Evidence-Based Clinical Assessment Toolkit

Cognition Workbook

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Acknowledgements

Barwon Health was funded by the Department of Health Victoria to develop an evidence based Aged Care Funding Instrument (ACFI) toolkit and associated process guidelines for public sector residential aged care services (PSRACS). Barwon Health engaged Applied Aged Care Solutions (AACS), developers of the original ACFI to conduct the project and develop the toolkit. AACS has extensive experience in designing assessment models and evidence-based tools for residential aged care.

Additional content matter expertise was provided to assist with the development of the materials. Applied Aged Care Solutions (AACS) worked with:

La Trobe University

Dr Deirdre Fetherstonhaugh (Director, Senior Research Fellow), Dr Michael Bauer (Senior Research Fellow) and Dr. Margaret Winbolt (Senior Research Fellow, Director Victoria and Tasmania Dementia Training Study Centre) from the Australian Centre for Evidence Based Aged Care (ACEBAC), Australian Institute for Primary Care and Ageing (AIPCA), La Trobe University provided feedback on the EBCAT framework and the process content of the workbooks (ADL, Continence, Medicines and Complex Health Workbooks).

Monash University

Professor Daniel O'Connor (Professor of Old Age Psychiatry, Faculty of Medicine, Nursing & Health Sciences, and Head of the Aged Mental Health Research Unit Monash University) provided feedback on the framework and the process content of the Cognitive and Behavioural Expressions Workbooks.

PRACS Leadership Group

AACS acknowledges the comments of the PSRACS Nurse Leadership Group and feedback and comment provided at the workshops for PSRACS staff hosted by the Department of Health Victoria.

Other Contributors

Professor Rhonda Nay who reviewed the Complex Health Workbook.

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Acronyms and Glossary

ACCR	Aged Care Client Record
ACFI	Aged Care Funding Instrument
ADL	Activities of Daily Living
BAF	Behavioural Assessment Form
BCOPE	Best Care For Older People Everywhere
BPSD	Behavioural and Psychological Symptoms of Dementia
CAM	Confusion Assessment Method
CCF	Care Continuum Framework
CDAMS	Cognitive, Dementia and Memory Service
CDC	Consumer Directed Care
CHA	Comprehensive Health Assessment (CHA) for Older People in the Health Care System
CHAOP	Comprehensive Health Assessment of the Older Person
DBMAS	Dementia Behaviour Management Advisory Service
DOMS	Dementia Outcomes Measurement Suite
EBCAT	Evidence Based Clinical Assessment Toolkit
EBCAT Assessment Packs	Each workbook has an assessment pack. This contains the recommended screens, assessments and Standardised Care Processes recommended within the workbook.
EBCAT Introductory Guide	This document presents: Project methodology; Overview of products; and details of the Management role;
EBCAT Reading Pack	This document provides the background reading for all EBCAT Workbooks.
EBCAT Topics	1. Nutrition; 2. Mobility; 3. Self-care (Personal Hygiene, Toileting) 4. Continence 5. Cognition 6. Behavioural Expressions (Wandering, Verbal & Physical, Mood) 7. Medicines 8. Pain; 9. Swallowing; 10. Skin & Wounds
EBCAT Workbooks	The toolkit is presented in six 'user friendly educational Workbooks' to walk the user through the process of using evidence-based clinical assessment tools for each domain of: • ADL Workbook (Topics 1-3) • Continence Workbook (Topic 4) • Cognition Workbook (Topic 5) • Behavioural Expressions Workbook (Topic 6)

	• Medicine Workbook (Topic 7) • Complex Health Workbook (Topics 8-10)
FRAT	Falls Risk Assessment Tool
GP	General Practitioner
IPA	International Psychogeriatric Association
KICA-Cog	Kimberley Indigenous Cognitive Assessment
MP	Medical Practitioner
M-VRBPI	Modified Resident Verbal Brief Pain Inventory
NATFRAME	National Framework for Documenting Care in Residential Aged Care Services http://webarchive.nla.gov.au/gov/20140803082152/http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-rescare-natframe.htm~ageing-rescare-natframe01.htm
NCD	Neuro-Cognitive Disorder
NPI-NH	Neuro-Psychiatric Inventory for Nursing Homes
NRS	Numeric Pain Rating Scale
PAINAID	Pain Assessment in Advanced Dementia
PAS-CIS	Psychogeriatric Assessment Scales- Cognitive Impairment Scale
PCC	Person Centred Care
PMS	Physical Mobility Scale
PSRACS	Public Sector Residential Aged Care Services
QoC	Quality of Care
QoL	Quality of Life
RACF	Residential Aged Care Facilities
RNDC	Resident Nutrition Data Card
ROM	Range Of Movement
RUDAS	Rowland Universal Dementia Assessment Scale
SCP	Standardised Care Process
SCORE	Strengthening Care Outcomes for Residents with Evidence
VDS	Verbal Descriptor Scale

Overview of the Toolkit Products

The Evidence-Based Clinical Assessment Toolkit (EBCAT) consists of the following products:

Resource	How used
Introductory Guide	The Introductory Guide is aimed at the lead nurse and the nursing management. It presents: the project methodology; an introduction to the products; and details on the Nursing Management role.
Reading Pack	The Reading Pack, provides further reference information for the background reading section of each workbook, it is aimed at care staff. This pack contains reading material which cannot be sourced from the internet. References for supporting material that can be sourced off the internet are provided in workbook appendices. There is also a sample Quality of Life questionnaire in the Reading Pack.
Workbooks	The EBCAT Workbooks are designed to be used by the lead nurse. The workbooks should be used as a training tool by the lead nurse when training the care staff on the EBCAT. There are six workbooks which cover the domains of: • Activities of Daily Living • Continence • Cognition • Behavioural Expressions • Medicine • Complex Health Each workbook contains detailed information and case studies on how to complete the recommended assessment tools as part of a nursing-based process. The Appendices provide references for the suggested resources, and a workbook exercise to practice what has been learnt.
Quick Guides	The Quick Guides are designed for use by care staff. There is one quick guide per workbook. The Quick Guide is a quick reference to the EBCAT process and tools. It is recommended it be kept handy for use on the 'floor', whenever required.
Assessment Packs	The assessment packs contains the recommended screen, assessment tools and relevant clinical risk tools. There is one assessment pack per workbook. The tools are used by the care staff when identifying the needs of the residents.

Suggested Roles for Staff Implementing the Toolkit

The toolkit requires the participation of three types of staff.

	Who and what they do in regard to the Toolkit
Nursing Management	This group would typically consist of nursing staff who do not work 'on the floor', for example the Director of Nursing or Nurse Unit Manager. They are vital to ensuring, that the toolkit is set up properly to support implementation at the site, to ensure that the process is continuously monitored and improved, and to monitor the process to ensure the documentation and ACFI claiming is accurate. The nursing management role includes: o Preparing the toolkit and auditing for readiness to implement o Selecting a lead nurse for the leadership role and to train the care staff o Implementing the toolkit and monitoring the progress The nursing management role is described in detail in the Introductory Guide.
Lead Nurse	This person will be selected by the Nursing Management group to lead the EBCAT process at the site. It is recommended they be a nurse (RN or EN). The lead nurse role includes: o Assisting the Nursing Management group to prepare the toolkit o Training the care staff on how to implement the EBCAT process and tools o Providing leadership to the care staff during the implementation of the process o Assisting the Nursing Management group to monitor the progress The lead nurse role is described in detail in the Introductory Guide.
Care Staff	This group are the nurses (RN or EN) and Personal Care Workers who deliver the daily care to the residents 'on the floor'. They receive the training and implement the EBCAT process and tools when undertaking the resident assessment process.

Introduction to the Cognition Workbook

The Cognition Workbook is one of six that form the Evidence Based Clinical Assessment Toolkit (EBCAT). This workbook is one of four resources relevant to the Cognition Topic which comprise:

- A Reading Pack
- Cognition Workbook
- Cognition Quick Guide
- Cognition Assessment Pack

The toolkit aims to provide a resource to assist Public Sector Residential Aged Care Services (PSCRACS) staff to systematically and consistently determine and manage resident care needs. . The toolkit uses evidence-based clinical assessment tools for assessing and managing residents with the goals of improving the clinical and quality of life for the residents and demonstrating accountability to government regulators for example, with the Aged Care Funding Instrument (ACFI) requirements.

During 2013, the Australian Government made changes to the Aged Care Funding Instrument (ACFI) requiring further evidence to support funding claims made by services in some domains (e.g. activities of daily living). In addition, the Australian government introduced more stringent penalties for providers with inaccurate or misleading ACFI appraisals from 1 July 2013.

While the ACFI assessment pack determines the mandatory assessment for the cognitive domain, this workbook looks beyond ACFI and has recommended further assessment options for cognition. The Cognition Workbook will assist a service to meet the ACFI evidence requirements using familiar and freely available Australian toolkits and resources including:

- ACFI User Guide
- An Initial Nurse Assessment, e.g. Comprehensive Health Assessment (CHA) for Older People in the Health Care System which was designed for recording assessment results based on the Comprehensive Health Assessment of the Older Person (CHAOP) resource
- Standardised Care Processes (SCP) developed as part of the Strengthening Care Outcomes for Residents with Evidence (SCORE) project
- The NATFRAME (National Framework for Documenting Care in Residential Aged Care Services)
- Best Care for Older People Everywhere (BCOPE). The toolkit.

Topic 5: Cognition

The Cognition Topic

This topic focuses on cognition. Cognition is the set of all mental abilities and processes related to knowledge, attention, memory, judgement, reasoning, decision making, comprehension and language.

Cognitive deficits will impair a person`s ability to function independently in performing everyday living activities, remembering things that have just happened, having insight into how others are feeling and will impact on how they interpret and respond to the environment and the people they are living with. This workbook aims to help you implement strategies that result in the best quality care outcomes for your residents with cognitive impairments.

Investigating Cognition

This topic focuses on the investigation of cognition issues and follows the same four process steps used across all the workbooks. The steps are:

1. **Preparation of staff** – ensuring that staff have the required qualifications or competencies and have completed background reading if required. The background reading includes:
    - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012)
    - PAS-CIS User Guide

The references for these resources can be found in the Continence Appendix.

2. **Identifying** – gathering the resident's history by collating documents and talking with residents and their family, looking for signs and symptoms in the initial nurse assessment, completing a comprehensive assessment approach and assessing the scope of the challenge. It is recommended that all new residents have a comprehensive assessment of cognition. A comprehensive approach will include:

    File Notes Review:

    - Aged Care Client Record (ACCR) – Parts 4 and 5 which includes diagnoses, assessment summaries and notes on cognition
    - Comprehensive Medical Assessment – which (if available) may have, for example, relevant diagnoses and cognition status

Screen:

- Initial nurse assessment e.g. the CHA is an initial nurse assessment based on the 'Comprehensive Health Assessment of Older Person' resource), which records information about the resident's cognition status

The reference for the CHA can be found in the Cognition Appendix and a copy is found in the Cognition Assessment Pack.

Further Assessment:

The following assessment tools and Standardised Care Processes (found in the Cognition Assessment Pack) are recommended for assessing cognition and identifying the person's care needs. It is recommended that all new residents have cognition assessed. The three recommended cognitive assessments for resident's who are suitable to be interviewed are:

- Psychogeriatric Assessment Scales- Cognitive Impairment Scale (PAS-CIS) for residents that speak English.
- Kimberley Indigenous Cognitive Assessment (KICA-Cog) for indigenous residents.
- Rowland Universal Dementia Assessment Scale (RUDAS) for residents from diverse cultural learning and language backgrounds

The SCORE Standardised Care Process for Delirium is also recommended for recognising and minimising the clinical risks of delirium.

The references for these assessment resources can be found in the Cognition Appendix and a copy of the tools are found in the Cognition Assessment Pack.

3. **Implementing** – based on the information from the identification phase this covers making needed referrals, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:

- Undertaking referral options to complete gaps or seek specialist advice
- Planning evidence-based care strategies to assist the person to maintain or possibly improve their participation ability
- Listening to and setting goals with the consumer (resident and family) to hear their understanding and personalise the approach
- Understanding the role of communicating the care needs, goals and strategies through care plans and resident file notes to provide the documentation trail
- Completing ACFI documentation

4. Evaluating – monitoring and evaluating the effectiveness of the process, interventions and looking for ways to further improve the care outcomes for residents.

The overall cognition process and associated activities is illustrated in Figure 1 which shows the phases (e.g. prepare, identify, implement, evaluate), the steps within each phase and the aim for each phase (e.g. have identified the care needs of the resident). Each topic of the Cognition Workbook follows the same pattern. Consistent application of this process will assist your home provide systematic, accountable care and facilitate the best possible resident care outcomes.

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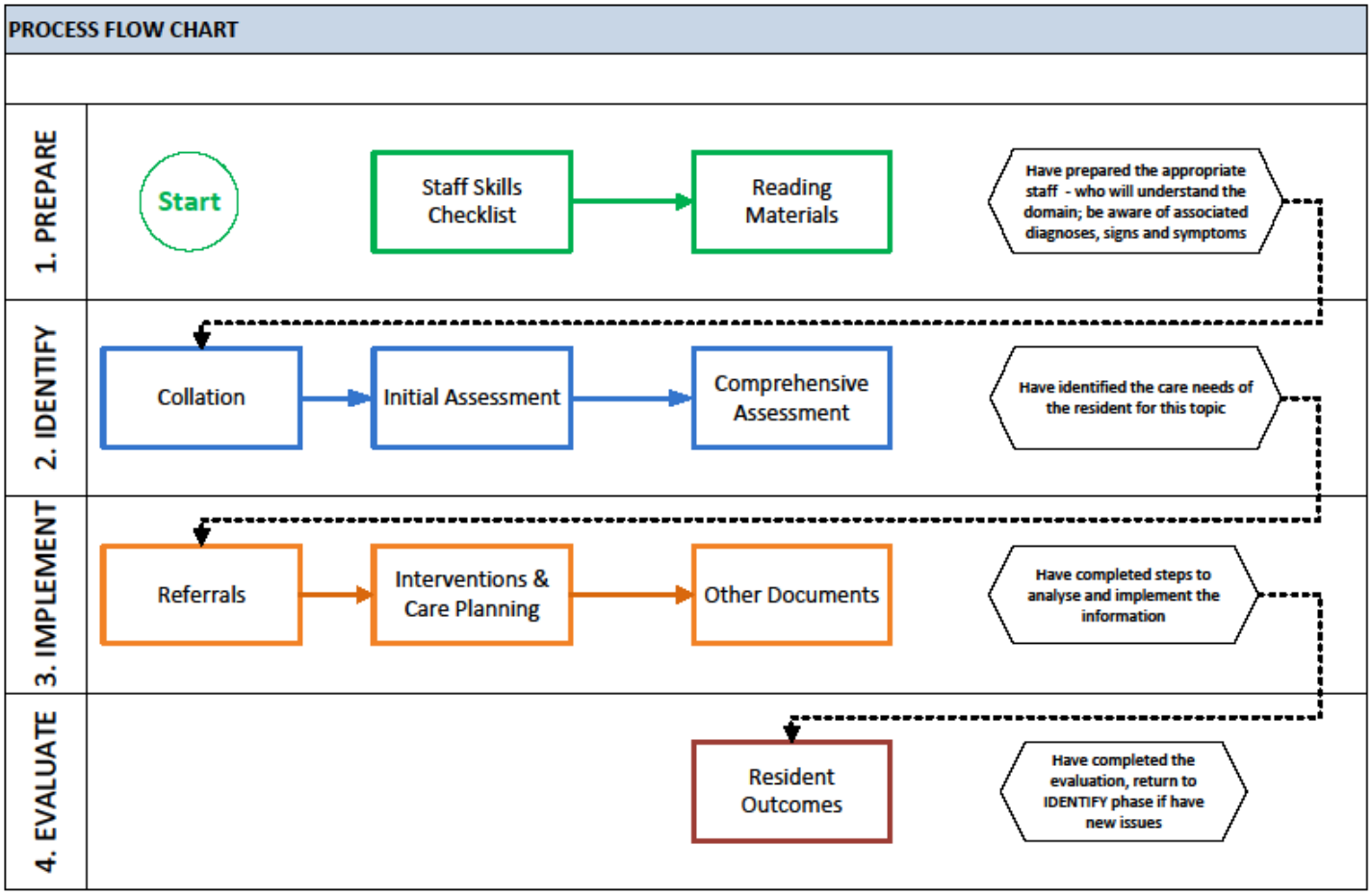
Figure 1: Cognition Process



Getting Started with a Cognition Example

This case study will be referred to as we discuss the cognition topic.

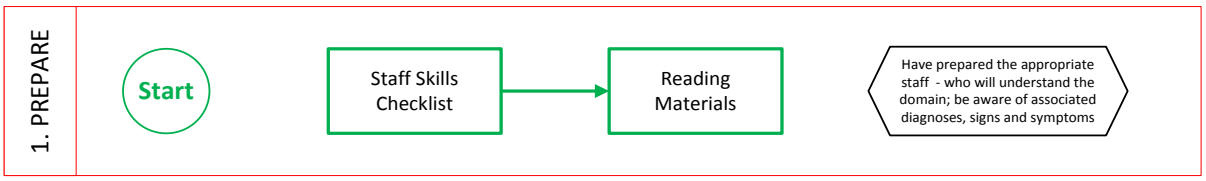
Mary is an 85-year old woman who was a school teacher until she retired at 65 years of age. She never married, but she is very close to her niece Debbie. She had been living at home alone with the support of local community services, and her friend and neighbor (June) and her niece. She received home help and meals on wheels, and June visited most days while Debbie helped her manage her financial issues.

Mary has been an insulin-dependent diabetic since 65 years of age and she managed it safely. Her GP had noticed a slow deterioration over time in her memory, but at one visit Mary was looking unkempt and very confused. Her insulin levels were low and the GP called an ambulance. In hospital she was she was diagnosed with dementia and was assessed by the Aged Care Assessment Service. It was determined that she was not taking the correct insulin doses, her diet was not adequate, and she could not safely live alone at home. She required supervision with her ADLs and medicines.

One year ago she came to live at Sunset Home, with her diet and diabetes now under control, she has had no other major medical issues. With staff supervision, she has been able to participate in her personal hygiene and self-care needs. She does not initiate conversations but is able to respond to simple questions with short responses.

In the last month, however, Mary has stopped communicating verbally, and she now requires physical assistance with some nutrition and self care tasks. Staff have noticed that she seems to be deteriorating quite noticeably.

Preparation



There are two specific aspects to **preparing** staff for the management of resident cognition care needs. They are:

1) Ensuring that staff have the required qualifications or competencies; and

2) Completing the pre-reading if required

Recommended Staffing Skill Set

Table 1 below provides a structure for management to identify which staff have the skills required to complete activities within the cognition process. The process includes:

- Identifying the required activities (examples provided in Table 1)
- Assessing staff competency to complete the activities
- Addressing identified gaps

This will assist nursing management to select and determine the roles of staff to ensure the process can be completed effectively. For example, if there is a gap found in the cognitive assessment and management activity, the facility could consider further training of current staff, or securing a nurse with the required clinical knowledge, or identifying a local Allied Health Professional (i.e. Psychologist) who could complete the assessment.

The introductory guide also provides further instructions for nursing management in preparation for implementing this toolkit.

Table 1: Staff Activities for the Cognition Process

Activity	Responsible for sign off	Does the activity
Gathering Documents		
Identifying Needs from documents		
Screening /Initial Nurse Assessment		
Assessment: PAS-CIS		
Assessment: KICA-Cog		

Activity	Responsible for sign off	Does the activity
Assessment: RUDAS		
Documenting into file notes		
Determine and action Referrals		
Develop Interventions and Strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Evaluate Resident Care outcomes		

Background Reading

Staff should complete the background reading or be able to demonstrate that they have adequate experience and knowledge of cognition issues in older people. It is expected that staff will have:

- A comprehensive understanding of the domain and how it is impacted by other health areas
- An awareness of associated diagnoses, signs and symptoms of cognitive impairment and dementia
- Knowledge about and training on how to use the assessment tools
- Knowledge about evidence informed practices associated with cognition - to assist with the development and implementation of evidence-based care plans

The background reading relevant to the cognition topic is:

- Best Care for Older People Everywhere (BCOPE). The Toolkit (2012) pp. 127-158. The content is summarised in the following sections. Please note that the BCOPE was primarily written for hospital settings with intended transferability to a range of other care settings. The language and terminology used may not always suit residential aged care.
- PAS-CIS User Guide. This provides information from the original source on how to administer the PAS-CSI.

The references for these resources are found in the Cognition Appendix.

Some Basics

It is important to understand why we assess cognition - what is cognition, why it is important, and how it affects resident care needs.

Cognition is the set of all mental abilities and processes related to knowledge, attention, memory, judgement, reasoning, decision making, comprehension and language. Cognitive deficits will impair a person`s ability to function independently in performing everyday living activities, remember things that have just happened, have insight into how others are feeling and it will impact on how they interpret and respond to the environment and the people they are living with (Diagnostic and Statistical Manual of Mental Disorders 5th Edition, 2013).

For example:

- A person with attention symptoms may have difficulties in an environment with multiple stimuli (TV, radio, conversation), difficulty maintaining attention to an activity, with learning information or may just take longer to process information
- Decision making deficits affect the ability to be able to plan or multitask. Judgement deficits impact on the ability to follow rules
- Learning and memory deficits impact on ability to recall information or events, difficulty following a conversation, and often requires frequent reminders
- Language deficits may impact on the person's expressive language (use of words) and/or to understand what is being said to them. It also often results in the use of non specific phrases like 'that thing'
- Inability to carry out once familiar tasks (e.g. use a tool) or movements (e.g. how to use pen)
- There are also social impacts when a person cannot recognise others' emotions, or acts outside of acceptable social ranges

Cognitive disorders are also known as neuro-cognitive disorders, which include dementia, delirium, amnesia and other disorders (Diagnostic and Statistical Manual of Mental Disorders 5th Edition, 2013).

BCOPE (p. 127- 128) discusses the importance of understanding the difference between the 3 D's- delirium, depression and dementia. They share some cognitive symptoms, however they are different diagnoses and they have different management strategies. An early and

accurate diagnosis is crucial because impaired cognition is not a normal part of ageing, and the symptoms need to be managed appropriately. Delirium should always be investigated if there is an abrupt change in the mental state of a person with dementia.

People with dementia are vulnerable to both delirium and depression. For example, a person who is relatively newly diagnosed with dementia may have enough awareness of its devastating effects to be depressed. A person with dementia can forget how to adequately maintain daily activities such as remembering to drink enough fluids, and this can lead to an infection (e.g., urinary tract infection), which can develop into a delirium episode.

BCOPE (p.127) highlights the following differences between the 3 D's:

- "Delirium is an acute organic disturbance of higher cerebral function associated with an impaired ability to attend to the environment.
- Dementia is a general term used to describe a form of cognitive impairment that is chronic, generally progressive and occurs over a period of months to years.
- Depression is a multifaceted syndrome, comprising a constellation of affective, cognitive, somatic and physiological manifestations in varying degrees from mild to severe."

Table 2 presents a further detailed comparison of delirium, dementia and depression (BCOPE, p.128) features.

Understanding the type and level of cognitive impairment helps in understanding what assistance the person needs. The impact of a cognitive impairment on an individual's way of life can vary greatly, from (i) those persons needing only temporary support (e.g. due to delirium) to (ii) minor or occasional support (e.g. assisting them to find their way with verbal supervising, setting up an activity which the person can then complete themselves) to (iii) those who require full physical assistance with all ADL tasks because they can no longer either physically do them due to severe cognitive impairment or they cannot remember how to participate in common daily activities.

While there is limited medical intervention for dementia, we can maintain a high quality of life in people with these conditions through our management strategies.

Table 2: Comparison of features between Dementia, Delirium and Depression

Feature	Dementia	Delirium	Depression
Onset	Slow and insidious – deterioration over months or years	Sudden – over hours or days	Often abrupt – may coincide with life changes
Course	Symptoms are progressive over a long period of time; not reversible	• Short and fluctuating – often worse at night and on waking • Usually reversible with treatment of the underlying condition	Typically worse in the morning. Usually reversible with treatment
Duration	Months to years	Hours to less than one month – not often longer	At least two weeks – can last for months or years
Psychomotor activity	• Wandering/exit seeking or • Agitated or • Withdrawn (may be related to coexisting depression)	• Hyperactive delirium: agitation, restlessness, hallucinations • Hypoactive delirium: sleepy, slow-moving	• Usually withdrawn • Apathy
Alertness	Generally normal	Fluctuates – may be hyper-vigilant through to very lethargic	Normal
Attention	Generally normal	Impaired – difficulty following conversation, fluctuates	Normal
Mood	Depression may be present in early dementia	Fluctuating emotions – for example: anger, tearful outbursts, fear	• Depressed mood • Lack of interest in usual activities • Change in appetite (increase or decrease)
Thinking	Difficulty with word-finding and abstraction	Disorganised, distorted, fragmented	Intact – themes of helplessness and hopelessness present
Perception	Misperceptions usually absent (can be present in Lewy body dementia)	Distorted – illusions, hallucinations, delusions; difficulty distinguishing between reality and misperceptions	Usually intact (hallucinations and delusions only present in severe cases)

How Cognition Interacts with Other Domains

As noted in the introduction, cognition is important in almost all aspects of a person's daily living, affecting both their psychological well-being and functional ability. Here are a few examples of how cognition interacts with other domains:

ADLs

Cognitive impairment can impact on the person's ability to perform or participate in all activities of daily living such as walking, dressing, bathing and maintaining personal hygiene.

Nutrition

The more complex cognitive skills associated to shopping and cooking are usually lost before eating and drinking skills. In residential care a person's access to good nutrition may improve, but eventually they may forget how to use utensils and need increasing assistance.

Continence

Continence issues arise as a person has difficulty with locating the bathroom and communicating the need for toileting. Eventually, they may lose the memory related to the procedure of toileting, and in severe dementia, may be completely incontinent.

Medication

The side effects and interactions of various medications can impact on cognition. Cognitive impairment will impact on the person's ability to safely self manage medicines (e.g. remembering to take medicines, understanding the purpose of medicines etc), and in the case of a person with severe dementia, they will be fully dependent on staff assistance with medications.

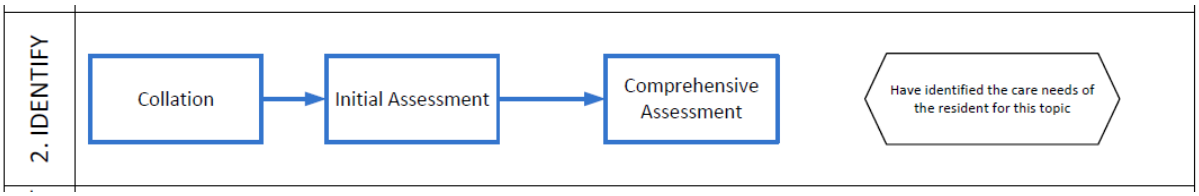
Complex Health Care

In severe dementia the person may become immobile, increasing the risk of skin integrity issues developing. As dementia advances, and the person's communication skills reduce, staff need to be alert to facial and body language that indicates pain is present.

Communication and Behaviour

A person's ability to verbally express themself diminishes with advancing dementia, and behavioural expressions may indicate a need. For example, wandering, pacing, agitation and aggression can all be signs of discomfort. As is illustrated as Mary's story unfolds, returning her to a state of comfort can greatly improve her wellbeing and also for those caring for her.

Identification Process



The steps in the process of **identifying** care needs are:

- Gathering the history from current documentation and information from carers, family and consumer if possible
- Screening to identify a need (e.g. initial nurse assessment); and
- Completing a comprehensive assessment of the cognition needs

Gathering the History

What documents (before you start assessing) do you have which provide information on the resident you are focusing on? You will be able to build a picture of the person's relevant history through current documentation (i.e. ACCR, medical notes) and their personal history through discussions with their family members and carers.

Documentation

The current documentation should be reviewed, checking for relevant diagnoses, information on signs and symptoms and previous assessments. Below is an example of the types of documents to be collated and reviewed and the information that is being sought for cognition.

Document	Looking for
ACCR	Mental and Behavioural Diagnoses (Q28), cognitive behaviour/psychological aspects, comments and care strategies in part 5
Medical Notes/CMA	Mental and Behavioural Diagnoses, cognitive status, needs, aids and assistance
Clinical Report on Cognition	Mental and Behavioural Diagnoses, cognitive status, cognitive behaviour/psychological aspects, comments and care strategies
AHP notes/assessment	Mental and Behavioural Diagnoses, notes on how cognitive status impacts on other areas

Here are a few examples of how the collated diagnoses and issues may be indicators of the person's care needs:

Diagnoses/impairments/strengths	Impact
Diagnosis or evidence of cognitive impairment	Because the cognitive signs and symptoms can lead to different diagnoses, an accurate diagnosis is essential for developing appropriate strategies and interventions.
Specific types of cognitive impairment	Different types of cognitive impairment will be managed differently e.g. dementia, delirium, depression. Dementia will progressively get worse, strategies need to manage the increasing dependency of the person and try to maintain their participation. Medication may help with some symptoms in the early stages. Delirium can be reversed; interventions will focus on the medical treatment. Depression can be treated with both medication and non-pharmacological interventions (e.g. experiencing pleasant events, sleeping disorder strategies)
How the level of cognitive impairment impacts on care needs	Minimal impairment- most likely will have no significant problems with daily activities, minor memory loss, will have some issues with instrumental activities (e.g. handling money or solving problems). Mild impairment- starting to have some impact on personal care. Possibly disorientated in unfamiliar places, dependent on others for undertaking instrumental activities. May need minor or occasional support with ADLs e.g. more likely to need prompting not a lot of physical assistance. Moderate Impairment- most likely to require physical assistance with some ADLs. Possibly disorientated to time and place. Possibly reduced communication skills and inability to learn new materials easily. Severe impairment- likely to have no short term

	memory ability and only fragments of long term memory, requiring physical assistance (fully dependent) with nearly all aspects of care, and have severe communication impairments (e.g. speech disturbances).
Activities of Daily Living/ Mobility aids/ Continence	As noted above, cognitive impairment can impact on the person's ability to manage everyday activities, requiring support with nutrition, personal hygiene, toileting and continence, and use of mobility aids.
Sensory Loss(e.g. sight, hearing)	Most likely to increase the effect of the cognitive impairment, making it more difficult for the person to participate in activities; may become withdrawn.
Communication issues of understanding others and/or communicating to others	Likely to have communication difficulties including understanding others and/or communicating to others
Behavioural and Psychological Symptoms of Dementia	The person with dementia has increasing trouble deciphering and interacting with their environment and the people in it. They may have a compromised ability to: - communicate their needs - understand verbal requests - remember how to do basic activities (e.g. the planning and sequencing of activities of daily living that underpin personal care independence) They may also misinterpret their environment (e.g. hearing and seeing things, holding incorrect beliefs) Their discomfort and confusion may cause them to communicate through their behaviour.

Resident and Family

Because people with cognitive impairment often can't speak for themselves, or they don't remember their recent history accurately, it is important to include and seek input from care staff and family members.

The knowledge provided by care staff and the family about the person's cognitive functioning is often of crucial importance. They can share their knowledge of the person's medical history, changes in the person's cognitive state and provide details about the person's life story, routines, preferences, and communication style. All of this information is invaluable in understanding and better assisting the person with dementia (and other cognitive impairments). Because medical treatments for dementia are limited, it is our understanding of the individual that is most likely to have a positive impact on the life, health and wellbeing of the person.

Family and friends can assist staff better support and engage the person with dementia, for example (BCOPE p.143);

- The person with dementia will find familiar people and familiar items reassuring (i.e. photos from home, a specific cushion or dressing gown).
- Inform on how to calm the person during periods of confusion
- Life stories provide staff with conversation cues that they can use to initiate conversations with (i.e. significant life events, pleasant events, favourite pastimes, work history, personal history).

Back to Mary

Mary has become distracted at meal times now and often wanders off to go to the toilet mid meal at her lunchtime meal. She is also now so tired by the evening meal that staff have to often stop her dozing and remind her to eat.

She is also no longer an active participant in the activities she once enjoyed – she sits on the sidelines without speaking, and frequently gets up and walks away to a chair where she promptly falls asleep. She is communicating less but seems to understand what others say to her, but she tends to respond with a smile and then just looks away.

A medical review has been initiated, and care staff will review her cognitive status, staff progress notes and care plan. They have also asked her niece for some mementos from her teaching life. Debbie found some photos and an old blackboard eraser that she thinks will stimulate some interest from Mary.

Initial Nurse Assessment

All residents should have an initial nurse assessment such as the Comprehensive Health Assessment (CHA) for Older People in the Health Care System. The CHA covers most domains and topics likely to impact on the health care needs of a person. Based on evidence informed practice, nurses (RN's and EN's) who have received training on a resource such as the Comprehensive Health Assessment of the Older Person (CHAOP) have the competencies to undertake a comprehensive health assessment.

The Comprehensive Health Assessment has items which record Neurological and Cognitive function in older people, although no specific validated tools are recommended. The box below presents the CHA items specific to the cognition domain:

NEUROLOGICAL/COGNITIVE FUNCTION

Subjective information (i.e. their perception of their memory, whether they have had any episodes of confusion, disorientation, history of headache, dizziness/vertigo, seizures, tremors, perception of gait, balance, difficulty in swallowing, difficulty in speaking)

.....

Conscious state – may require assessment with validated tool (Glasgow Coma Scale)

Orientation to time and place……..

Abstract thinking – explanation……

Concentration – carry out a task……

Memory:

- Immediate……..
- Recent……..
- Distant……

Judgement – able to make a day to day decision……..

COGNITION

Normal ☐ Impaired ☐ Test or use of validated screening tool ☐

Comprehensive Assessment

For the cognition topic, it is recommended that all new residents have a comprehensive assessment. The recommended assessment approach for cognition involves:

- Identifying relevant diagnoses, cognitive impairments and cognitive status from the **resident history and family**. If objective evidence is found from the documentation review (e.g., a recently completed Mini Mental State Examination) that a person has no cognitive impairment, the facility may decide against further testing. But to provide valuable base information for all residents, it is recommended that they have a cognitive assessment at admission. Those with little or no cognitive impairment can be interviewed using on of the recommended tools.
- **Initial nurse assessment** (e.g., CHA which is referenced in the Cognition Appendix). Based on evidence informed practice, it is recommended that nurses (RNs and ENs) should undergo a CHAOP type training to be competent in a broad assessment that collects information across the domains. As the CHA is not a validated cognition assessment, the CHA cognition items should only be used to initially identify an issue.
- If a **resident can be interviewed**, then the recommended validated tools can be undertaken.
- If the **resident cannot be interviewed or the PAS-CIS is not suitable**, then the ACFI 6 checklist is used to determine the cognitive impairment level.
- When a resident is identified as having a possible **change in his or her cognitive status**, a cognitive assessment review is recommended.

Determine if the resident is suitable to be interviewed using the **PAS-CIS**, if yes then complete the PAS-CIS if the resident consents.

Refer to the ACFI User Guide page 25 for reasons the PAS-CIS may not be suitable.

- ☐ Nil or minimal cognitive impairment
- ☐ Cannot use PAS - CIS due to severe cognitive impairment or unconsciousness or have a diagnosis of 520, 530, 570 or 580
- ☐ Cannot use PAS - CIS due to speech impairment
- ☐ Cannot use PAS - CIS due to cultural or linguistic background
- ☐ Cannot use PAS - CIS due to sensory impairment
- ☐ Cannot use PAS - CIS due to resident's refusal to participate

Psychogeriatric Assessment Scales- Cognitive Impairment Scale (PAS-CIS)

References for the following resources are found in the Cognition Appendix

- The PAS-CIS tool
- ACFI Assessment Pack
- PAS User's Guide and materials

It is recommended that readers of this toolkit refer to the ACFI Assessment Pack and the PAS-CIS User Guide to support their assessment process. As the PAS-CIS is the mandatory cognitive assessment tool (when suitable) for claiming under ACFI 6, users should be familiar with its use. The Cognition rating can be derived directly from the PAS-CIS score.

There is also a YouTube video demonstrating a live cognitive assessment using the PAS-CIS at the **Dementia Outcomes Measurement Suite (DOMS)** website which provides a link to this resource (refer to the Cognition Appendix).

The readers are also referred to the **CHAOP (module 7)** as it discusses how to undertake cognitive assessments (refer to the Cognition Appendix and the Reading Pack).

When the PAS assessment tool is not suitable for a resident that can be interviewed and depending on their cultural background and level of cognitive impairment, we have provided two further assessments to help inform on completing the ACFI 6 checklist.

Determine if the resident is better suited to be interviewed using the **KICA-Cog** or **RUDAS** – if they are suitable then complete the appropriate assessment if the resident consents.

Kimberley Indigenous Cognitive Assessment (KICA-Cog)
The residents will need to be able to be interviewed and have given consent. The KICA-Cog is the only validated screening tool for older Indigenous Australians.

Rowland Universal Dementia Assessment Scale (RUDAS)
The residents will need to be able to be interviewed and have given consent. This is a short cognitive screening tool designed to minimise the effects of cultural learning and language diversity on the assessment of cognitive performance.
When using the KICA-Cog or RUDAS, the assessor will still have to identify the level of cognitive impairment based on the ACFI 6 checklist. However, the alternative assessment may assist in that determination and provide valuable information for your care planning. Remember that an assessment is not just a score, but the source of information to be considered when determining strategies for the care process. This will be discussed further

in the Implementation section.

When you have identified a resident is unsuitable for the PAS, document the evidence to support your decision. For these residents, the **ACFI 6 checklist** is used to identify the level of impairment based on their care needs assistance due to a cognitive impairment.

References for the screens and assessment tools can be found in the Cognition Appendix.

Clinical Risks

If delirium is flagged as possible (from history, symptoms etc) it is recommended that the Standardised Care Process (SCP) for Delirium be undertaken (found in the Cognition Assessment Pack and the reference is found in the Cognition Workbook Appendix).

The Delirium SCP describes a systematic approach to addressing delirium covering:

- A recognition and assessment step starting at admission or as required, using the PAS-CIS and the CAM (Confusion Assessment Method)
- Risk minimisation
- Referrals
- Evaluation and assessment
- How to involve the resident
- Staff knowledge and education requirements

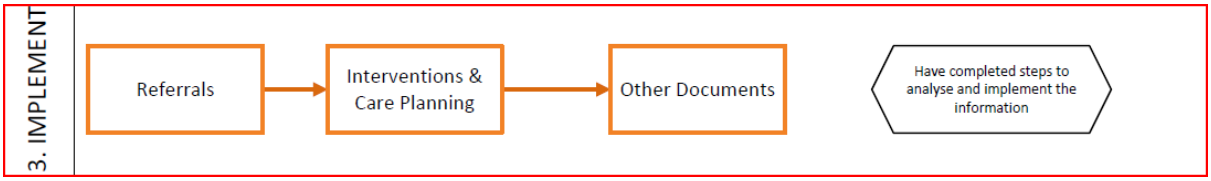
Bringing the information together

As is the case with all of the EBCAT topics, the assessor should also consider the impact from other domains and care topics. These might include:

- Sensory impairment (e.g. as identified in an initial nurse assessment)
- Physical impairment (e.g. as identified in an initial nurse assessment)
- Behavioural issues (e.g. as identified in the Behaviour domain)
- Psychological/Psychiatric symptoms (e.g. as identified in the Cornell Depression Scale)
- Medications being taken as reported in the medication record or chart

Once you become familiar what you have to do (the steps) and how to do it (the process), the basics apply to all the topics and domains in this toolkit. You will however, always need to know how to apply it to individuals.

Implementation Process



This phase of the toolkit demonstrates how to use the information gained from the identification phase to implement interventions and care planning.

The implementation process has three main aspects. These are:

- Undertaking **referrals as identified** to gather further needed information
- Designing **interventions** and developing **care plans that provide a coherent picture of what is to be done and why**;
- Completing **other documents** that support the care process and the accountability systems, such as for the ACFI funding claims and quality of care aspects for accreditation

Considering Mary's case study:

The medical evaluation by her General Practitioner ruled out delirium, an infection, any medicine interactions and her blood sugars were well controlled by the insulin. She was however referred to the dietitian to review her fluid and food intake as prevention against future dehydration and urinary tract infections. The dietitian ordered a supplement drink for Mary at tea time when she was tired and extra fluids during the day.

As Mary didn't talk much anymore, the interview based cognitive assessment (PAS-CIS) could not be completed. A cognitive review based on the ACFI 6 checklist indicated her dementia had progressed to severe. She now requires physical assistance with most ADLs (she doesn't initiate eating, personal hygiene etc), she is disorientated to time (needs cueing at meal times) and place (needs to be shown where the toilet, her bedroom etc), and she rarely demonstrates any fragments of speech. This resulted in the care plan being updated to reflect the need for increased assistance with ADLs.

The staff completed a depression assessment (CSDD) by observation and by using the staff and family as informants. While she didn't score above 8 (minimal signs of depression) she was showing a new behavioural symptom (she had lost interest in her usual activities) and a new physical sign (fatigue). She was quieter but still smiled a lot. New strategies were developed:

(1) To address the loss of interest the care staff were provided with new memory

resources (photos and mementos) and showed how to use them to engage with and interest Mary. During daily activities they talked to Mary about their own school experiences and the teachers. Mary did not reply, but she listened and smiled.

(2) To address the fatigue, a regular nap was introduced in the afternoon. It was found that after a nap, she awoke more alert for the rest of the hours she was up.

It appeared that Mary was naturally transitioning into a later, more dependent stage of Alzheimer's disease. While there is limited medical intervention for dementia, we can maintain a high quality of life in people with these conditions through our management strategies.

Referrals

If there is an identified need regarding medication or medical issues, then the matter should be directed to a Medical Practitioner (i.e. G.P.), who can implement treatments, or make referrals to medical specialists (i.e. geriatrician, psychogeriatrician).

If there is an identified need for further cognitive assessment, then a referral to a cognitive assessment service such as CDAMS (Cognitive, Dementia and Memory Service) or DBMAS (Dementia Behaviour Management Advisory Service) should be considered.

*"**CDAMS** is a specialist diagnostic clinic which aims to assist people with memory loss, or changes to their thinking, and those who support them. CDAMS provides:*

- *Expert clinical diagnosis*
- *Information on appropriate treatments*
- *Education, support and information*
- *Direction in planning for the future*
- *Information on dealing with day to day issues*
- *Linkages for clients or their family to other service providers or community supports*

The Cognitive, Dementia and Memory Service (CDAMS) was developed by the Victorian Government in recognition of the need to provide a specialist multidisciplinary diagnostic, referral and educational service for people experiencing memory loss, or changes to their thinking, and for those who care about them.

Early diagnosis is important to determine appropriate treatment needs and to plan for the future. It provides people with a timely opportunity to learn about their condition, understand changes as they occur and to cope with day to day issues of cognitive impairment. Anyone experiencing changes to their memory and thinking, or those who support them, are welcome to contact CDAMS. Referrals can be made through general

practitioners, community agencies or by self-referral directly to CDAMS.[1]"

*Victoria's **Dementia Behaviour Management Advisory Service** (DBMAS Vic) operates under the auspices of St Vincent's Health, Melbourne Aged Psychiatry Services.*

Partnerships include: Victorian Aged Persons Mental Health Service, Alzheimer's Australia Victoria, The National Ageing Research Institute (NARI).

DBMAS Vic aims to improve the quality of life for people with dementia whose behaviour is having an impact on their care by improving the capacity of care workers, family carers and service providers to meet their specific needs. We predominantly provide services to care workers, aged care service providers and carers of people with dementia who receive support through Australian Government funded aged care services.

DBMAS Vic is staffed by a multidisciplinary team of clinicians from nursing, psychology, occupational therapy and old age psychiatry backgrounds. All DBMAS clinicians have extensive experience in dementia care.

DBMAS services are focused on the management of behavioural and psychological symptoms of dementia (BPSD) and include:

- *Assessment of the person with dementia and their carer/support network*
- *Clinical support, information and advice (face to face and via telephone or email);*
- *Care planning, case conferences, referrals and short term case management;*
- *Mentoring for care providers and clinical supervision*
- *Education and training on BPSD for care providers.*
- *Help to link to current research, literature and evidence based practice guidelines relevant to dementia and BPSD*
- *More general issues relating to dementia care, support and education will be managed through the **National Dementia Helpline 1800 100 500.***

DBMAS Vic also aims to support people with other diverse needs and covers:
Translation and Interpreting services are available to assist with referrals to DBMAS Vic for clients from Culturally and Linguistically Diverse (CALD) backgrounds
Use of the translated Alzheimer's Australia Help and Advice sheets
Behaviour consultants with Aboriginal and Torres Strait Islander and CALD portfolios have undertaken cultural sensitivity training and can also provide advice on specific cultural resources related to dementia.
Advice and support that is relevant to other special needs groups such as those with atypical dementia, younger onset dementia, learning disability and dementia[2].

We recommend for cognition assessment and programs that the nursing management develop referral lists, based on what your health service can provide, what is available in

[1] Ref date 18/7/2014, at http://www.health.vic.gov.au/subacute/cdams.htm
[2] Reference date 18/7/2014, at http://dbmas.org.au/your-state/vic/

your local area and a list of important website contacts to help find a practitioner or advice (Table 3).

Table 3: Referrals for Cognition

Health Professional	Source	Contact
Medical Practitioner	Health Service X	Name, contact details
Geriatrician	Health Service X	Name, contact details
Psychogeriatrician	Health Service X	Name, contact details
Cognitive assessment service such as CDAMS	Health Service X	Name, contact details
DBMAS	Health Service X	Name, contact details

Interventions

In the identification phase, the resident's healthcare and personal needs were identified. The intervention program will address these identified issues by developing strategies to improve or maintain the resident's health status and their quality of life.

The intervention program should involve evidence informed strategies that address the cognitive needs, and importantly the strategies should be specifically tailored for each individual to be most effective. The approach and actions you use to support one resident may be very different from those implemented for another resident.

When designing interventions consider the resident history and personal preferences, the assessment outcomes, the context the strategy will operate in (i.e. the physical environment, the social environment), the knowledge and attitudes of staff, residents and family, and the types of resources required and their availability. Interventions are likely to be medical, psychosocial, educational or nursing in nature.

It is also important that all staff follow a systematic process when implementing an intervention 'program'. This will increase the likelihood of your intervention's success. Having a systematic process which you can describe will also enable other staff to repeat your interventions if they prove successful.

Dementia Care Principles to support a good quality of life for the resident

To provide a good quality of life for all residents requires a system approach- with support from your broader systems, care services, environment and staff. Consider if your home enacts the following:

- Principles of Person-Centred Care (PCC) and Consumer-Directed Care (CDC) to support self-determination, enjoyment of life, dignity and respect, participation in meaningful activities and a purposeful role
- The board of management recognises and addresses good dementia care through strategic planning and the quality system
- The built environment is homelike, domestic size, safe for the person and the staff, and provides privacy
- Specialist support services are in place (e.g. an effective referral system and access to specialist support for staff is available)
- Staff knowledge and dementia skills are identified and supported with education and training opportunities
- The home and staffing model of care are designed to support the person with dementia to live well by providing staff to meet the resident needs when required
- Evaluation of care processes and outcomes is in place to ensure a high standard of dementia care practices and behavior management.
- Use of a range of informants in the identification and assessment process as caring for residents with dementia requires specific knowledge of the individual.

The above considerations are also supported by the **NICE (National Institute for Health and Care Excellence)** approach[3]. They have developed ten quality statements to demonstrate how quality standard statements can support best practice care that is designed to enable people to live well with dementia.

The 10 NICE quality statements are[4]:

1. People with dementia receive care from staff appropriately trained in dementia care.

2. People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.

3. People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.

4. People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care coordinator and addresses their individual needs.

5. People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of:

- Advance statements

[3] http://www.nice.org.uk/guidance/QS1/chapter/How-this-quality-standard-fits-into-the-NICE-Pathway
[4] http://www.nice.org.uk/guidance/qs1/chapter/list-of-statements

- Advance decisions to refuse treatment
- Lasting Power of Attorney
- Preferred Priorities of Care.

6. Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.

7. People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.

8. People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health.

9. People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.

10. Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.

Using information about the type of cognitive impairment

Staff may have a diagnosis or a clinical report that identifies the location of the impairment. Understanding what parts of the brain have been impaired also helps to understand the strengths and weaknesses of the person with the cognitive impairment. This information can then be used to understand the behavior and how you can support the person better. It can also be used to support the ACFI 6 checklist when the PAS-CIS is not completed. For example damage to particular parts of the brain impacts on some specific functions, for example:

Location	Explanation
Frontal lobes	Affects organising skill, problem solving, personality, regulating social behavior, starting and stopping actions. Executive functions such as planning, decision making, working memory, responding to feedback, error correction, inhibition, mental flexibility. e.g. They may display socially inappropriate behaviour
Temporal lobes	Storing new information, short term memory, long term memory, distinguishing sounds and smells e.g. Be unable to follow more than one command at a time
Parietal lobes	Language and reading, spatial perception, touch and pressure, judgement of size and shapes. Creates our perception of the world

Location	Explanation
	based on what we feel, hear, and see. e.g. Hand-Eye In-coordination
Occipital lobes	Visual reception, recognition of colours and shapes e.g. Visual hallucination
Limbic system	It includes the hypothalamus, the hippocampus, the amygdala, and several other nearby areas. It appears to be primarily responsible for our emotional life, and has a lot to do with the formation of memories. Regulates sleep and appetite.

Using information from assessment outcomes

The outcomes from a cognitive assessment not only provide a cut off score for criteria purposes, the individual responses more importantly also inform on specific strengths and areas of difficulty for the person. This information can be used to understand how you may support the person better.

First, a broader look at neuro-cognitive disorders (NCD). The term neuro-cognitive disorder (NCD) is now widely used in place of 'dementia' (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition). The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition) classifies each neuro-cognitive domain as either mild or major, and dementia is now subsumed under the new entity of a major neuro-cognitive disorder (NCD).

The criteria for a neuro-cognitive disorder includes a significant decline in one or more of the following cognitive domains (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, 2013):

Complex attention	Sustained attention, divided attention, selective attention, processing speed. e.g. major difficulties - will have difficulty in environments with multiple stimuli (TV, radio, conversation); difficulty holding new information, thinking takes longer.
Executive functioning	Planning, decision making, working memory, responding to feedback, error correction, inhibition, mental flexibility. e.g. major difficulties - needs to focus on one task at a time, relies on others to plan and make decisions

Learning and memory	Immediate memory, recent memory (free recall, cued recall, recognition memory), long term memory (semantic, autobiographical, implicit learning). e.g. major difficulties - repeats self in a conversation, requires frequent reminders to orient to task.
Language	Expressive and receptive. e.g. major difficulties - significant difficulty with expressive or receptive language, may not recall family names
Perceptual motor	Visual perception, visuo-constructional, perceptual-motor, praxis, gnosis e.g. major difficulties -often confused at dusk and with changing light levels, significant difficulties with previously familiar tasks.
Social cognition	Recognition of emotions, theory of mind. e.g. major difficulties – has little insight, may show insensitivity to social standards of modesty or sexual conversations, makes decisions without regard to safety

The mandatory assessment tool - the Psychogeriatric Assessment Scales- Cognitive Impairment Scale (PAS-CIS) - can also provide valuable information when developing care strategies around cognitive impairments. While the PAS-CIS is a cognitive screen, not a diagnostic tool, and it does not investigate all of the neuro-cognitive domains, the items can help you to understand some of the capabilities of the person. For example:

Area	**PAS-CIS**	**An incorrect response…**
Language	Q1: write a sentence	Impaired reading and writing- the person cannot provide written responses or follow written cues.
Memory	Q2: Registration - name the three objects Q5: - repeat the name and address	If memory is compromised, then do not complete higher level cognitive testing. Provides insight into attention and duration of period of focus.
Memory (Episodic recall)	Q2: Re-call the three objects Q5: recall name and address	Episodic memory is the recollection of where and when events happened in one's own experience. The person will not be able to recall information, such as whether a relative has visited, or how long they

Area	PAS-CIS	An incorrect response…
		have been somewhere.
Memory (Semantic recall)	Q3: Famous people Q4: New years eve	Semantic memory is a person's knowledge about the world e.g. facts about events. Usually deteriorates later than episodic memory. The person may have lost access to well learned knowledge- they will not know why they are in the facility, are unlikely to recognise close relatives, and may have loss of recall of earlier life activities.
Perceptual Motor (Praxis-Ideomotor)	Q7/8: Read aloud and do the action	The inability to execute a learned purposeful movement is called apraxia. Reading a sentence is also testing language skills. If they cannot do the action they will probably not respond to verbal requests to undertake some daily activities like showering or toileting independently.
Perceptual Motor (Praxis - Constructional)	Q6: Copy the drawing	Loss of skill in ordering processes to make up a whole sequence, so they cannot complete an entire activity like bathing.
Perceptual Motor (Gnosis - Visual)	Q9: What objects are seen in the picture	Agnosia is the loss of ability to recognise objects, persons, sounds, shapes, smells (when the specific sense is not defective). The person is no longer able to make sense of the complexity of the sensory world. This is associated with sundowning behavior, misunderstanding of things seen (e.g. phantom spouse or other delusional phenomena). They are likely to become agitated and distressed due to the misperception.

Medicines

Medicines are available in Australia to help with the cognitive (memory and thinking) issues of dementia for people with Alzheimer's disease. These medicines might be useful for people with vascular dementia or Lewy body disease.

Many people with dementia also experience depression and medicines can assist with this.

People with dementia may experience anxiety, panic attacks or (unreasonable) fearfulness. Mild symptoms can be assisted with reassurance, environmental or routine adjustments. Severe symptoms may be treated with medicines if the benefits outweigh the unwanted side effect.

Sleep disturbances can also be associated with dementia (e.g. waking at night and wandering), however the benefits of medicine needs to be considered against the side effects of associated sedation at other times[5].

Care Planning

A comprehensive care plan will be more than a summary of care needs, it will be individualised for each resident and reflect an understanding of their story, history, preferences and care needs.

Facilities may have their own care plan or the NATFRAME Care Profile could be used as a starting point e.g. as a summary care plan. Although the NATFRAME Care Profile will probably not record enough details for your home, it is an example of how to collect and document information in a systematic, professional and accountable manner (the resource reference is found in the Cognition Appendix)

Goal Setting

Moving beyond compliance, the care planning should also address setting goals based on clinical outcomes and the resident's perspective on their care needs and what is important to maintain their quality of life. It is recommended that a **Quality Of Life** (QoL) questionnaire be used to ascertain the resident's view of their quality of life. This could be implemented during the resident/family meeting to sign off on the Care Plan. The goals developed with the resident/family should cover **resident QoL**, **clinical outcomes** and **quality care outcomes** to address a wide range of documentation needs (i.e. consumer satisfaction and clinical expectations).

SMART Goals are an example of a standardised approach to goal setting with measureable outcomes. The SMART acronym (www.projectsmart.co.uk) stands for goals that are:

- **Specific**, that is, they provide clarity, focus and direction.
- **Measurable -** Objective measures can demonstrate the effectiveness of the goals.
- **Action-oriented**, that is, they provide a strategy for achieving them.

[5] http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Dementia_explained

- **Realistic** – because if they're not, we're just setting up for almost certain failure that will then impact on the residents motivation, interest and involvement; and
- **Time-based**, meaning for a specific duration. That enhances their ability to be measured and re-evaluated on an ongoing basis

Role of Documentation

Documentation of care is essential because members of the care staff are accountable to each resident for their actions and decisions. Accountability is also a vital function of professional, legal, accreditation and funding mechanisms and processes.

Documentation is also a communication tool about what has been investigated and the information collected, what interventions have been tried for a particular problem with a particular resident and to identify what is and isn't working. It's a communication tool that can help all staff give the best possible care.

Good documentation supports the nursing process which drives your process. It should incorporate evidence informed practices, assessments and interventions, utilise staff skills and drive a quality care approach.

The documentation process should leave a trail that provides robust and accountable information, leaving your facility audit ready. The documentation is the basis of an evidence profile which provides objective and transparent information for the reason that assistance is or is not required. This supports the ACFI claim which is an outcome of the process, not a driver.

The process for documenting care is as follows:

- Summarise the relevant points from the collated background information and personal history
- Record the assessment and referral outcomes
- Record the identified capabilities and need for assistance following an analysis of the background information and assessment outcomes. This forms the basis of an evidence profile which provides objective and transparent information about the reason that assistance is or is not required.
- Prepare the care plan with details on the care to be provided, why, and the residents goals and desired outcomes (in consultation with the family if appropriate) Record the evaluation of the care provided and the resident's response to the care and quality of life outcomes
- Continue to document new activities or identified issues (e.g. developed strategies and changes to care planning) in the progress notes and in the care plan, as this assists the information and communication flow and allows the process to be tracked for quality purposes.
- Incident forms should be completed recording episodes of falls. The analysis of such incidents should take into consideration the resident's right to take risks. For

example, a resident who is capable of making his own decisions may choose to walk outside even though he cannot be fully supervised at all times. This would be documented in the resident's goals and care plan.

Linking the Evidence

This is about showing the link between the evidence from the background and assessment information (what has been collected in the identification phase) and the care that has been provided to address the identified care needs (in the implementation phase).

The links are:

- Begin by looking at and noting any underlying issues (e.g. diagnosis of dementia) or symptoms (e.g. behaviour changes), connect the link to the body structures and/or functions that are impacted (e.g. reduced ability to self-care in ADLs)
- Describe the associated activity limitations (e.g. reduced social interaction). It's important to look at remaining strengths (e.g. personal interests)
- Describe the intervention program and how it addresses the limitations to assist the resident to improve or maintain his or her status and ensure continued participation in a quality life (e.g. new memory tools to comfort the resident)
- Finally, define the care goals (e.g. reduce fatigue) and resident goals (e.g. provide social interaction) that will be evaluated. Goals give purpose to the care and provide a measurement for evaluating the outcomes.

Below is an example of linking the evidence based on our case study of Mary:

- There was a diagnosis of diabetes and dementia, and recent changes in the level of independence with ADLs, increased fatigue and loss of interest was evidenced in Medical Notes and Progress Notes.
- From the identification process, we identified the body structures/ functions that were affected. The dementia progression had further reduced her ability to self-care and reduced the opportunities for social interaction. This was evidenced in the latest Cognitive and Depression assessments.
- Strategies and subsequent interventions were developed to address the activity limitations by the use of memory cues to assist staff interact with a personal topic of interest of Mary (addressing quality if life), a nutrition approach (extra fluids etc) and an afternoon nap to reduce fatigue. This was evidenced in the updated Care Plan and notes.
- The aims of the care plan can then be defined as goals that will be evaluated e.g. to provide daily nutritional supplements to protect Mary's hydration and nutritional

status, staff to communicate using the memory cues during ADLs, provide increased physical assistance with ADLs). Evidenced in the updated Care Plan.

Below is an example of how to document one of Mary's goals using the SMART goal approach:

- Specific e.g. to improve social interaction opportunities
- Measureable e.g. staff to record when they use the new memory tools
- Actions e.g. develop the memory tools and guidelines
- Realistic e.g. you have staff with the skill set to develop the memory tools and guidelines, the resident's family has agreed to the strategy
- Time based e.g. you set the evaluation date at one month after the commencement of the new strategy by reviewing the progress notes and intervention chart, and interviewing the family and staff.

Completing the ACFI documentation

The data collected can now be used to complete the **ACFI 6 assessment summary and checklists** as described in Tables 4 to 6**.**

Table 4: ACFI Question 6 Cognitive Skills Assessment Summary

ACFI 6 Cognitive Skills Assessment Summary	Supporting Evidence
No PAS undertaken – and nil or minimal cognitive impairment	Care plan, summary care plan, progress notes, Clinical Report
Cannot use PAS due to severe cognitive impairment or unconsciousness	ACCR, Medical Practitioner notes, CMA, AHP notes, Clinical Report, Care plan, summary care plan, progress notes
Cannot use PAS due to speech impairment	Documented speech impairment in - ACCR, Medical Practitioner notes, AHP notes, noted in the Carer Plan, summary care plan, progress notes.
Cannot use PAS due to cultural or linguistic background	Documented demographic information in the -ACCR or Medical Practitioner notes, AHP notes. Noted in the Care Plan, summary care plan, progress notes.
Cannot use PAS due to sensory impairment	ACCR, Medical Practitioner notes, AHP assessment or notes, documented impairments in summary care plan

ACFI 6 Cognitive Skills Assessment Summary	Supporting Evidence
Cannot use PAS due to resident's refusal to participate	Noted in the Care Plan, summary care plan, progress note, PAS-CIS assessment form
Clinical report provides supporting information for the ACFI 6 appraisal	Clinical Report related to cognitive status. A clinical report for these purposes is a report that has been completed by **consultants** in the following disciplines: - general or specialist medical practitioner, physician, - geriatrician or psychogeriatrician - registered psychologist - nurse practitioner or clinical nurse (mental health).
Psychogeriatric Assessment Scales-Cognitive Impairment Scale: enter score	PAS-CIS assessment form

If the PAS-CIS was completed then the score can be used to complete the checklist (Table 5).

Table 5: ACFI Question 6 Cognitive Skills Checklist (abbreviated)

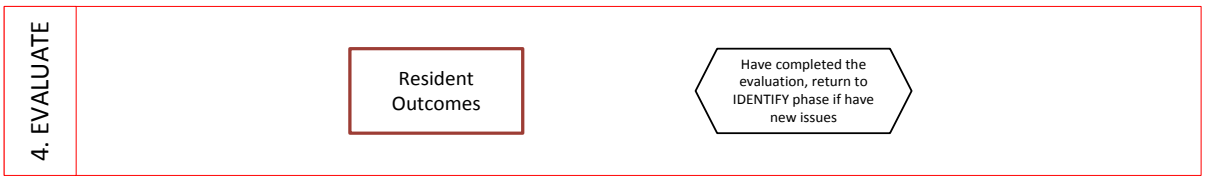
ACFI 6 Cognitive Skills Checklist	Supporting Evidence
1 No or minimal impairment PAS = 0–3, including a decimal fraction below 4	PAS-CIS assessment
2. Mild impairment PAS = 4–9, including a decimal fraction below 10	PAS-CIS assessment
3 Moderate impairment PAS = 10–15, including a decimal fraction below 16	PAS-CIS assessment
4 Severe impairment PAS = 16–21	PAS-CIS assessment

If the PAS-CIS was not completed, then indicate which checklist item best represents the resident's impairment (Table 6). Remember to keep track of which document provides the supporting information for your selection.

Table 6: ACFI Question 6 Cognitive Skills Checklist (detailed)

ACFI 6 Cognitive Skills Checklist	Supporting Evidence
1. No or minimal impairment No significant problems in everyday activities. Demonstrates no difficulties or only minor difficulties in the following–memory loss (e.g. may forget names, misplace objects), handling money, solving problems (e.g. judgement and reasoning skills are intact), cognitively capable of self-care	ACCR, CMA, Allied Health notes, care plan, progress notes, clinical reports, alternative cognitive assessment
2. Mild impairment May appear normal but on investigation has some problems in everyday activities. Memory and personal care: memory loss of recent events that impacts on ADLs (i.e. needs prompting not physical assistance) Interests: not independent in chores/ interests requiring reasoning judgement, planning etc. (i.e. cooking, use of telephone, shopping). Orientation: disorientation in unfamiliar places	ACCR, CMA, Allied Health notes, care plan, progress notes, clinical reports, alternative cognitive assessment
3. Moderate impairment Has significant problems in the performance of everyday activities, requires supervision and some assistance. Memory: new material rapidly lost, only highly learned material retained Personal care: requires physical assistance with some ADLs (e.g. personal hygiene, dressing) Orientation: disorientation to time and place is likely Communication: possibly fragments of sentences, more vague	ACCR, CMA, Allied Health notes, care plan, progress notes, clinical reports, alternative cognitive assessment
4. Severe impairment Has severe problems in everyday activities and requires full assistance as unable to respond to prompts and directions. Memory: only fragments of past events remain Personal care: requires full assistance with most or all ADLs Orientation: orientation to person only Communication: speech disturbances are common	ACCR, CMA, Allied Health notes, care plan, progress notes, clinical reports, alternative cognitive assessment

Evaluation Process



The evaluation process considers:

- Resident Quality of Life outcomes

  Assess if the resident's life is better? In what ways? e.g. happier, healthier. What might have produced this outcome? This could be determined by revisiting the Quality of Life questionnaire or by interviewing the resident and/or family.

- Resident Care Outcomes

  Have the memory tools been regularly implemented? Has Mary shown interest in this activity?

  Has the nutritional supplement been acceptable to Mary? Has it improved her level of self-care at the tea-time meal?

  Has Mary shown less fatigue after the afternoon naps?

- Further improvements

  What needs re-assessing, what could be implemented in a slightly different way?

Evaluation involves a systematic determination of the intervention outcomes, to ensure quality care is being provided. The goal setting stage provides criteria or measures to determine success or otherwise of the intervention. The criteria can be quantitative or qualitative.

The primary purpose of evaluation is to identify the effectiveness of the intervention, to guide further improvements to the interventions to achieve the desired outcomes, and to identify emerging new issues. The finding of new issues would trigger a return to the identification phase.

Evaluation forms the basis of the iterative process that leads to a cycle of continuously improving the quality of the care provided.

Outcomes

Mary's niece met with the members of the care planning staff to evaluate how far they have come and discuss any changes that needed to be made. They reviewed the file notes, including the notes and assessments made by Mary's doctor, nursing staff and dietitian. They also assessed the outcomes against the goals included in her care plan one month after it was written. They found that overall it was positive:

- Mary appeared to enjoy the the staff interactions during ADL assistance as shown by her settled and calm behavior and smiling with staff when looking at the photos.
- The afternoon nap had provided some needed rest for Mary, and she was alert and not agitated in the late afternoon and early evening, and she was sleeping well throughout the night.
- Mary was able to manage the nutritional supplement (after the drinking activity is initiated by the staff).
- There have been no signs of dehydration or urinary tract infections.

Summary: Steps and Information Flow

Figure 2 shows the cognition topic phases and steps in the process. It involves:

The Identification phase which comprises:

- Collation of history from documentation and resident/family interviews
- Initial Nurse Assessment as a screen
- Completing the Comprehensive Assessment (PAS-CIS,RUDAS, KICA-Cog if appropriate; Cognitive Checklist; and completing the Standardised Care Process to address any clinical risks)

The implementation phase which comprises:

- Completing referrals as required to fill in assessment gaps or for specialist advice
- Analysing the information to develop strategies based on evidence informed practice
- Setting goals with the resident and family and completing the care plan
- Documenting the evidence steps and completing the ACFI

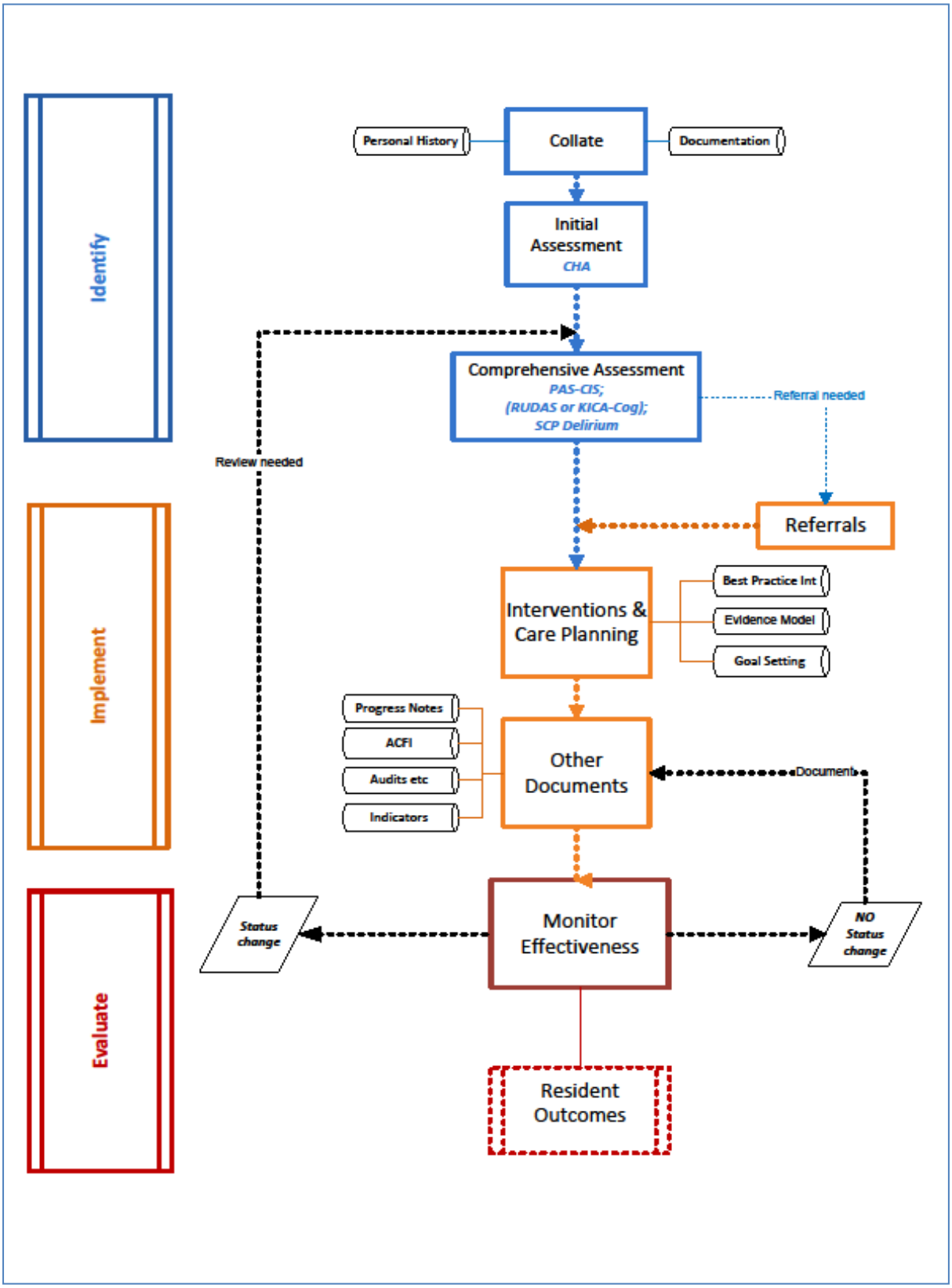
The evaluation phase which comprises:

- A review of the effectiveness of the interventions on resident outcomes Monitoring the progress and effectiveness of the interventions will inform if any changes should be considered
- If a review is required, then at this point the process returns to the identification phase and the associated steps

The Evidence Based Clinical Assessment Toolkit (EBCAT) is so named because evidence gives us a reason to follow a particular plan toward improved health.

Prepare | Identify | Implement | Evaluate

Figure 2: Cognition Information Flow



Cognition Resources

The recommended resources and information on where they are found in the toolkit are listed below (Table 7).

Table 7: Cognition Workbook Resources

Resource Type	Details	Document
Background Reading	BCOPE pp. 127-158	Reading Pack (facility to download)
Background Reading	PAS-CIS User Guide	Reading Pack (facility to download)
Screen	Initial Nurse Assessment (e.g. CHA)	Cognition Assessment Pack
Mandated Assessment	PAS-CIS	ACFI Assessment Pack (facility to download)
Other Assessment	KICA-Cog	Cognition Assessment Pack
Other Assessment	RUDAS	Cognition Assessment Pack
Standardised Care Processes (SCP)	Delirium	Cognition Assessment Pack
Goal setting example	Quality Of Life Questionnaire	Reading Pack
Workbook Exercises	Practice using a Case Study	Cognition Workbook Appendix

Cognition References

The recommended resources and references are provided in Table 8.

Table 8: References for the Cognition Workbook

Document name	Reference
ACFI Assessment Pack October 2014	Sourced from the DSS website https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/aged-care-funding-instrument-acfi-assessment-pack
ACFI User Guide October 2014	Sourced from the DSS website https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/aged-care-funding-instrument-acfi-user-guide
Best care for older people everywhere. (BCOPE)	Department of Health Victoria (2012) Best care for older people everywhere. The toolkit. http://www.health.vic.gov.au/older/toolkit/index.htm
Better Health Channel	http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Dementia_explained
Comprehensive Health Assessment (CHA) for Older People in the Health Care System	Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria The CHA is an example of an initial nurse assessment, it is based on the CHAOP resource.
Comprehensive Health Assessment of the Older Person (CHAOP)	Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria Resource developed for comprehensive health assessment training for PSRACS (2013).
Cognitive Assessment of Older People	DHS Quality Improvement Seminar 20 & 21 Feb 2008 "ACFI Opportunity For Excellence" Presentation by Dr Simon Crowe
Dementia Outcomes Measures (DOMS)- Cognition Assessment Measures	http://www.dementia-assessment.com.au/cognitive/index.html
Diagnostic and Statistical Manual of Mental Disorders	American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA, American Psychiatric Association, 2013
KICA-Cog – Kimberley	Can be sourced from the DOMS website

Document name	Reference
Indigenous Cognitive Assessment.	http://www.dementia-assessment.com.au/cognitive/KICA-Tool.pdf
Mayo Clinic	http://www.mayoclinic.org/diseases-conditions/
NATFRAME Care profile	Section 11 of the National Framework for Documenting Care in Residential Aged Care Services. Australian Government resource https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/suggested-assessment-tools-for-aged-care-funding-instrument-acfi
National Institute for Health and Care Excellence (NICE)	http://www.nice.org.uk/guidance/QS1/chapter/How-this-quality-standard-fits-into-the-NICE-Pathway
PAS User's Guide and materials	PAS-CIS is one of six interviews found in the Psychogeriatric Assessment Scales, this can be sourced from the DOMS website http://www.dementia-assessment.com.au/cognitive/index.html http://www.dementia-assessment.com.au/cognitive/pasGuide.pdf
PAS-CIS	Part of the ACFI Assessment Pack which includes guidelines, sourced from the DSS website. https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/psychogeriatric-assessment-scales-pas-user-guide
PAS-CIS Assessment Demo	Sourced from the DOMS website http://www.youtube.com/watch?v=wkkRwElEjS8
RUDAS – Rowland Universal Dementia Assessment Scale.	Can be sourced from the DOMS webiste http://www.dementia-assessment.com.au/cognitive/index.html http://www.dementia-assessment.com.au/cognitive/RUDAS_scale.pdf
Standardised Care Processes (SCP) Delirium	Published by the Ageing and Aged Care Branch, Victorian Government, Department of Health, Melbourne, Victoria (2012). Authors: La Trobe University ACEBAC Sourced @ http://www.health.vic.gov.au/agedcare/downloads/score/delirium_scp.pdf

Cognition Workbook Exercises

Now that you have worked through the Workbook, you are ready to complete a small case study. You may choose to do this by yourself or as a group discussion.

Facility to insert a case study relevant to ACFI 6

What clinical history is relevant?

What personal history is relevant?

Start to link the evidence together from your case study

Diagnoses

……

Body structure/function that is affected

……

What activities have been restricted

……

Would you recommend a referral? If yes,

What advice or assessment is missing

……

Who would the referral be sent to

……

What information would you prepare for the Health Professional?

……

What information would you expect from the Health Professional?

……

Develop two goals with the following aspects:

- Has a single issue focus
- Measurable
- Action orientated strategy
- Realistic and achievable
- Can be evaluated

Resident QoL goal

……..

Clinical Care goal

……..

What documents do you have, and where are they stored (i.e. documentation trail)

Document Name (insert name)	**Location**	**Date Completed**
Resident /family Interview		
ACCR		
CMA/ other medical notes		
Clinical Report		
Initial Assessment		
□ PAS-CIS or □ KICA-Cog or □ RUDAS or □ Not Applicable		
Checklist evidence		
Resident Goals		
Other		

Complete the following ACFI 6 Checklists and note the evidence for that claim.

	ACFI 6 Cognition Checklists
☐	**1 No or minimal impairment** ☐ PAS - CIS = 0–3 (including a decimal fraction below 4) ☐ If no PAS - CIS assessment: No significant problems in everyday activities. Demonstrates no difficulties or only minor difficulties in the following–memory loss (e.g. may forget names, misplace objects), handling money, solving problems (e.g. judgement and reasoning skills are intact), cognitively capable of self-care.
☐	**2. Mild impairment** ☐ PAS - CIS = 4–9 (including a decimal fraction below 10) ☐ If PAS - CIS assessment is inappropriate: May appear normal but on investigation has some problems in everyday activities. Memory and personal care: memory loss of recent events that impacts on ADLs (i.e. needs prompting not physical assistance). Interests: not independent in chores/ interests requiring reasoning judgement, planning etc. (i.e. cooking, use of telephone, shopping). Orientation: disorientation in unfamiliar places
☐	**3 Moderate impairment** ☐ PAS - CIS = 10–15 (including a decimal fraction below 16) ☐ If PAS - CIS assessment is inappropriate: Has significant problems in the performance of everyday activities, requires supervision and some assistance. Memory: new material rapidly lost, only highly learned material retained Personal care: requires physical assistance with some ADLs (e.g. personal hygiene, dressing) Orientation: disorientation to time and place is likely Communication: possibly fragments of sentences, more vague
☐	**4 Severe impairment** ☐ PAS - CIS= 16–21 ☐ If PAS - CIS assessment is inappropriate: Has severe problems in everyday activities and requires full assistance as unable to respond to prompts and directions. Memory: only fragments of past events remain Personal care: requires full assistance with most or all ADLs Orientation: orientation to person only Communication: speech disturbances are common

	The evidence to support the claim
	If the PAS-CIS was not completed- provide the reason: **Describe the evidence (and note the documents) that support the claim:**