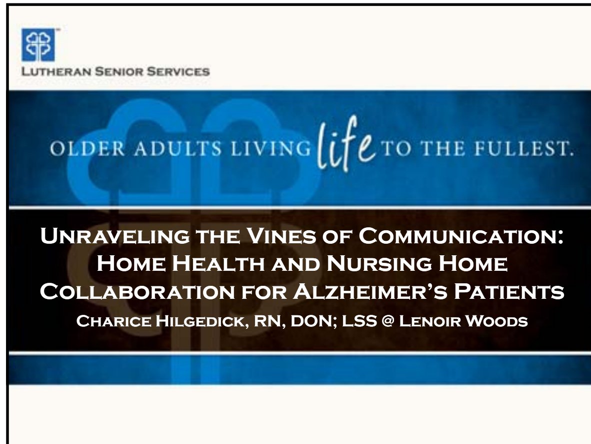
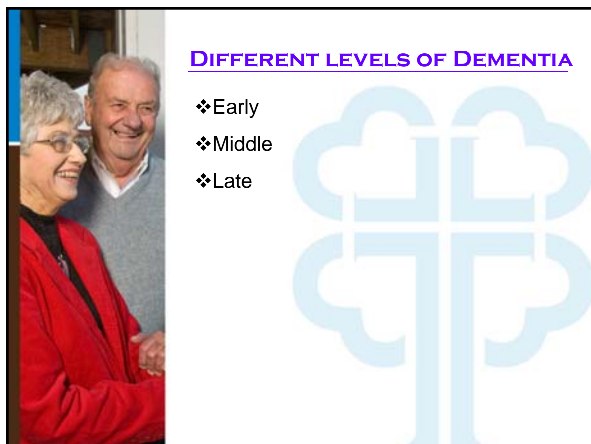


Objectives:

- ❖Describe the 3 different levels of Dementia
- ❖Discuss different methods of communication to use in assessing the Alzheimer's patient
- ❖Be able to list/describe at least 3 common questions the MDS and OASIS share.
- ❖Describe 3 effective ways of communication/report to share across the different levels of care.



Early Stage

Language – Will start to see problems with word finding; forgetting the names of people and unable to name familiar objects.

Orientation – Will start to see confusion in new surroundings; some difficulty with time.

Memory – May only have partial recollection of events; with mild loss of recent events.

Adapted from the St. Louis Chapter of the Alzheimer's association.

Middle Stage

Language – Will start to see difficulty with organization of thoughts and following of directions.

Orientation – Will get confused in new situations and has difficulty with time and place.

Memory – Will have difficulty recognizing family and friends; will repeat questions and have shorter attention span; will have increased confusion

Adapted from the St. Louis Chapter of the Alzheimer's Association.

Late Stage

Language – Patient will not be able to verbalize basic needs; either 2 – 3 word sentences or no speech at all.

Orientation – Will only know self by name; severe difficulty with time and place.

Memory – Will not recognize self in pictures or in the mirror; fragments of memory remain.

Adapted from the St. Louis Chapter of the Alzheimer's Association.

Communication in all stages:

Most important to not use the word interview or test. Approach as a conversation or "chit-chat"

The way to communicate with people with dementia is through the 5 senses with speech being the least effective.

To know what the person understands, but can't communicate, use props for non-verbal communication/cues.

Remember, when chatting with the resident/patient with dementia; they determine the time – we determine the mood.

Communication cont.

If the weather is nice outside, take the resident/patient out for 15 minutes. Sunshine will increase cognition of people with demenita.

Setting the Stage:

1. Get a historic snapshot – life story
2. Enlist help from a family member or friend.
3. Prepare for spending meaningful time
4. Talk to the person alone first; then with others.

(edited from WI DHFS, Bureau of Aging and LTC Resources 3/2002)

Setting the Stage, cont.

5. Utilize a familiar and comfortable environment.
6. Take note of your body language
7. Work the key information you need into the conversation by knowing the info before beginning.

Edited from WI DHFS, Bureau of Aging and LTC Resources 3/2002)

Early Stage Interview

1. First, do NOT assume that difficulty in communicating means loss of understanding.
2. Look for reminders set up in their environment.
3. Keep questions simple, open ended.
4. Keep it "light and simple", until the person is comfortable with you and the conversation.
5. Avoid questions in which the person can just agree
6. You may not notice a deficit until conversation is more detailed.

Adapted from the St. Louis Chapter of the Alzheimer's Association

Middle Stage Interview

1. Ask to enter their "space" and keep movement slow.
2. Ask what and why questions.
3. Use familiar objects/props to promote conversation.
4. Behavior is communication at this stage – watch their feelings for uncertainty, anxiety or fear.
5. Watch body language closely – observation is important.
6. Don't be scared to "go into their world" – follow their themes – they have high energy – walk and talk with them.

Adapted from the St. Louis Chapter of the Alzheimer's Association.

Late Stage Interview

1. Use caring touch and gently soft voice to provide connection. May lead to communication.
2. Remember people have usually lost insight into their situation.
3. Observation in this stage is critical.
4. Again, behavior is communication in late stage, as well as middle stage.
5. Use familiar objects from life story to illicit reactions of comfort/dislike/joy/sorrow.

Adapted from St. Louis Chapter of the Alzheimer's Association.

Commonalities between MDS/OASIS

The MDS and OASIS have several commonalities that can help Home Health Agencies and Long Term Care as well as Short Stay Rehab Communities continue to provide continuing care to their patients/residents across the continuum.

Learning both tools can be successful to continue care.

Background information

Section A of the MDS gives you background information of the patient/resident, as well as Medicare and secondary payers information and numbers. Birth dates and dates of service are also in this section to verify dates of where, and what level of care, the patient/resident has been.

Page 1 of 20 of the OASIS provides this same information.

Senses

Section B of the MDS touches on hearing, speech, and vision. All information on the MDS has a 7 day look back period unless another time frame is indicated.

From the OASIS M1210, M1220, M1230, and M1200 are shared questions.

Senses

Though the questions may be worded differently, they are essentially the same. For example, B0200 of the MDS is ability to hear (with hearing aid or hearing appliances if normally used)

From the OASIS, M1210 is Ability to Hear (with hearing aid or hearing appliance if normally used)

Pain

Section J of the MDS is Pain management that will let you know if the resident/patient has been on a scheduled pain med regimen, if they have received prn pain meds and if they have received any non-medication interventions, as well as pain presence, frequency, effect on function and intensity.

Goes hand in hand with OASIS M1240 and M 1242 as well as corresponding assessment on page 6.

Wounds/Pressure

Section M of the MDS is skin conditions which tells the referral agency the determination of pressure ulcer risk, unhealed pressure ulcers, current number of unhealed ulcers and which stage, current measurements, tissue present in wound bed, if any have worsened since admission and healed ulcers.

Corresponds with M1300, 1302, 1306, 1308, 1310, 1312, 1314, 1320 and 1324 on pages 7 and 8 of the OASIS.

Wounds/Pressure

Section M also tells you number of venous or arterial ulcers, other ulcers, wound and skin problems and all treatments used for all ulcers.

Corresponds with M1330, 1332, 1334, 1340, 1342, and 1350 as well as corresponding assessment on page 8.

Continence/UTI

Section H of the MDS is Bladder and Bowel. This will give you information on any appliances used, urinary toileting programs, continence of both, bowel toileting program and bowel patterns.

Corresponds with M1600 and M1610 and assessment on page 10, as well as M1620 and 1630 with assessment on page 11.

Neuro/Emotional

Section C of the MDS is Cognitive patterns where the BIMS (Brief Interview for Mental Status) is performed by a social worker, as well as temporal orientation and recall. Short-term memory and long-term memory are also assessed. Delirium and acute onset of mental status changes are also assessed.

M1700, 1710, 1720, 1730, 1740, 1745 are corresponding questions on the OASIS page 12.

Neuro/Emotional

Other valuable information can be gained from Section C and D of the MDS. Mood is assessed in section D, using the PHQ-9 Mood Interview. Both the BIMS and PHQ-9 scores are calculated and will let you know if there was a safety notification of self harm.

Neuro/Emotional

Section E of the MDS focuses on Behavior. This includes psychosis, behavioral symptoms, presence of symptoms, impact on the resident/patient and impact on others. Will also let you know if there has been any rejection of care and the frequency of that. Will also alert you to any concerns with wandering.

ADL's/IADL's

Section G of the MDS and the ADL/IADL section on page 13and 14 of the OASIS are very similar and are coded similarly. Remember the MDS has a 7 day look back period, so that you can tell what progress the patient has made thus far. Though not all ADL's and IADL's covered in these assessments are the same, once again there are similarities. For instance – shared assessments include: Dressing, Eating, Toilet use and personal hygiene to name a few.

ADL's/IADL's

Coding on the MDS defines if the activity occurred 3 or more times, and also defines ADL support provided. The coding is similar to the OASIS coding.

Let's take a look

MDS page 14. OASIS, page 13 and 14.

Question M1850 on page 14 of the OASIS – transferring.

Fall Risk

Section J of the MDS covers fall risk, with any history to include the last 1 month, the last 2 – 6 months and if there were any fractures related to a fall.

Will also let you know if patient/resident fell while in short stay or nursing home.

Corresponds with fall assessment and M1910 on page 13 of the OASIS.

Medications:

Medications are covered in Section N of the MDS. This section will allow you to know if any injection were given, insulin, antipsychotics, antianxietys, antidepressants, hypnotics, anticoagulants, antibiotics and diurectics. Also will let you know if any of these weren't given.

Other valuable pieces:

Section F of the MDS is an interview for daily preferences and activity preferences and how much or how important these things are important to them. Example How important is it to you to choose what clothes to wear, or how important is it to you to listen to music you like.

Also in Section J, you will find other health conditions, such as shortness of breath, tobacco use, prognosis, etc.

Other valuable pieces:

Section K is swallowing and nutritional status. Lets you know if there are any swallowing disorders, current height and weight, if there has been a weight loss and if there are any special nutritional approaches, such as a feeding tube or special diet. Will also give you the percentage of intake by artificial route.

Section L is the oral/dental status that lets you know about their teeth, or any abnormal mouth tissues to name a couple.

Other valuable pieces:

Section O is other special treatments, procedures, and programs. Lists several different things the patient/resident received either while or while not a resident such as chemo, radiation, suctioning, BIPAP, IV meds, etc…

This is also the section you will find the FLU AND PNEUMONIA VACCINE INFORMATION!!!

All therapy information will be found in this section as well.

Last doctor visit is listed here also.

Effective Communication across Care Levels

As you can see, the MDS and OASIS can be used as a continuing care tool as long as home health agencies and short stay rehab communities are willing to share the information.

Though each of us needs to perform our own assessment, when taking care of the Alzheimer's patient, this shared information is most valuable to effectively continue care, as there are not always other resources for information available.

Effective Communication across Care Levels

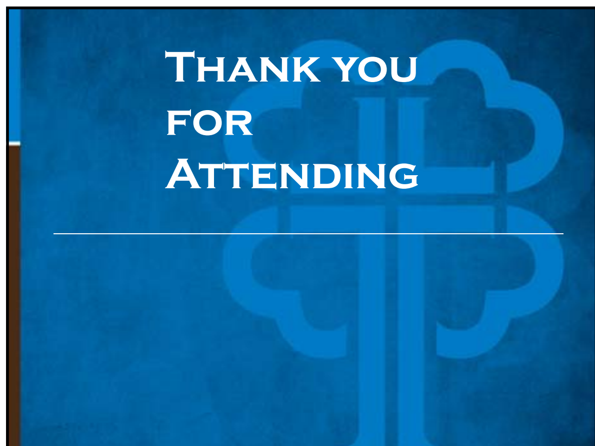
So how do we get to the point of communicating that we need report on the OASIS and MDS?

1. Work together.
2. Understand both tools, so that you know what you are looking for, as well as what to ask for.
3. Don't feel like the organization you are referring the patient/resident to is stealing your information. You are promoting good continuity of care.
4. Give a good report based on the knowledge that you have gained.

Effective Communication across Care Levels

5. Don't be scared to ask.
6. Ask if there are any special considerations, tools, or methods to use in caring for the resident.
7. Ask about family support.
8. Make connections for effective communication and report on continuing care for our residents.
9. Take what you have learned today, and use the tools for what they are meant for – continuing care.

Questions


Thank you
for
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