

NRS 321 Chronic 2 and End of Life
Concept Based Learning Activity-Dementia
Guidelines

Purpose of Activity: To provide the student with an opportunity to experience a therapeutic relationship with a resident who has dementia. The student will also gain a deeper understanding of the types of dementia, signs and symptoms, and the challenging aspects of care. The student will be able to use a variety of assessment tools that are specific to identifying problems and concerns of a person with dementia. And lastly as a result of the assessments the student will develop a plan of care that will be individualized to the resident, evidenced based, and shared with the facility and staff.

Objectives: The following objectives provide specific focus to the student's learning in this concept based learning activity

- Become more knowledgeable in dementia nursing care by recognizing the types, how it is diagnosed, the signs and symptoms and treatment modalities.
- Challenge one's own myths, biases and fears regarding dementia.
- Have the opportunity to obtain the story of a resident's life (past and present) in order to appreciate the attributes, contributions, character and individuality of the resident.
- Observe and interact with the staff of a memory care unit with the goal of understanding their roles, their significant contributions to care and the complexity of their jobs when caring for residents with dementia.
- Perform a variety of assessments that will identify problems, concerns and/or strengths regarding the physical, emotional, mental, social and environmental aspects of a resident with dementia.
- Observe for potential changes and challenges and also strengths in the resident's responses and behavior during the following times and activities
 - Shower and hygiene
 - In the morning
 - In the evening close to bedtime
 - Eating a meal
 - Taking medications
 - Doing an activity
- Evaluate the resident's current plan of care in relationship to the student's assessments in order to ensure that the resident has a current and effective plan.
- Identify one major problem your resident is experiencing. Develop a plan of care by performing a thorough literature search in order to provide interventions and rationales that are best practices and evidenced based.
- Share findings of the research and interventions with the staff and resident.

Flow of Learning Activity: Students are expected to make a minimum of 4 visits to the facility over the four week rotation. The total hours should be 2-3 hours per visit.

- **Week One: “Who is this Resident”**

- Before going through the chart or talking with staff about the resident, observe the resident’s appearance, interactions and behavior for about 15-30 minutes. Be sure to look at how resident responds to other residents and staff. What are they doing when staff is not present? What is the quality and nature of the staff/resident communication?
- Walk around the unit to familiarize yourself with the environment. Look at the Shadow box that is outside the room of your resident as well as others. Go into the room and observe the personal items and other effects that might give you a “snapshot” about who the resident is.
- Also orient yourself to the facility in general. As you walk around use the Oregon Regulations for Memory Care Units to evaluate how well Pelican Pointe conforms to the state standards and regulations.
- Introduce yourself to staff and let them know what resident you have. Find out from a variety of health care providers (resident aides, resident manager, RN, and Activity Director) their knowledge and impressions of the resident.
- Fill out the Resident Personal History form. Do this by exploring the chart, asking the resident as well as staff the questions and information suggested in this form.
- Make sure to go through the chart to determine what type of dementia the resident has, identify other co-morbidities/chronic conditions, and any other problems and concerns that are significant to the health and quality of life of the resident.
- Make sure to find out what times the resident eats, days and times for showers, times of activities, medication times etc., in order to plan the times that you can come to accomplish the objectives of this learning assignment.

- **Week Two: “Cognitive/Behavioral Assessments”**

- Perform the following assessments on the resident
 - Mini Cog
 - Mini Mental (PRSQ)
 - Geriatric Depression Scale
 - Fall Risk
 - Functional Assessment/Mobility
 - Social Interaction

*****The tools can be found by going to the CBLA for Dementia and clicking on Assessment Tools for CBLA or click [HERE](#).**
- Evaluate the chart and plan of care for any changes that have occurred in the past week.
- Continue to work on Activity Observations: (meal, hygiene, medication, bedtime etc)

- **Week Three: “Medication and Physical /Health Assessments”**

- Perform the following assessments on the resident
 - Vital Signs
 - Bbrief head to toe, focusing on patients current chronic conditions
 - Skin assessment and the Braden Scale
 - Oral assessment and use the Kayser-Jones Brief Oral Assessment Tool
 - Pain (PAINAD)

- Elimination Assessment
 - Nutritional and hydration Assessment
 - List of Medications and an assessment using the Beers Criteria
 - *****The tools can be found by going to the CBLA for Dementia and clicking on Assessment Tools for CBLA or click [HERE](#).**
 - Evaluate the chart and plan of care for any changes that have occurred in the past week.
 - Continue to work on Activity Observations: (meal, hygiene, medication, bedtime etc)
- **Week Four: “Resident’s Plan of Care”**
 - Spend time with staff: medication aide, resident assistant, resident case manager, RN and/or activity director in order to get a sense of their job in terms of roles and responsibilities, challenges, limitations etc. This would also assist you with an idea of how well your interventions can be realistically implemented.
 - Observe and interact with other residents.
 - Evaluate the plan of care with the assessments that you have made over the last three weeks and note similarities and differences.
 - Identify one major problem for the resident and through research provide a plan of care using best practices and evidence for the interventions as well as taking into consideration that they are realistic and individualized to the resident. Present a written document for the staff.
 - Evaluate the chart and plan of care for any changes that have occurred in the past week.
 - Continue to work on Activity Observations: (meal, hygiene, medication, bedtime etc)
 - One last time for 15 minutes observe your resident’s appearance, interactions and behaviors noting similarities and/or differences from the first week.
 - Initiate closure with the resident and the staff.