Proactive Care Plan Meetings for Residents with Dementia

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There are many different types of settings in assisted living centers in which patients with end-stage dementia reside. These settings may take the form of a specialized floor within a larger building of normally functioning residents; separate assisted living facilities that solely take care of patients with dementia; and specialized units within Continuing Care Retirement Communities (CCRCs). As the entire field of assisted living becomes more complicated, we may see further hybridization from these basic models.

The issues of the demented patient are unique in many ways, especially since dementia has a natural history of progression of the disease, with increasing decline and eventual demise. There is a wealth of scientific literature describing the expected decline in function over time; so that while for the individual patient, the pattern may not be predictable, the pattern for the larger group of patients reveals general trends that can be anticipated. Certainly, the goal of a well-run assisted living facility with specialized programs in dementia would be to maintain the resident in the current setting as long as possible. However, there are many cases where the individual is no longer safe in the environment or it is no longer desirable for the resident (or the family) to remain in that setting due to medical complications, psychosocial issues, and/or financial issues.

Our quality improvement organization has helped several assisted living facilities to develop a policy that addresses changes in the function of the resident who is no longer safe in their environment. We selected a proactive approach, which we will outline below, to address these patients because their decline may affect their ability to reside safely in an assisted living facility. We initiated this set of guidelines so that there would be few or no surprises for the family members of the resident. Our policy was designed to help the family anticipate the need to change to another type of setting. Once a resident has been identified as approaching the need for a higher level of care (eg, skilled nursing facility or more personal care, while remaining at the assisted living facility), the following action items are performed:

- The family is notified.
- The medical provider is notified.
- The staff increases the resident

care plan meetings on a monthly, rather than a quarterly, basis.
- The family is provided with information about care management agencies available to assist them in decision-making and appropriate placement to meet the changing needs of their loved one.

There are several conditions that trigger circumstances where an assisted living environment may no longer be appropriate for the resident. One example is when the resident becomes bedridden (except in cases of hospice). Sometimes the resident is no longer able to participate in transfers or the transfers become complicated. Once a mechanical lift is required, clearly the patient requires additional assistance that cannot be delivered at the usual assisted living facility level of care. If the resident requires a restraint, then he or she is not appropriate for this setting. Half-rails on the bed may be acceptable for care if they are being used for mobility and self-transfers within the bed; however, as with the resident in skilled nursing facilities, they must be able to demonstrate their use unaided or else they will increase injuries to the resident. The perceived need for side rails for patient safety is another indicator that the resident's function may be declining. If the resident becomes a danger to himself or others that cannot be explained by concurrent medical illness, such as an infectious process, we also address this issue with the family. If the resident requires therapy at any level that cannot be provided by a home health agency, such as physical therapy, occupational therapy, and simple wound care, that also triggers a response. In addition, if the resident requires intravenous therapy or other skilled nursing services that are not provided by a home health agency, that would be included. If the resident consistently refuses medication or the resident's medical power of attorney (MPOA) refuses to allow the use of medication to assist in behavior management when such medication is deemed appropriate by the medical provider (eg, physician, nurse practitioner, physician assistant, and/or consultant, such as a psychiatrist), we initiate the actions noted above. If the resident begins to refuse care on a consistent basis and we feel that this may be a danger to the resident or a sign of significant decline, we also initiate these meetings.

Because of the disease process of dementia, there are times that that a resident's rate of decline does not allow for this transition process to go to the monthly care plan meetings. Certainly, when that occurs, the family and medical provider are notified immediately and appropriate actions initiated.

If the resident begins to refuse care on a consistent basis and we feel that this may be a danger to the resident or a sign of significant decline, we initiate care plan meetings.

As the field of assisted living continues to develop over time, it is of utmost importance to begin to develop policies and procedures that are consistent with both patients' rights and their medical safety within the facility. We believe that by initiating the protocol described in this article, we have been able to deal proactively with difficult patients and issues within our facility. ALC

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Case Management of Dementia Residents in Assisted Living

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Keeping Residents from Disappearing

Dementia residents, by nature of their condition, often "disappear into the wallpaper." They can be loud, disruptive, and demanding. But demented residents also can be quiet, undemanding, and unassuming. Either way, these residents may not have received a thorough medical assessment and the correct diagnosis of dementia. Through good case management, assisted living staff may help facilitate these residents getting the correct medical diagnosis and care. Proper diagnosis and medical care can help stabilize the resident's condition and allow him or her to enjoy a better quality of life.

The challenge for ALFs is to be able to successfully integrate many of these dementia residents into your environment while successfully meeting their needs. The case management approach for dementia residents in assisted living environments helps ensure that their health and social needs are met. It also allows the staff to be proactive, improve communication with involved family members, and help to avoid crises that may require the resident to move from their assisted living home. ALC

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