Q&A

Each issue of *Assisted Living Consult* presents learning opportunities for assisted living facility staff. We urge practitioners and facility leaders to have their staff read the articles and challenge their knowledge using this Q&A section as a training test. By copying this page for each of your key staff, you can assess their knowledge on these critical issues by having them answer these questions. Please note that each article topic appears in color with specific related questions.

Case Management of Dementia Residents

1. An Alzheimer's Association study found that over 50% of residents with dementia had:
   a. Low food and fluid intake
   b. Poor quality of life
   c. Some degree of urinary incontinence
   d. All of the above

2. A monthly case management program for dementia residents monitors:
   a. Clinical outcomes
   b. Social outcomes
   c. Progress of the dementia
   d. A and b
   e. A and c

3. The stage and progression of the dementia is tracked through the resident's:
   a. Brain scans
   b. MMSE score
   c. FAST score
   d. None of the above

4. Tracking the frequency of and medical follow-up for infections helps staff:
   a. Determine the most common causes of infection in residents with dementia
   b. Monitor that adequate medical care is being delivered in a timely way
   c. Monitor the progress of the dementia
   d. Prevent common infections in the facility

Care Plan Meetings in Dementia ALFs

5. What actions are performed when a resident has been identified as approaching the need for a higher level of care?
   a. Family is notified; medical provider is notified; staff increases care plan meetings; family is provided with information
   b. Family is notified and invited to participate in care plan meetings and decision-making; medical provider is notified after the plan is in place
   c. Medical provider is notified; staff increases care plan meetings; provider is encouraged to involve family members, although this is optional
   d. Family is notified; medical provider is notified; staff initiates care plan meetings; staff follows up with provider

6. Half-rails on the bed may be acceptable for care if they are being used for:
   a. Prevention of wandering
   b. Safety of residents and staff
   c. Mobility and self-transfers within the bed
   d. Transfers from place to place in the facility

Eden and Beyond

7. What led to early skepticism among nursing home administrators about the Eden Alternative?
   a. Impression that Eden is a fringe philosophy
   b. Impression that Eden is too expensive
   c. Lack of willingness to bring animals into the facility
   d. Lack of willingness to bring plants into the facility

8. What common values do Eden and Wellspring share?
   a. Facility-directed; administrator-led
   b. Resident-led; cost-effective
   c. Resident-centered; empowering of staff to deal with resident concerns
   d. Resident-centered, low cost

9. ALFs have an opportunity to assess customer need and:
   a. Spend more money than other care settings to meet these needs
   b. Do so in concert with customers themselves
   c. Use this information to attract new residents
   d. None of the above

10. Quality management is not quality management unless it reflects:
   a. Customer focus; reliance on data; empowered staff
   b. Customer focus; family buy-in; empowered staff
   c. Reliance on data; informed staff; administrative expertise
   d. Reliance on data; customer focus; guidance from objective external experts

Urge Incontinence in ALFs

11. A 2001 study estimated direct costs of incontinence to be:
   a. $5 billion
   b. $10.5 billion
   c. $16.3 billion
   d. $26.3 billion

12. What has been the treatment of choice for incontinence?
   a. Anticholinergic agents
   b. Anti-inflammatory agents
   c. Anticoagulants
   d. None of the above

13. What disorders can lead to an overactive contractility of the detrusor muscle?
   a. Parkinsonism, MS, dementia
   b. Depression, delirium, other psychiatric disorders
   c. Stroke, other central nervous system disorders

d. A and b
e. A and c

14. Typical adverse effects seen with all anticholinergic agents include:
a. Dry mouth, constipation, tremor, migraines, blurred vision, dizziness, drowsiness
b. Dry mouth, constipation, nausea, headache, blurred vision, dizziness, drowsiness
c. Constipation, seizures, migraines, double vision, vertigo, drowsiness
d. Constipation, dry mouth, vertigo, migraines, tremor, dizziness

15. Anticholinergic agents are contraindicated in patients with:
a. Any psychiatric diagnosis
b. Urinary retention, gastric retention, uncontrolled narrow-angle glaucoma
c. Urinary retention, gastric retention, macular degeneration
d. Urinary retention, gastric retention, diabetes

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Better Vision for ALF Residents

16. The most common age-related ophthalmic disease causing blindness includes:
a. Macular degeneration
b. Cataracts
c. Diabetic retinopathy
d. Glaucoma
e. All of the above

17. Other conditions that can cause changes in vision include:
a. Strokes or brain tumors
b. Medication side effects
c. Infection or injury
d. Changes in blood flow or enervation into the eye
e. All of the above

18. The American Academy of Ophthalmology guidelines for eye exams in patients 65 years old and older is:
a. Every one or two years
b. Every three months
c. Every six months
d. Every five years

19. In developing vision wellness programs, ALFs should identify:
a. Local ophthalmologists who provide cost-effective examinations
b. Local ophthalmologists who provide the best quality services, regardless of cost
c. Residents at greatest risk for visual impairment or further visual decline
d. None of the above

20. Presbyopia is the:
a. Age-related inability to focus on objects close up
b. Common vision problem in children and adolescents
c. Age-related inability to see distances
d. Inability to distinguish colors

Please see Answer Key below.

Answer Key

1. a	2. d	3. c	4. b	5. a
6. c	7. a	8. c	9. b	10. a
11. c	12. a	13. e	14. b	15. b
16. e	17. e	18. a	19. c	20. a

Resources *(continued from page 34)*

Some of the numbers below are available for state residents only, and the number can only be accessed by calling within that state.

- Arizona Smoker's Helpline: 1-800-556-6222
- California Smoker's Helpline: 1-800-NO-BUTTS
- Illinois Tobacco Helpline: 1-800-548-8252
- Iowa Quitline: 1-866-U-CAN-TRY
- Massachusetts Smoker's Quitline: (English) 1-800-879-8678; (Spanish/Portuguese) 1-800-833-5256
- Michigan Quit Smoking Coaching Hotline
  Free counseling for Michigan residents: 1-800-480-7848; Free printed materials, coupons, quit kits 1-800-537-5666
- Minnesota Helpline
  (English) 1-877-270-7867; (Spanish) 1-877-266-3863; (TTY) 1-877-777-6534
- Mississippi Tobacco Quitline: 1-877-4US-2-ACT (1-877-487-2228)
- Montana Tobacco Quit Line: 1-877-612-1585
- Nevada Tobacco Users Helpline: 1-888-866-6642 or 702-877-0684
- New Jersey Quitline: 1-866-657-8677
- New York Quitline: 1-888-609-6292
- Oregon Tobacco Quit Line
  (English) 1-877-270-7867; (Spanish) 1-877-266-3863
- Texas Quitline: 1-877-937-7848
- Utah Quitline: 1-888-567-8788
- Vermont Smokers Quitline: 1-877-YES-QUIT
- Washington State Quit Line
  (English) 1-877-270-STOP; (Spanish) 1-877-2NO-FUME
- Wisconsin Tobacco Quitline
  (English) 1-877-270-STOP; (Spanish) 1-877-2NO-FUME; (TTY) 1-877-777-6534

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