hartford/ABCs_lecture.DOC+&cd=12&hl=en&ct=clnk&gl=us.

Texas Health and Human Services Quality Monitoring Program: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf/quality-monitoring-program-qmp/evidence-based-best-practices-qmp/pain-management.

Appendix B

Risk Assessments

Falls Risk Assessment

Fall Risk Checklist

Patient: Date: Time: AM/PM

Fall Risk Factor Identified	Factor Present?	Notes
Falls History		
Any falls in past year?	☐ Yes ☐ No	
Worries about falling or feels unsteady when standing or walking?	☐ Yes ☐ No	
Medical Conditions		
Problems with heart rate and/or rhythm	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Incontinence	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Foot problems	☐ Yes ☐ No	
Other medical conditions (Specify)	☐ Yes ☐ No	
Medications		
Any psychoactive medications, medications with anticholinergic side effects, and/or sedating OTCs? (e.g., Benadryl, Tylenol PM)	☐ Yes ☐ No	
Gait, Strength & Balance		
Timed Up and Go (TUG) Test ≥12 seconds	☐ Yes ☐ No	
30-Second Chair Stand Test Below average score (See table on back)	☐ Yes ☐ No	
4-Stage Balance Test Full tandem stance <10 seconds	☐ Yes ☐ No	
Vision		
Acuity <20/40 OR no eye exam in >1 year	☐ Yes ☐ No	
Postural Hypotension		
A decrease in systolic BP ≥20 mm Hg or a diastolic bp of ≥10 mm Hg or lightheadedness or dizziness from lying to standing?	☐ Yes ☐ No	
Other Risk Factors (Specify)		
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

STEADI Stopping Elderly Accidents, Deaths & Injuries

Braden Scale for Predicting Pressure Sore Risk

Instructions:

Use the Braden Scale to assess the patient's level of risk for development of pressure ulcers. The evaluation is based on six indicators: sensory perception, moisture, activity, mobility, nutrition, and friction or shear.

Scoring:

The Braden Scale is a summated rating scale made up of six subscales scored from 1-3 or 4, for total scores that range from 6-23. A lower Braden Scale Score indicates a lower level of functioning and, therefore, a higher level of risk for pressure ulcer development. A score of 19 or higher, for instance, would indicate that the patient is at low risk, with no need for treatment at this time. The assessment can also be used to evaluate the course of a particular treatment.

Sources:

- Ayello EA. Predicting pressure ulcer risk. In: Boltz M, series ed. *Try This: Best Practices in Nursing Care to Older Adults*. 2003 July. Revised January 2004; Vol 1, No 5. The Hartford Institute for Geriatric Nursing. www.hartfordign.org
- Ayello EA, Braden B. How and why to do pressure ulcer risk assessment. *Adv Skin Wound Care*. 2002 May-Jun;15(3):125-131.
- Bergstrom N, Braden BJ, Laguzza A, Holman V. The Braden Scale for Predicting Pressure Sore Risk. *Nurs Res*. 1987;36:205-210.
- Braden Scale for Preventing Pressure Sore Risk. Prevention Plus. 2001. Available at: http://www.bradenscale.com/bradenscale.htm. Accessed December 16, 2004.
- Panel for the Prediction and Prevention of Pressure Ulcers in Adults. Pressure Ulcers in Adults: Prediction and Prevention. Clinical Practice Guideline, Number 3. AHCPR Publication No. 92-0047. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. May 1992 (reviewed 2000).

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name _____ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours.				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
				Total Score				

Appendix C

“This is Me”

Royal College of Nursing

Alzheimer's Society | Leading the fight against dementia

This is me

This leaflet will help you support me in an unfamiliar place.

Please place a photograph of yourself in the space provided.

My full name _____

photo

For someone with dementia, changes such as moving to an unfamiliar place or meeting new people who contribute to their care can be unsettling or distressing. **This is me** provides information about the person at the time the document is completed. It can help health and social care professionals build a better understanding of who the person really is.

This is me should be completed by the individual(s) who know the person best and, wherever possible, with the person with dementia. It should be updated as necessary. It is not a medical document.

On the back page you will find more detailed guidance notes to help you complete **This is me**, including examples of the kind of information to include. You might find it helpful to read through these notes before you begin to fill in the form.

Name I like to be called

Where I live (list your area, not your full address)

Carer/the person who knows me best

I would like you to know

My life so far (family, home, background and treasured possessions)

Current and past interests, jobs and places I have lived

The following routines are important to me

Things that may worry or upset me

What makes me feel better if I am anxious or upset

Royal College of Nursing

Alzheimer's Society | Leading the fight against dementia

My hearing and eyesight

How we can communicate

My mobility

My sleep

My personal care

How I take my medication

My eating and drinking

Other notes about me

Date completed _____ By whom _____

Relationship to person _____

I agree that the information in this leaflet may be shared with health and social care professionals.

Guidance notes to help you to complete **This is me**

Name I like to be called: Enter your full name on the front and the name you like to be called inside.

Where I live: The area (not the address) where you live and how long you have lived there.

Carer/the person who knows me best: This may be a spouse, relative, friend or carer.

I would like you to know: Include anything you feel is important and will help staff to get to know and care for you, eg I have dementia, I have never been in hospital before, I prefer female carers, I am left-handed, I am allergic to …, other languages I can speak.

My life so far (family, home, background and treasured possessions): Include place of birth, education, marital status, children, grandchildren, friends and pets. Any religious or cultural considerations.

Current and past interests, jobs and places I have lived: Include career history, voluntary experience, clubs and memberships, sports or cultural interests.

The following routines are important to me: What time do you usually get up/go to bed? Do you have a regular nap or enjoy a snack or walk at a particular time of the day? Do you have a hot drink before bed, carry out personal care activities in a particular order, or like to watch the news at 6pm? What time do you prefer to have breakfast, lunch, evening meal?

Things that may worry or upset me: Include anything you may find troubling, eg family concerns, being apart from a loved one, or physical needs such as being in pain, constipated, thirsty or hungry. List environmental factors that may also make you feel anxious, eg open doors, loud voices or the dark.

What makes me feel better if I am anxious or upset: Include things that may help if you become unhappy or distressed, eg comforting words, music or TV. Do you like company and someone sitting and talking with you or do you prefer quiet time alone?

My hearing and eyesight: Can you hear well or do you need a hearing aid? How is it best to approach you? Is the use of touch appropriate? Do you wear glasses or need any other vision aids?

How we can communicate: How do you usually communicate, eg verbally, using gestures, pointing or a mixture of both? Can you read and write and does writing things down help? How do you indicate pain, discomfort, thirst or hunger? Include anything that may help staff identify your needs.

My mobility: Are you fully mobile or do you need help? Do you need a walking aid? Is your mobility affected by surfaces? Can you use stairs? Can you stand unaided from a sitting position? Do you need handrails? Do you need a special chair or cushion, or do your feet need raising to make you comfortable? What physical activity do you take?

My sleep: Include usual sleep patterns and bedtime routine. Do you like a light left on or do you find it difficult to find the toilet at night? Do you have a favoured position in bed, special mattress or pillow?

My personal care: List your usual practices, preferences and level of assistance required in the bath, shower or other. Do you prefer a male or female carer? Do you have preferences for brands of continence aids, soaps, cosmetics, toiletries, shaving, teeth cleaning or dentures? Do you have particular care or styling requirements for your hair?

How I take my medication: Do you need help to take medication? Do you prefer to take liquid medication?

My eating and drinking: Do you need assistance to eat or drink? Can you use cutlery or do you prefer finger foods? Do you need adapted aids such as cutlery or crockery to eat and drink? Does food need to be cut into pieces? Do you wear dentures to eat or do you have swallowing difficulties? What texture of food is required to help – soft or liquidised? Do you require thickened fluids? List any special dietary requirements or preferences including being vegetarian, and religious or cultural needs. Include information about your appetite and whether you need help to choose food from a menu.

Other notes about me: Include additional details about you that are not listed above and help to show who you are, eg favourite TV programmes or places, favourite meals or food you dislike, significant events in your past, expectations and aspirations you have.

Indicate any advance plans that you have made, including the person you have appointed as your attorney, and where health and social care professionals can find this information.

To order further copies please call 01628 529240.

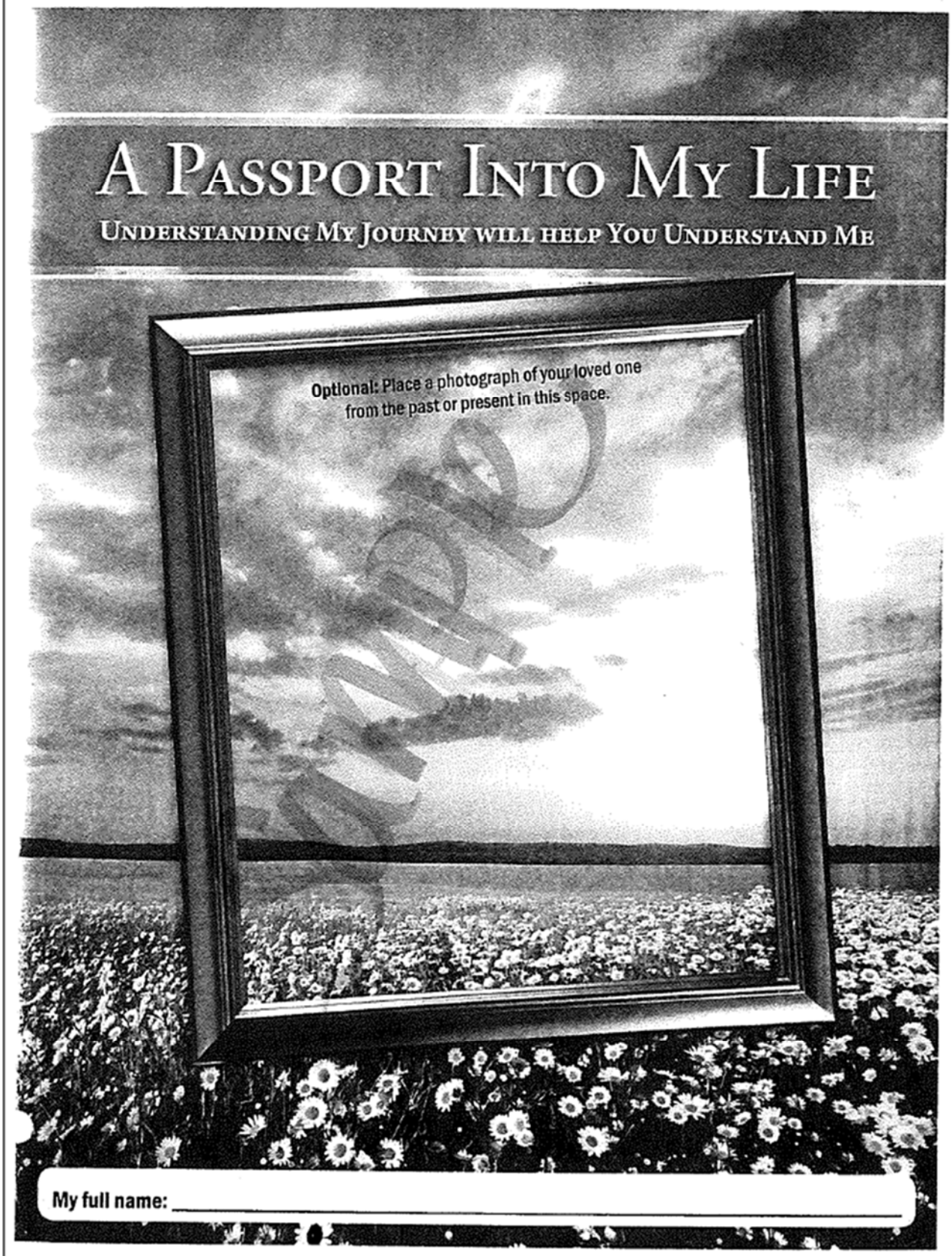
Phone the National Dementia Helpline on 0300 222 11 22 or visit alzheimers.org.uk

1553 Dedicated to the memory of Ken Ridley, a much valued member of the Northumberland Acute Care and Dementia Group.

Appendix D

A Passport Into My Life:

Understanding My Journey Will Help You Understand Me


A Passport Into My Life
Understanding My Journey will help You Understand Me
Optional: Place a photograph of your loved one from the past or present in this space.
My full name: _____

Name I like to be called _____

Where I lived (i.e. state, city, rural, farm, other places) as a:

child: _____

young adult: _____

adult: _____

I would like you to know:

Favorites: (topics to talk about, music, dessert, movie, childhood game, candy bar, TV shows):

_____

Pet(s) and their name(s): _____

Accomplishments in life (things I am proud of): _____

Places I have traveled: _____

Current and past interests: _____

How I enjoy spending my time: _____

Jobs and occupation (including military): _____

PAGE 1

The following daily routines are important to me: _____

Driving: ☐ Still drives – Describe extent of driving: _____

☐ Has stopped driving

My hearing and eyesight: _____

How we can communicate: _____

Interaction with a female caregiver: _____

Interaction with a male caregiver: _____

Things that are helpful to know while providing care, giving medications and meals:

Daily care routines:

- Prefers bath ☐ shower ☐
  - Preferred time _____
  - frequency _____
- Wakes in a.m. around _____
- Takes a daily nap ☐ Time _____
- Right or left handed _____
- Sleep pattern/preferred position/concerns _____
- Goes to bed at night around _____
- Most active time of day _____
- Eats most at which meal(s) _____

Other comments about daily care: _____

Familiar names and their relationship i.e. positive (Donna-daughter) negative (Bob-son)

Positive: _____

Negative: _____

Important things I want you to know about me:

Traumatic life events: _____

_____

_____

Dislikes: _____

_____

_____

What makes me feel better if I am anxious or upset: _____

_____

_____

Personality traits (i.e. easy going, authoritative, passive, quick to anger, loner, enjoy being around people, making new friends):

Past: _____

Present: _____

Behaviors

Misidentification

- ☐ Thinks image in mirror is not him/herself
- ☐ Fails to recognize friends, distant family
- ☐ Fails to recognize spouse/caregiver
- ☐ Other_____

When does misidentification occur (e.g., particular time of day or situation)?

_____

_____

Warning signs (what happens before the behavior?

_____

_____

Effective ways to respond including any redirection objects (i.e. communication board, comfort item, food/beverage):

_____

_____

☐ None

Depression

- ☐ Mood is depressed most of the time (e.g., says he/she is sad or appears tearful)
- ☐ Fatigue or loss of energy
- ☐ Recent loss of member of their support system
- ☐ Specify dates (i.e. anniversary) that may trigger depression

_____

_____

☐ None

Hallucinations

- ☐ Hears voices
- ☐ Talks to people who are not there
- ☐ Sees things not seen by others
- ☐ Other unusual sensory experiences (e.g., things touching skin, unusual tastes, smelling odors)

When do hallucinations occur (e.g. particular time of day or situation)?

Warning signs (what happens before the behavior?

Effective ways to respond including any redirection objects (i.e. communication board, comfort item, food/beverage):

☐ None

Delusions (false beliefs). Patient believes:

- ☐ He/she is in danger, others are planning to harm him/her
- ☐ Others are stealing from him/her
- ☐ Spouse is having an affair
- ☐ Strangers are in their room
- ☐ People on television are real
- ☐ Other_____

When do delusions occur (e.g., particular time of day or situation)?

Warning signs (what happens before the behavior?

Effective ways to respond including any redirection objects (i.e. communication board, comfort item, food/beverage):

☐ None

Anxiety

- ☐ Expresses worry or concern
- ☐ Avoids places/situations that make him/her nervous (e.g., meeting friends, going new places)
- ☐ Is restless during previously enjoyed, familiar activities
- ☐ Constantly restless, wants to keep moving – cannot sit or keep still
- ☐ Nervous and upset when separated from, (or clings to) caregiver
- ☐ Anxiety increases as the day progresses

When does anxiety occur (e.g. particular time of day or situation)?

Warning signs (what happens before the behavior?

Effective ways to respond including any redirection objects (i.e. communication board, comfort item, food/beverage):

☐ None

Agitation/Aggression

- ☐ Gets upset with caregivers
- ☐ Resists help from others
- ☐ Shouts or curses angrily
- ☐ Slams doors, kicks furniture, or throws things
- ☐ Tries to hurt or hit others or injure self
- ☐ Other aggressive behavior

☐ Agitation is present, but no aggression

When does behavior occur (e.g., particular time of day or situation)?

Warning signs (what happens before the behavior?

Effective ways to respond including any redirection objects (i.e. communication board, comfort item, food/beverage):

☐ None

Irritability/Emotional Ability

- ☐ Cranky, irritable or argumentative
- ☐ Rapidly changes moods from one to another; fine one minute and angry the next
- ☐ Impatient, has trouble coping with delays or waiting for planned activities

When do mood fluctuations occur (e.g., particular time of day or situation)?

Warning signs (what happens before the behavior?

Effective ways to respond including any redirection objects (i.e. communication board, comfort item, food/beverage):

- ☐ Mood is stable, no irritability present

Wandering

- ☐ Paces with no apparent purpose, but does not attempt to walk away
  Paces: ☐ day ☐ night
- ☐ Awakens at night thinking it is daytime, and wants to go out
- ☐ Other pacing/wandering behaviors:

When does wandering occur (e.g., particular time of day or situation)?

Warning signs (what happens before the behavior?

Effective ways to respond including any redirection objects (i.e. communication board, comfort item, food/beverage):

- ☐ None

Repetitive Behavior

- ☐ Repeatedly asks the same question
- ☐ Repeatedly changes clothing
- ☐ Rummages around, opening and unpacking drawers or closets
- ☐ Engages in repetitive activities such as handling buttons, rubbing face, wrapping string, etc.
- ☐ Other repetitious behaviors:

When does behavior occur (e.g., particular time of day or situation)?

Warning signs (what happens before the behavior?

Effective ways to respond including any redirection objects (i.e. communication board, comfort item, food/beverage):

- ☐ None

Disinhibition

- ☐ Acts impulsively without appearing to consider the consequences
- ☐ Removes clothing in public
- ☐ Makes crude remarks or sexual comments that he/she would not usually have said
- ☐ Takes liberties to hug or touch others
- ☐ Is sexually inappropriate:
- ☐ Shows any other signs of loss of control of his/her impulses:

When does behavior occur (e.g., particular time of day or situation)?

- ☐ None

Please describe any other behaviors that are of concern to you:	Additional Comments:

Other notes about me:

_____

_____

_____

_____

_____

I agree that the information in this packet "A Passport Into My Life" may be shared with the healthcare professionals involved with caring for my loved one.

Date completed: _____ By whom: _____

Relationship to resident: _____

Signature: _____

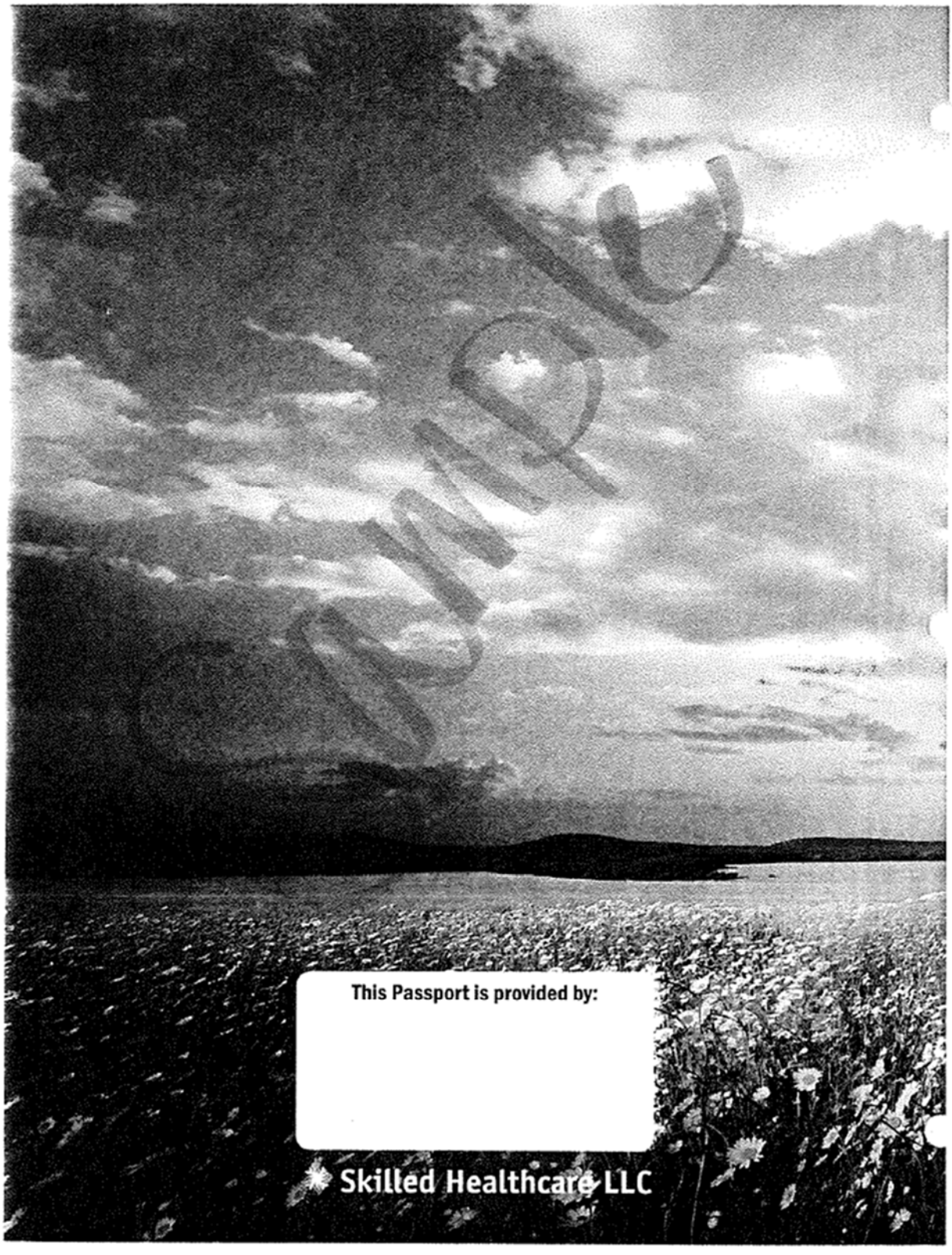
Optional: Resident Signature _____

Caregiver observations and/or updates:

Date: Description:

Caregiver observations and/or updates:

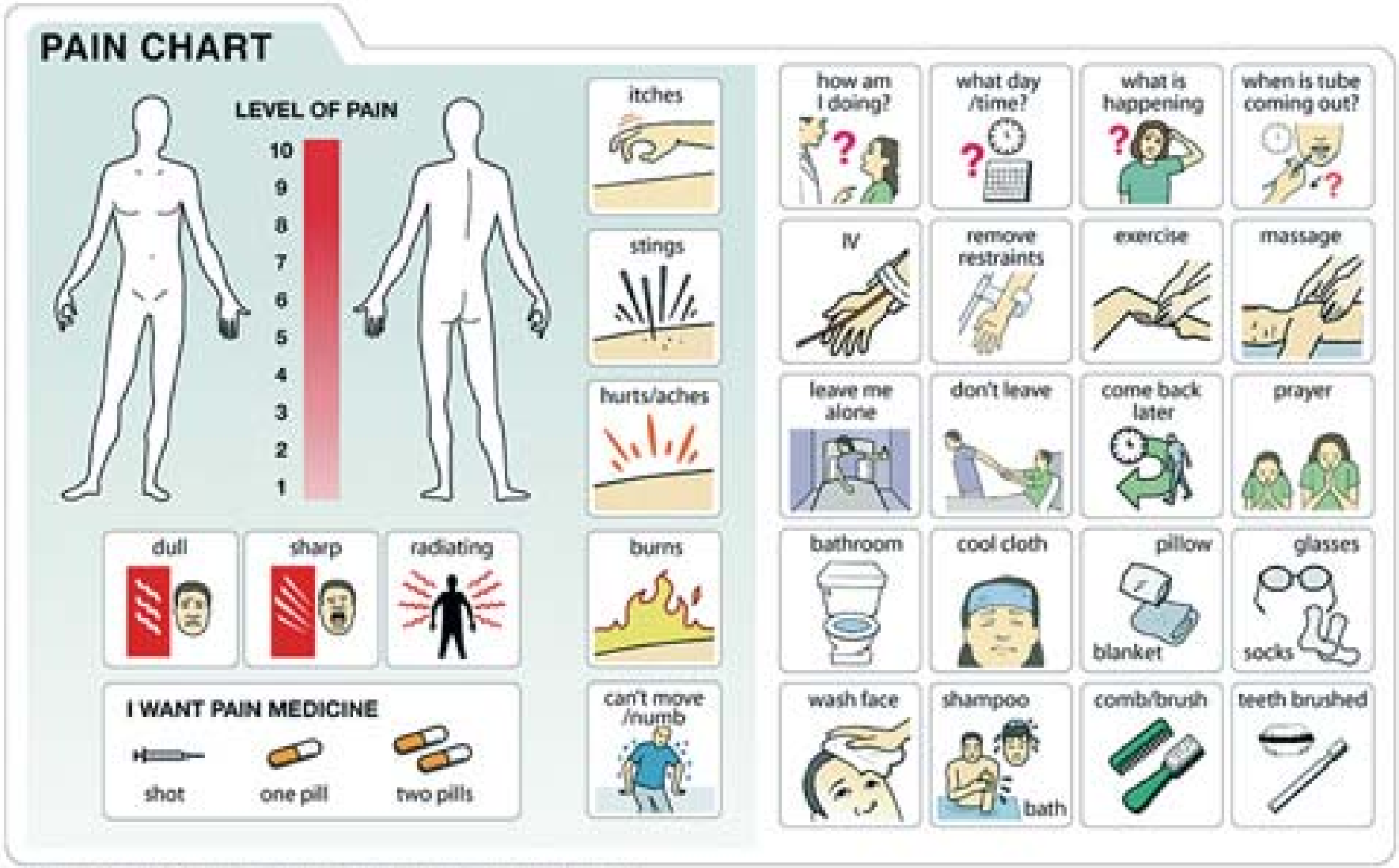
Date: Description:

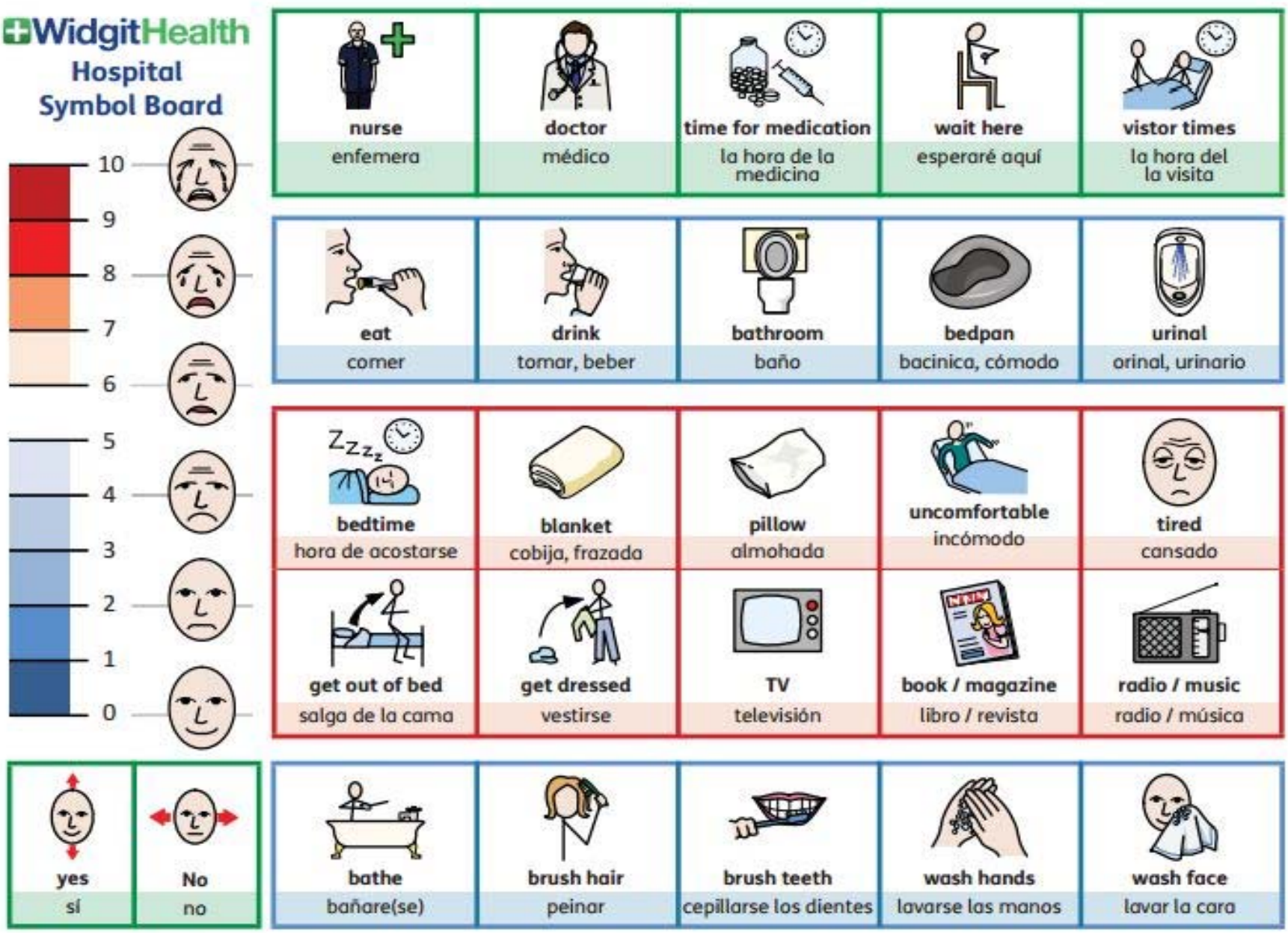

This Passport is provided by:
Skilled Healthcare LLC

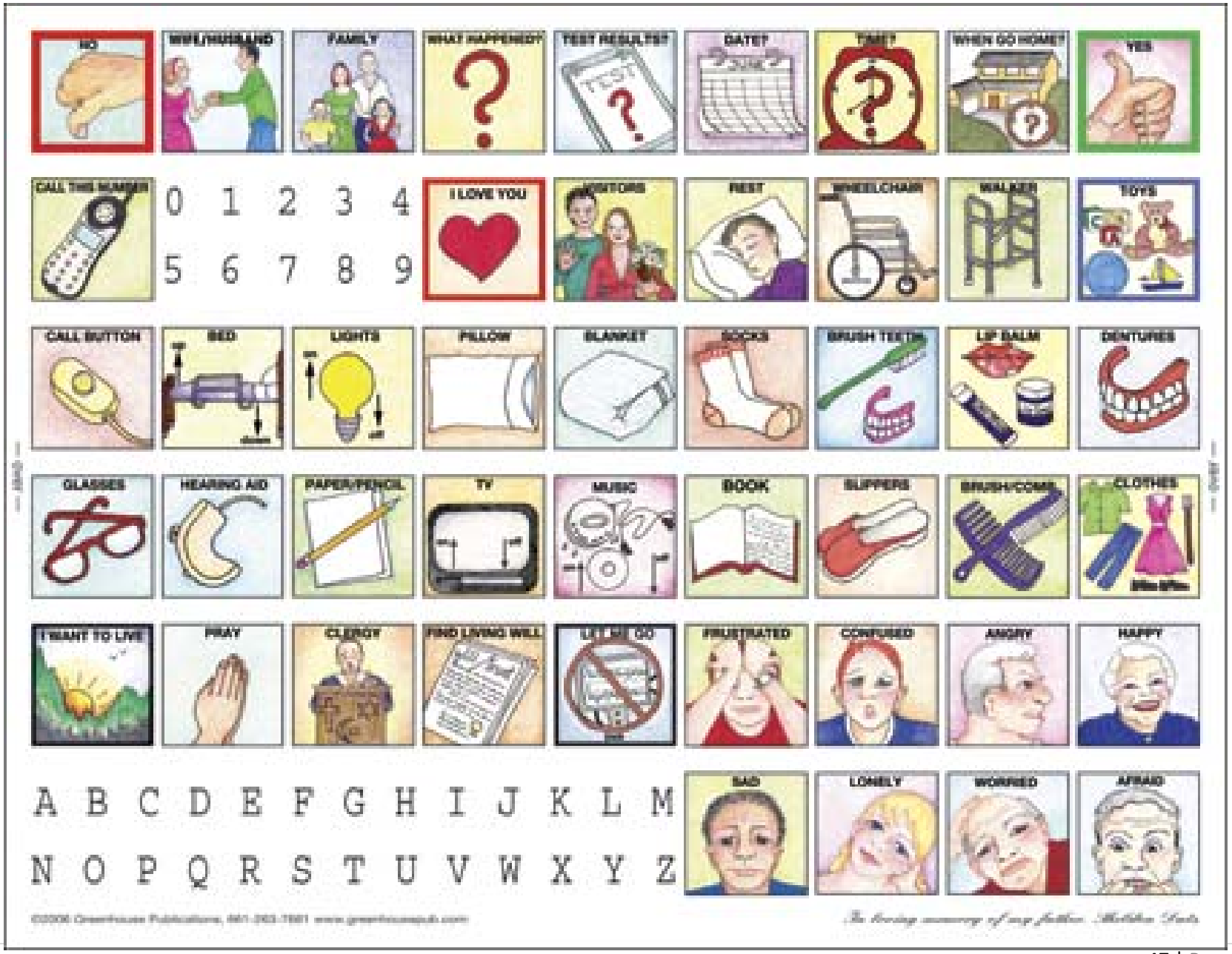
Appendix E

Alternate Communication Boards


I AM
short of breath
in pain
choking
feeling sick
hungry/thirsty
cold/hot
tired
dizzy
angry
afraid
frustrated
sad
I WANT
EZ PICTURE BOARD BY VIDATAK
AN INNOVATION IN PATIENT COMMUNICATION
to be suctioned
lip moistened
water
ice
to be comforted
to sleep
tv/video/dvd
call light /remote
it quiet
lights off/on
to go home
to sit up
to lie down
to turn left/ right
head of bed up/down
get out of bed
I WANT TO SEE
doctor
nurse
family
chaplain
no
yes
STOP
pen/ paper
A B C D E F G H I
J K L M N O P Q R
S T U V W X Y Z .
' , ? !
SPACE
1 2 3
4 5 6
7 8 9
+ 0 -
Thank You
I Love You
SINGLE PATIENT USE. Please do not re-use between patients.
VIDATAK
EZ BOARD




WidgitHealth
Hospital
Symbol Board
10
9
8
7
6
5
4
3
2
1
0
nurse
enfemera
doctor
médico
time for medication
la hora de la medicina
wait here
esperaré aquí
vistor times
la hora del la visita
eat
comer
drink
tomar, beber
bathroom
baño
bedpan
bacinica, cómodo
urinal
orinal, urinario
bedtime
hora de acostarse
blanket
cobija, frazada
pillow
almohada
uncomfortable
incómodo
tired
cansado
get out of bed
salga de la cama
get dressed
vestirse
TV
televisión
book / magazine
libro / revista
radio / music
radio / música
yes
sí
No
no
bathe
bañare(se)
brush hair
peinar
brush teeth
cepillarse los dientes
wash hands
lavarse las manos
wash face
lavar la cara


SO
WIFE/HUSBAND
FAMILY
WHAT HAPPENED?
TEST RESULTS?
DATE?
TIME?
WHEN GO HOME?
YES
CALL THIS NUMBER
0 1 2 3 4
5 6 7 8 9
I LOVE YOU
VISITORS
REST
WHEELCHAIR
WALKER
TOYS
CALL BUTTON
BED
LIGHTS
PILLOW
BLANKET
SOCKS
BRUSH TEETH
LIP BALM
DENTURES
GLASSES
HEARING AID
PAPER/PENCIL
TV
MUSIC
BOOK
SLIPPERS
BRUSH/COMB
CLOTHES
I WANT TO LIVE
PRAY
CLERGY
FIND LIVING WILL
LET ME GO
FRUSTRATED
CONFUSED
ANGRY
HAPPY
A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z
SAD
LONELY
WORRIED
AFRAID

YES	Nurse	Doctor	Carer	Walking Frame	Wheelchair	NO
Medicine	Pills	Bathroom	Bed	Toilet	Bath	Shower
Bedroom	Hot Drink	Cold Drink	Food	Help	I don't understand	Slippers
Light	Sit up/down	TV	Telephone	Newspaper	Walk	Teeth
Glasses	Clothes	Bag	Walking Stick	Shopping	Cold	Hot
Alone	Husband/Wife	Family	Garden	Noise	Hearing Aid	Watch
Hairdresser	Priest/Vicar	Worried	Pain	Bored	Tired	Angry