Evidence-Based Clinical Assessment Toolkit

Quick Guide for Cognition

PRAC
LEADERSHIP
PUBLIC SECTOR RESIDENTIAL AGED CARE

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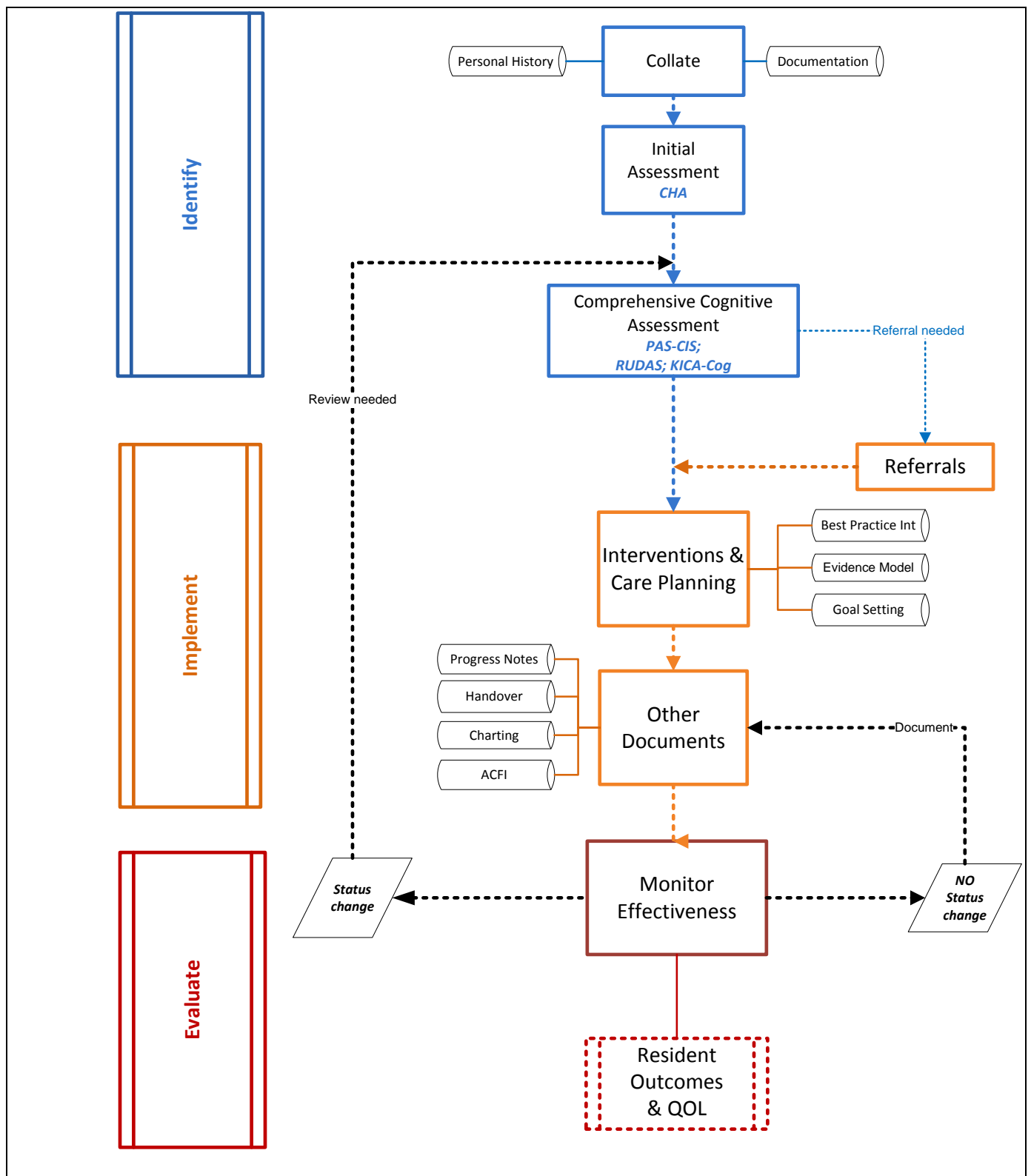
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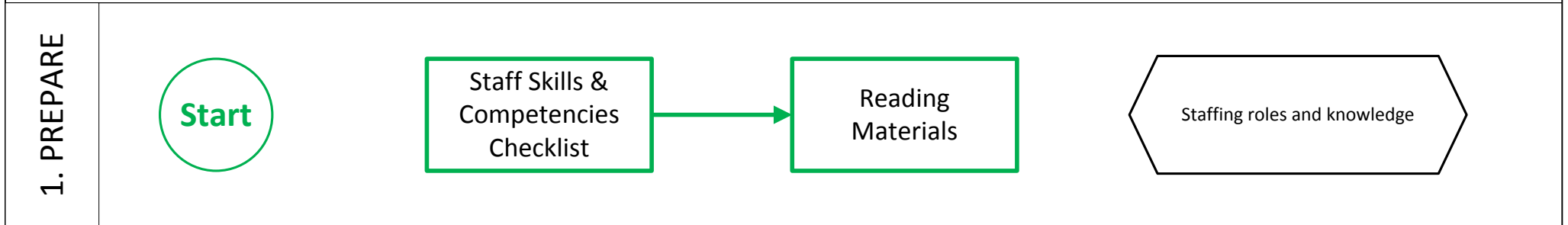
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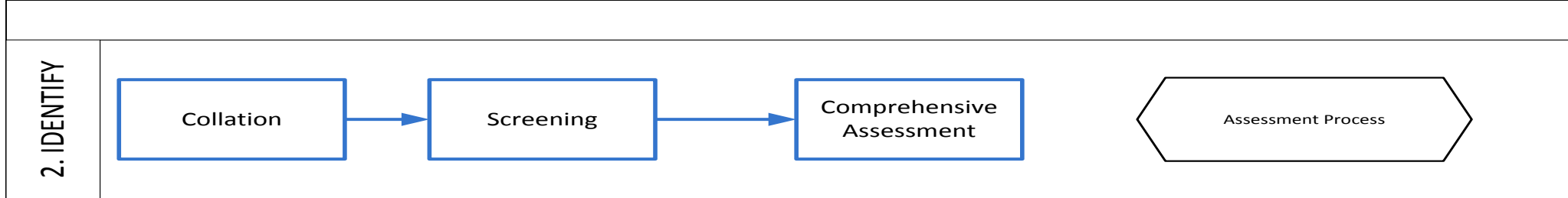
Cognition Summary: Steps and Information Flow

Identify

- Personal History → Collate ← Documentation
- Initial Assessment *CHA*
- Comprehensive Cognitive Assessment *PAS-CIS; RUDAS; KICA-Cog* — — — Referral needed
- Referrals

Implement

- Interventions & Care Planning
  - Best Practice Int
  - Evidence Model
  - Goal Setting
- Other Documents
  - Progress Notes
  - Handover
  - Charting
  - ACFI
- Document

Evaluate

- Review needed
- Status change
- Monitor Effectiveness
- NO Status change
- Resident Outcomes & QOL

QUICK GUIDE: Cognition

<table>
<tr><td rowspan="2">1. PREPARE</td><td>(Start)</td><td>Staff Skills & Competencies Checklist → Reading Materials</td><td>Staffing roles and knowledge</td></tr>
</table>

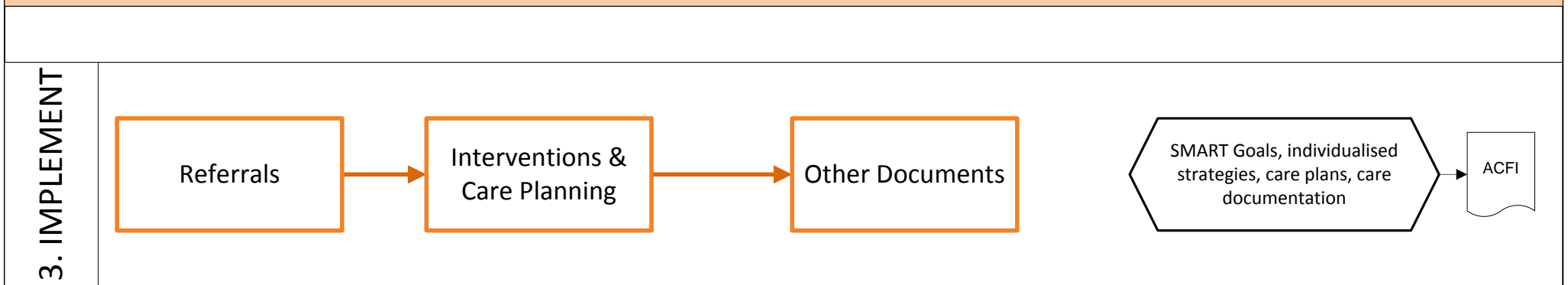| Step	Action	Outcomes
Staff Skills & Competencies Checklist	☐ Determine the skills or competencies required to complete each activity	Due diligence is applied to the process
	☐ Identify staff or staff type competent to complete each activity	Management have identified the staff that fit the required skill set to complete activities within the process. It assists to select staff and determine the roles of staff to ensure the process can be completed, and assists to identify training and education needs

Step	Action	Outcomes
Reading Material	☐ Reading materials or summaries from the recommended resources are provided for each topic	Introduces some basic information staff should understand about the topic. Discusses the interaction with other domains.

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2. IDENTIFY

Collation → Screening → Comprehensive Assessment   Assessment Process

Step	Action	Outcomes
Collation	☐ Gathering the history from the resident and family	Preferences (related to the care, social and environmental aspects), pleasant events, what has been tried, what works for the family. Involving the resident and family in their care underpins the principles of Person Centred Care.
	☐ Gathering diagnoses, clinical information, personal history from file note (ACCR, CMA, AHP)	Diagnoses and information associated to cognition- delirium or dementia or depression, or other neuro-cognitive disorders. Information about other domains that may interact e.g. sensory impairment, physical functioning, mobility, continence, medications etc

Step	Action	Outcomes
Screening/ Initial Assessment	☐ Comprehensive Health Assessment (CHA) items	CHA can inform on the screening process and parts of the comprehensive assessment (i.e. can inform on impact from other domains). Cognitive responses are not based on a validated assessment tool. CHA covers: subjective information (their perception of their memory etc), conscious state, orientation to time and place, abstract thinking, concentration, memory and judgement. The outcome is normal or impaired.

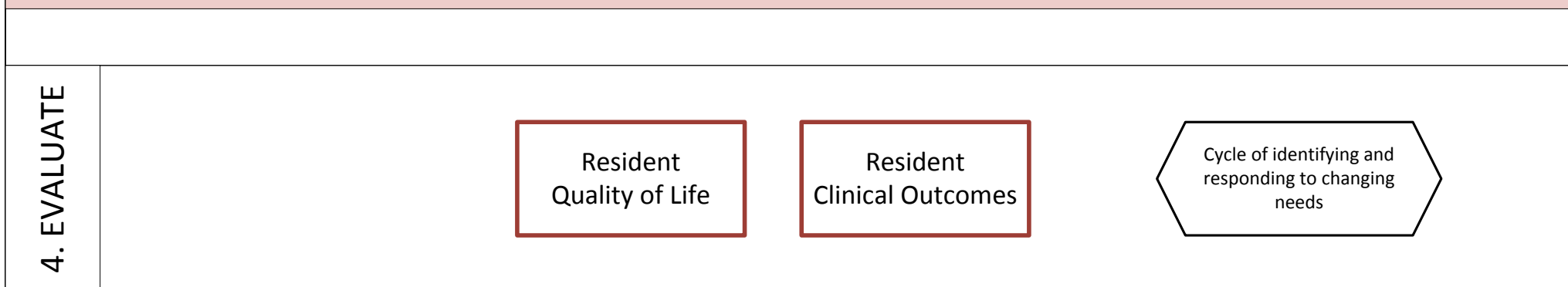| Step	Action	Outcomes
Comprehensive Assessment	☐ PAS- CIS	Interviewer administered, takes ~ 10-20 minutes. Nine questions covering language, memory and perceptual motor (praxis, gnosis, constructional). For English speaking resident who can be interviewed.
	☐ RUDAS	Interviewer administered, takes ~ 10minutes. Designed to enable the easy translation of the items into other languages and to be culture fair. Six questions covering language, memory, visuospatial, praxis, visuoconstructional, judgement.
	☐ KICA-Cog	Interviewer administered, takes ~ 10minutes. The only validated dementia assessment tool for older indigenous Australians. 18 questions
	☐ Clinical Risk management	Recognising and minimising system wide risk factors of Delirium
	☐ Clinical Reasoning	Includes the awareness of the impact of other impairments e.g. sensory, physical, medications

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3. IMPLEMENT

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┌─────────────┐     ┌─────────────┐     ┌─────────────┐          ⬡ SMART Goals, individualised        ⬦ ACFI
│  Referrals  │ ──▶ │Interventions│ ──▶ │   Other     │            strategies, care plans, care
│             │     │& Care       │     │  Documents  │            documentation
└─────────────┘     │Planning     │     └─────────────┘
                    └─────────────┘
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Step	Action	Outcomes
Referrals	☐ Management to complete Referral Tables	Completed Referral Tables based on a due diligence approach (see below)
	☐ Referral Process	Provide a protocol and process that provides a documentation trail for the referral process, is there -a referral request template; - an information pack prepared for the Health Professional you refer out to; - an outcomes template for the Health Professional to report the outcomes to you; - a current log of Health Professionals (and their expertise) to refer out to.
	☐ Medical Specialist e.g. Geriatrician	Specialist Medical Assessment and best practice interventions
	☐ MH Specialist e.g. Psychogeriatrician	Specialist Mental Health Assessment and best practice interventions
	☐ Cognitive assessment and support services e.g. CDAMS or DBMAS	Comprehensive assessment, staff support and best practice interventions

Step	Action	Outcomes
Interventions	☐ Dementia Care Principles	To provide a good quality of life for all residents requires a systematic approach
	☐ Medications	To possibly improve memory, mood, sleep or anxiety outcomes for the individual
	☐ Staff / family education	To improve knowledge, co-operation and understanding of interventions
	☐ Physical Environment	Domestic size, homelike, supports resident and staff safety and resident independence
	☐ Psychosocial environment	To improve the person's interaction with their social environment (e.g. community, staff, family and friendships)
	☐ Meaningful activities	To improve the quality of life of the resident

Step	Action	Outcomes
Goal Setting	☐ Specific	State exactly what it to be accomplished (Who, What, Where, Why)
	☐ Measurable	How will you demonstrate if the goals were met?
	☐ Action-oriented	What is the action to be completed?
	☐ Realistic / Relevant	Ensure the changes are feasible and affordable
	☐ Time-based	Date or elapsed time to complete the goal
	☐ Consumer focus	Consumer has participated in the process, and have listened to the resident view on their Quality of Life (enjoyment of life)

Step	Action	Outcomes
Care Planning	☐ Documentation	Recording care needs, strategies, goals and the evaluation of the goals and the care. Consumer participation in the process and feedback is to be sought.
	☐ Communication	Provides information about care needs in an accessible format. Congruent with other documentation.
	☐ Consumer focus	Consumer has participated in the process. Involving the resident and family in their care underpins the principles of Person Centred Care (PCC).

Step	Action	Outcomes
Linking the Evidence	☐ Diagnosis and symptoms	Accurate diagnosis is crucial for understanding the cognitive impairment and possible interventions
	☐ Impact on body structure/function	Link a diagnosis to a body structure/function e.g. frontal lobe impairment
	☐ Activity Limitation	Link the body structure/function impact to the activity that is impacted e.g. may be socially inappropriate, lacks insight into actions
	☐ Strategies (actions) to improve enjoyment of life and participation	Document how the interventions address the activity limitation e.g. supervision required in group activities

Step	Action	Outcomes
Other documents	☐ Progress Notes	Document new observations, assessments, strategies, and changes made to the care plan. Care plan, progress notes and assessments to be congruent with each other. Provide clear and consistent communication to staff and other Health Professionals.
	☐ Handover Notes	Use Handover notes to update Progress Notes and Care Plan.
	☐ Charting	Update Charting information
	☐ Complete the ACFI	Use the assessment outcomes and the evidence links to determine and support the claims.

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<table>
<tr><td rowspan="3" style="writing-mode: vertical-lr">4. EVALUATE</td><td></td></tr>
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Resident Quality of Life	Resident Clinical Outcomes	Cycle of identifying and responding to changing needs

Step	Action	Outcomes
Quality of Life Outcomes	☐ Repeat Quality of Life questionnaire (if suitable)	Objectively evaluate Quality of Life goals as relevant to the topic Learning about the resident view of their life. Involving the resident in their care underpins the principles of Person Centred Care (PCC).
	☐ Seek feedback from the resident and/or family	Involving the resident and family/friend in their care underpins the principles of Person Centred Care (PCC).
	☐ Seek staff feedback	Identify any incongruence between staff and consumer views; this may identify education opportunities for staff and/or family.

Resident Care Outcomes	☐ Evaluate Care Goals	Objectively evaluate care goals as relevant to the topic.
	☐ Monitor Incident Forms	Update risk assessments and strategies
	☐ Monitor Standardised Care Processes	Monitor system level clinical issues
	☐ Monitor Resident File documents	Ensuring the Resident File documentation is current and congruent. Ensuring the communication to care staff and other Health Professionals is congruent. This would include Progress Notes (by nursing/ AHP/Medical Practitioners etc), new assessments and Care Plans.