Healthcare

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Memory Care: Creating Safer Settings for the Cognitively Impaired

The Alzheimer's Association® notes that approximately half of all aging services residents exhibit some form of cognitive impairment, and its prevalence is associated with duration of stay. According to the American Health Care Association and the National Center for Assisted Living, four in 10 assisted living residents are diagnosed with Alzheimer's disease or another form of dementia. Yet only 18 percent of the nation's approximately 31,000 assisted living communities have a designated dementia care unit, wing or floor. In view of this apparent mismatch between resident condition and organizational capabilities, it seems reasonable to infer that some assisted living communities and other aging services facilities may be attempting to provide memory care services without fully implementing appropriate oversight and safety measures.

One factor accelerating the trend toward accommodation of individuals with increasing mental and physical disabilities is the strong desire among most of today's seniors to age in place. So great is consumer preference to avoid relocation in the face of cognitive decline that some organizations have rebranded themselves as memory care providers. (See "Avoiding the Pitfalls of the Aging-in-Place Model of Care" on page 2.) Unfortunately, these relabeled settings sometimes fail to meet accepted standards for memory care in such areas as program certification, staffing ratios and caregiver training, as well as resident access to neuropsychologists, geriatric psychiatrists and other related specialists. Furthermore, although "aging in place" may be a useful marketing concept, it presents its share of liability concerns, especially when applied to residents showing signs of dementia. Before marketing itself as a memory care provider, an organization must commit itself to meeting the many challenges posed by such a designation, including achieving certification, developing and implementing safety-oriented policies and practices, and maintaining a staffing ratio that accurately reflects acuity levels.

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Also fueling the growth in memory care is the impact of hospice waivers, which permit residents to receive palliative care for dementia. Residents must demonstrate a continuous mental decline to be eligible for such a waiver. However, if their condition improves, they are subject to disenrollment from the hospice program. Thus, residents may move in and out of hospice, which can create uncertainty over the parties responsible for providing dementia care. This ambiguity, combined with staff limitations and failure to properly manage family expectations, can magnify liability exposure. (See "Hospice Waivers and Home Healthcare: Addressing the Uncertain Trajectory of Dementia Care" on page 7.)

From a risk control perspective, when aging services organizations accept cognitively challenged residents without appropriate staffing levels, sound assessment and care planning protocols, specialized staff training and effective environmental safeguards, they are placing those individuals at risk of harm and rendering both the facility and its caregivers vulnerable to lawsuits alleging neglect, negligence and/or failure to transfer. This edition of *CareFully Speaking*® reviews current memory care certification efforts, revisits nationally recognized dementia care practices and makes practical recommendations designed to help facilities strengthen their memory care capabilities while reducing exposure to associated liabilities.

Memory Care Certification

As increasing numbers of aging services facilities claim to offer expertise in memory care, industry leaders are recognizing the need for formal certification programs. Certification validates and confirms to residents, their families and the larger community that a facility has attained advanced competency in the care of cognitively impaired residents, met evidence-based standards in dementia care and implemented a quality improvement process designed to ensure resident safety. Certified memory care programs typically offer the following features, among others:

- **Specialized dementia care and services** centered on a resident's unique needs, preferences, abilities and interests.
- **Multidisciplinary care coordination** emphasizing management of behavioral and psychological symptoms.
- **Advanced staff training in dementia care** in order to ensure understanding of current best practices.
- **Ability-based social and recreational experiences** designed for residents, families and intergenerational participants.
- **Safe, functional residential environments** that minimize sonic and visual stimuli, while protecting residents against the risks of falls, wandering and elopement.
- **Support groups and family councils** to improve communication and promote resident and family engagement.
- **A culture that promotes ongoing learning and improvement,** including participation in educational and advocacy activities sponsored by national dementia-related organizations.

The Joint Commission – which has long offered a memory care certification option for skilled nursing facilities that exceeds basic accreditation standards – recently launched a memory care certification program aimed at assisted living communities. Facilities that earn this certification obtain tangible benefits, such as recognition on the Commission's *Quality Check*® website, as well as inclusion in the Alzheimer's Association® *Community Resource Finder*, a database of dementia and aging-related resources for prospective residents and their families.

Avoiding the Pitfalls of the Aging-in-Place Model of Care

The concept of aging in place, whereby residents remain in one location as their care needs evolve, serves as a popular recruitment strategy for aging services facilities. As acuity levels rise, such arrangements may extend to the promise of memory care. However, overstating memory care resources may produce unrealistic expectations, leaving a facility vulnerable to potential allegations, such as false advertising, improper resident placement, neglect and wrongful resident retention.

There is no single formula to determine exactly when a resident should be transitioned from an assisted or independent living setting into a specialized memory care unit or program. For this reason, facility leaders must communicate to residents and families the realities of advancing cognitive impairment prior to admission. By conveying accurate information about memory care capabilities and limitations, administrators can foster reasonable resident/family expectations and minimize the potential for future conflict.

The following questions help operators, administrators and staff examine their memory care-related marketing and resident screening practices:

- **Do marketing materials underscore that effective memory care involves tracking disease progression,** and that appropriate services and care level may change over time?
- **Does the admissions process focus on providing honest information** about program limitations and capabilities, including selection criteria, staffing levels, support services and environmental safeguards?
- **Is there a medical director and nursing director specifically dedicated to the memory care program,** and are both involved in the resident screening and selection process?
- **Are residents and family members asked to sign an agreement** documenting their understanding and acceptance of the facility's memory care services and limits?
- **Does the resident selection process include a pre-admission visit by a certified memory care nurse** in order to ascertain whether the resident is physically and mentally capable of participating in the program?
- **Are prospective residents examined by a physician** to ensure that the individual's acute medical needs are within the facility's scope?
- **Do admission contracts state that residents with changing healthcare needs may be asked to transition** to another facility or unit offering a higher level of dementia care and services?
- **Is the appropriateness of continued residency reviewed whenever the resident's condition changes** and, at a minimum, on a quarterly basis, or more frequently if required by state laws and regulations?

For additional measures to reduce aging-in-place exposures, see CNA *AlertBulletin*® 2021-Issue 2, "Pre-admission Screening: Key to Reducing Unsafe Retention Risks."

Eight Dementia Care Essentials and Important Reminders

The Alzheimer's Association® has articulated basic principles of care for individuals living with dementia. These fundamentals are summarized in the following table:

 **Detection and Diagnosis**	• **Educate all non-physician care providers** about dementia and the signs and symptoms of cognitive impairment. Document training sessions in personnel records. • **Perform a mental status screen of all memory care (MC) residents** and document the results in the resident healthcare information record. (For assessment tools, see the website of the Alzheimer's Association®.) • **Refer all residents who score below a preset score for a diagnostic evaluation.** Remember that signs and symptoms alone do not constitute a diagnosis.
 **Multidisciplinary Assessment**	• **Conduct a multidisciplinary, resident-centered assessment upon admission** and at least every six months thereafter. Include specialists, caregivers, social workers and family members in the process to ensure a comprehensive evaluation. • **Complete a physical examination for medical stability,** as well as a psychiatric examination if the resident is taking a psychotropic drug or has signs of chronic depression. • **Digitize assessment findings** in order to promote ongoing discussion about a resident's cognition, behavior and function. • **Appoint an assessment coordinator** to integrate, document and share relevant information with the treatment team, and to enhance communication among multiple providers.
 **Resident-centered Care Planning**	• **Identify comorbidities that potentially affect dementia care** – such as congestive heart disease or cardiovascular disease, restrictive lung disease, cerebrovascular disease and diabetes mellitus – and note them in the resident healthcare information record. • **Promptly report acute changes in health and function to healthcare providers,** and document them in the resident healthcare information record. • **Whenever possible, utilize non-pharmacological interventions** to treat behavioral and psychological symptoms of dementia. When drugs are clinically required, clearly document the rationale for their use, as well as the parameters for reviewing and/or discontinuing them. • **Initiate end-of-life care discussions early in the care planning process,** preferably while the resident is still competent to make decisions.
 **Resident and Family Engagement**	• **Request that family members participate in important care-related issues,** including discussion of resident preferences. • **Develop educational modules for transitional moments,** such as from early-stage to middle- or late-stage dementia, when living arrangements change, and when residents shift to home health or hospice care. • **Ensure that educational programs are culturally sensitive** and address the needs of racial and religious minorities, socially disadvantaged populations and members of the LGBTQ+ community.
 **Staffing and Training**	• **Encourage staff certification in dementia care** so that caregivers obtain greater expertise in understanding and meeting the needs of cognitively impaired residents. • **Staff to acuity levels,** which can mean a staff-resident ratio as low as 1:2 in MC settings with high impairment levels. • **Maintain staffing continuity** to encourage stronger relationships between residents/family members and caregivers. • **Schedule regular intradepartmental/interdisciplinary in-service programs and meetings** to enhance staff skills and knowledge. • **Monitor employee satisfaction on an ongoing basis,** focusing on such areas as orientation, training and educational programs, work scheduling, supervision and career opportunities. Address observed deficiencies via continuous quality improvement initiatives.

Ongoing Care

- **Note changes in residents' behavior,** identifying aspects of their physical and social environment that may exacerbate symptoms of dementia.
- **Divide care into separate periods,** with distinct interventions selected to prevent or mitigate adverse behaviors at different times of day.
- **Establish resident-centered care practices** that emphasize choice, simple verbal commands, individual toileting schedules and flexible dining accommodations.
- **Utilize** behavioral tracking worksheets that focus on shifts in mood, behavior and cognition. (See page 55 of linked resource.)

Environmental Safety

- **Install alarm doors** and provide residents with WanderGuard bracelets to minimize the risk of elopement.
- **Provide quiet spaces,** monitored by cameras and security systems, for personal retreat and solitude.
- **Conduct frequent room checks,** especially for residents at heightened risk of elopement.
- **Situate activity stations throughout the facility** to stimulate residents' memory and provide them with purposeful tasks and sensory input.
- **Create indoor wander paths** for residents to move around safely within a larger area.
- **Eliminate confined spaces,** to the extent possible.
- **Design spaces with subdued lighting and colors,** as glare or excessive brightness can induce agitation and disorientation.

Transition Planning

- **In admission materials, describe available services and existing safeguards** (such as 24/7 observation and other anti-elopement measures), as well as care limitations for cognitively impaired residents.
- **Include placement criteria in the admission screening protocol** for prospective residents with signs of cognitive impairment.
- **Initiate transitional planning** upon admission, i.e., from assisted living to hospital, from MC unit to skilled care, or from assisted living to home- or hospice-based dementia care, emphasizing that cognitive decline and other health changes cannot always be prevented.
- **Communicate regularly with residents and family members** about available services and limits of care.

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Measures to Mitigate Liability

Promulgate safe admissions policies. Admission protocols for memory care should realistically reflect the scope of available services, with criteria that strictly prohibit admission of residents with high risk mental health conditions, such as primary diagnoses of schizophrenia or bipolar disorder.

Avoid mixing behavioral health and memory care residents. Housing psychotic and/or potentially violent individuals together with dementia residents represents a potentially dangerous proposition. By placing memory-impaired residents within their own designated and protected environment, organizations may reduce both their risk of physical harm and their level of stress.

Employ sufficient staff. As the demand for memory care grows, the challenges of maintaining adequate staffing levels also increase. Depending upon overall acuity, safe staffing ratios may range from as high as one caregiver for every five residents to as low as 1:2.

Adopt a team-based nursing model. Facilities can enhance both efficiency and staff retention by implementing a relationship-centered team nursing model, which features the following four core elements:

- **Clear, open and timely communication of resident care issues** through team huddles, shift-to-shift reporting and multiple "touch points" (i.e., designated times for team members to discuss priority tasks and address special resident issues, including transfer), among other protocols.
- **Staff empowerment,** which involves eliminating micro-management, recognizing and rewarding staff expertise and professionalism, offering wellness/fitness and stress-management programs, and aligning compensation and benefits packages with education and experience.
- **Supportive supervisory relationships** that emphasize mentoring, joint decision-making and problem-solving, and two-way sharing of suggestions and insights.
- **Family involvement** in resident assessment and care planning.

Move from paper to electronic records. Electronic documentation formats and other computerized systems help reduce errors, streamline data collection and enhance the sharing of key resident information, such as symptoms, level of functioning, medication orders and comorbidities.

Prepare for combative residents. Staff must be ready to de-escalate episodes of combativeness in residents living with dementia. Upon admission to the memory care unit, assess residents' tendency toward aggression and violence, utilizing a standard tool such as the Brøset Violence Checklist, and determine if they are manageable through therapeutic and/or pharmacological approaches. In addition, all staff members should be trained to respond in a safe and effective manner to aggressive outbursts, utilizing the following strategies, among others:

- **Approach the resident from the front,** never the back.
- **Keep one's arms at one's side,** which signals peaceful intentions.
- **Remain at a safe distance** from the resident.
- **Refrain from touching residents** who are acting out.
- **Speak in a relaxed tone,** while maintaining eye contact.

Require specialty training and staff certification. As memory care offers a unique set of challenges, an increasing number of providers require staff certification in dementia care through such organizations as the National Council of Certified Dementia Practitioners or the Alzheimer's Association®. Certification serves to confirm that staff members have attained proficiency in anticipating the needs of residents with impaired memory, providing appropriate sensory stimulation and activities, and responding to crisis situations without undue overreliance on medication.

Schedule regular care conferences. The dementia care team should convene frequently to review the following status items and adjust the plan of care accordingly:

- **Recent psychosocial assessments** and neurological findings.
- **Lab values** and diagnostic testing.
- **Medication orders** and reports on their effectiveness.
- **Specialty referrals** and orders.
- **Updates on outside services,** including home health and hospice care.
- **Family input** and interactions.

Foster a tele-network of specialty providers. In general, memory care residents require more than a superficial review of medications by a licensed physician. Yet many memory care facilities lack in-house geriatric and psychiatric specialists. For these facilities, tele-medical connections with gerontologists, geriatric nurse practitioners, neurologists, geriatric psychiatrists, neuropsychologists and related specialty providers become a vital resource for residents with complex mental and physical health needs.

Develop consultation protocols. Caregivers must be taught to recognize the types of behaviors requiring the attention of mental health specialists. Some undesirable behaviors are actually an attempt by the resident to communicate distress, necessitating therapeutic intervention. The following conditions create the need for specialty consultation and assessment:

- **Worsening cognitive impairment,** affecting basic functioning.
- **Behavioral changes**, such as increased aggressiveness, verbal outbursts or social withdrawal.
- **Delusions or other psychiatric symptoms,** potentially related to medical and neurological comorbidities, or to adverse drug reactions.
- **Self-harm behaviors,** including suicidal thoughts or attempts.

Promptly notify physicians and family members of changes. When a resident experiences a sudden change of condition, memory care staff are responsible for assessing the individual, notifying the medical director and/or personal physician, and informing family members of the situation once it has stabilized. The following conditions, among others, warrant immediate notification:

- **Signs of an impending stroke,** such as paralysis or weakness on one side of the body, difficulty speaking or understanding, loss of balance, confusion, headache and dizziness.
- **Abrupt decline** in mental status.
- **Episodes of bleeding,** e.g., bloody vomitus, bloody stools not due to hemorrhoids, dark or bloody urine.
- **New onset of chest pain,** chest pain not relieved by nitroglycerin, or chest pain accompanied by changes in vital signs, sweating, nausea, vomiting and/or shortness of breath.
- **Loose stool** with evidence of dehydration and changes in vital signs.
- **Falls with bodily injury,** including cuts, bruises or lacerations, as well as sharp pain.
- **Falls with head injury** and subsequent changes in mental status and/or functioning.
- **Red-flag test results,** including any lab findings reported as a critical value, positive urine culture and abnormal radiology results.
- **Medication errors** that cause resident injury or decline.
- **New onset of seizures** or other neurological symptoms.
- **Sudden-onset shortness of breath** with chest pain and/or change in vital signs.
- **New pressure injury** or worsening of an existing one.
- **Vital sign changes** indicating disease process.
- **Behavioral changes** creating potential danger to the resident or others.

Institute pharmacological safeguards. The following strategies may help protect vulnerable residents from the threat of polypharmacy and other medication-related risks:

- **Draft written guidelines for the pharmacological treatment of dementia,** delirium and agitation in memory impaired residents.
- **If possible, consult a geriatric psychiatrist/psychologist and a pharmacist** before administering psychotropic medications.
- **Instruct staff to comprehensively communicate and document rationale** for use of pharmaceutical therapies.
- **Conduct pharmacy reviews** during monthly care team conferences for residents receiving two or more medications, noting any changes in behavior or health status.

Cognitively impaired seniors are an especially vulnerable resident population. Any aging services setting attempting to provide dementia care must, therefore, satisfy a broad range of additional requirements in such areas as certification, staffing, training, policy formulation, access to relevant specialists and environmental safety. The strategies outlined in this publication may serve as a point of reference for leaders seeking to assess their organization's memory care strengths, limits and liability exposures, and to remedy noted deficits.

Hospice Waivers and Home Healthcare: Addressing the Uncertain Trajectory of Dementia Care

As the number of cognitively impaired aging services residents grows, hospice and home healthcare providers are becoming a more important factor in the dementia care equation. The Medicare hospice model, initially designed to deliver palliative care to cancer patients, is a suitable end-of-life care option for residents with dementia. To be eligible for a hospice waiver, residents must demonstrate a clear decline in mental and physical status, often marked by an inability to speak and/or the need for full assistance with activities of daily living. The strict prognostic requirements mean that residents with dementia risk disenrollment from the hospice program if their conditions improve, leaving facilities and staff members to provide for the daily needs of seriously impaired individuals. The movement in and out of hospice (and home healthcare as well) can have significant liability implications, relating to unclear staff roles and delayed intervention.

Some industry experts are advocating for a removal, or at least a relaxing, of hospice eligibility criteria in order to ensure that residents have access to high quality end-of-life care. Until such adjustments are made, organizations must provide effective care coordination and transition management for residents with end-stage dementia, and clearly delineate their own responsibilities with respect to both hospice and home healthcare. Educating staff on the similarities and differences between these two supplemental forms of care – as summarized in the diagram below – is the first step in helping them understand their roles and duties in caring for these highly vulnerable residents.

The following additional measures can help improve communication and information flow between aging services facility staff and hospice and home healthcare providers:

- **Assign responsibility for care coordination and oversight** of hospice and home healthcare providers to one or more designated staff members.
- **Determine what hospice/home healthcare providers need to know** when attending to residents.
- **Utilize daily shift logs** to facilitate information sharing among hospice and home healthcare providers.
- **Consider adopting established, consistent communication techniques** – such as Situation-Background-Assessment-Recommendation (SBAR) – at point-of-care handoffs.
- **Share changes made to service plans** with physicians and all caregivers, as well as residents and family.
- **Coordinate communication during resident transitions** at both the start and end of hospice and home healthcare episodes, using a standard reporting format.

Hospice

Comfort care is offered for residents with advanced illness when curative medical treatments are no longer effective or preferred.

Daily resident care is supplemented by an interdisciplinary team of hospice care experts, including a nurse, aide, physician, chaplain, social worker and bereavement counselor.

There is a comprehensive care team, which can provide round-the-clock skilled care.

Unlimited visits are permitted for six months or longer, depending on whether the resident's mental and physical condition continues to decline.

Costs are reduced for residents, with most incurring zero out-of-pocket expenses for hospice care.

Similarities

Both forms of care require documentation of eligibility, as well as a physician's order.

Both may be provided in any type of setting, e.g., assisted living, memory care, skilled care, respite.

Both are less costly than inpatient care.

Both include assistance with activities of daily living, such as bathing, dressing, grooming and feeding.

Both are covered by Medicare, Medicaid and many private insurance companies.

Home Healthcare

This curative form of care is intended to help residents recover from injury or illness, or progress toward improved functionality.

Care is episodic in nature, designed for residents who may require intermittent physical or occupational therapy, speech/language services, wound care or skilled nursing care for chronic medical conditions.

The service team typically comprises registered nurses, certified nursing assistants, speech/language pathologists and physical therapists.

Service limitations exist, with the Medicare benefit excluding 24-hour care.

Duration of home healthcare services varies, depending upon the resident's care plan and goals.

Not all expenses are covered, with residents potentially responsible for medications, supplies and equipment.

Quick Links

- CNA *AlertBulletin*® 2023-Issue 4, "Remote Patient Monitoring: Five Basic Risk-reduction Strategies."
- CNA *AlertBulletin*® 2023-Issue 1, "Hourly Resident Rounding: Key to Enhanced Safety and Satisfaction."
- CNA *CareFully Speaking*® 2020-Issue 1, "Geriatric Psychiatric Units: Six Keys to Safe and Efficient Care."
- CNA *CareFully Speaking*® 2018-Issue 2, "Strengthening Facility-Family Relationships: Transparency Is Key."
- CNA *Vantage Point*® 2023-Issue 1, "Home Healthcare: Common Exposures and Effective Mitigations."

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