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Acute Care for Patients with Dementia

A review of best practices for integrating person-centered care throughout the hospital stay.

ABSTRACT: Among adults ages 65 and older, dementia doubles the risk of hospitalization. Roughly one in four hospitalized patients has dementia, and the prevalence of dementia in the United States is rising rapidly. Patients with dementia have significantly higher rates of hospital-acquired complications, including urinary tract infections, pressure injuries, pneumonia, and delirium, which when unrecognized and untreated can accelerate physical and cognitive decline, precipitating nursing home placement and death. The authors discuss the unique needs of patients with dementia who require acute care, highlighting evidence-based strategies for nurses to incorporate into practice.

Keywords: Alzheimer's disease, dementia, person-centered care

The prevalence of Alzheimer's disease and other forms of dementia in the United States is rising rapidly. Alzheimer's disease, which has no known cure, represents 60% to 80% of all U.S. dementia cases.[1] In 2016, it was ranked the sixth leading cause of death in the United States and the fifth leading cause of death for those ages 65 and older.[2] Based on data from the 2003 Chicago Health and Aging Project and the 2010 U.S. Census, the number of people with Alzheimer's disease was projected to increase from 5 million in 2013 to 5.8 million in 2020 and 13.8 million by 2050.[3]

Nearly 25% of hospitalized patients have Alzheimer's disease or some other form of dementia.[4] Compared with older adults who do not have dementia, those who do have twice the number of annual hospitalizations[1,5] and significantly higher rates of hospital-acquired complications, including urinary tract infections, pressure injuries, pneumonia, and delirium, resulting in longer hospital stays and higher hospital costs.[6] Delirium, which occurs four to five times more often in patients with dementia than without, is frequently misattributed to the patients' underlying dementia and is thus untreated, precipitating physical and cognitive decline, nursing home placement, and death.[7] Pain management for patients with dementia is also inconsistent because of the patients' inability to communicate pain and the inadequacy of assessment tools in gauging pain in this group.[8]

The rising prevalence of Alzheimer's disease highlights the importance of preparing nurses and other health care providers to address the unique needs of patients with dementia. A systematic review of studies conducted between 1997 and 2015 that explored nurses' knowledge of and attitudes toward dementia care, and included 4,274 nurses working in hospitals or in community, mental health, or residential care facilities, identified significant knowledge deficits in the care of patients with dementia.[9]

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This article describes the unique care needs of hospitalized patients with dementia, highlighting strategies for incorporating into nursing practice the 4Ms of Age-Friendly Health Systems[10]:

- What Matters (to the patient)
- Medication
- Mentation
- Mobility

It discusses national responses to address the growing number of patients with dementia as well as the knowledge deficits among their caregivers (see *Federally Funded Resources*[10-12]) and suggests that effective collaboration between nurses, other health care providers, patients with dementia, and their family members or caregivers can improve the treatment of older adults in any setting. Although this article focuses on hospital patients, the principles discussed can be applied in all health care settings.

ALZHEIMER'S DISEASE: THE MOST PREVALENT FORM OF DEMENTIA

Alzheimer's disease is a progressive, insidious disease of the brain that may remain undetected for years. It is typically described as progressing through the following three stages[13]:

- mild (early stage), characterized by difficulty with word finding, forgetfulness, and the gradual loss of executive function
- moderate (middle stage), in which such behavioral changes as moodiness, irritability, suspiciousness, or delusions occur and physical decline limits activities of daily living (ADLs)
- severe (late stage), during which the person becomes more withdrawn; requires round-the-clock assistance with personal care; has increasing difficulty communicating, walking, and swallowing; and is at elevated risk for developing infections, especially pneumonia

ESTABLISHING PERSON-CENTERED CARE FOR ALZHEIMER'S DISEASE

Laura Kemp, a 78-year-old woman, presents to the ED of a rural hospital accompanied by her husband of 51 years. (This case is a composite based on our experience.) Mr. Kemp tells the nurse that his wife has been experiencing increasing shortness of breath and running a fever. Her past medical history includes type 2 diabetes, osteoarthritis in both knees, and hypercholesterolemia. Mr. Kemp informs the nurse that two years ago his wife received a diagnosis of probable Alzheimer's disease. Based on this information, the nurse applies person-centered care principles for patients with dementia that were recently shared at a unit in-service training on the care needs of older adults in the ED (see *The Person-Centered Care Philosophy*[14]). The nurse first establishes eye

contact with the patient, extending her hand to shake the patient's hand and introducing herself, saying, "Hello, I'm Luisa Cordova, your nurse. You can call me Luisa. And how should I address you?" The patient tells the nurse that she can call her Mrs. Kemp. "Nice to meet you, Mrs. Kemp," the nurse responds. "I'm here to take your blood pressure and temperature so we can start figuring out why you're not feeling well."

Noticing that Mrs. Kemp has clutched onto her husband's arm, while looking warily at the bright lights, numerous people, and beeping monitors in the ED, the nurse again establishes eye contact with her. Speaking slowly, she reassures Mrs. Kemp that Mr. Kemp will remain with her during her ED stay. She then draws a curtain around the bed to provide privacy and reduce the level of distraction. The nurse offers Mrs. Kemp a warm blanket, explaining that patients often find the ED a little cool. As she gently guides Mrs. Kemp to a reclining chair, the nurse uses short sentences to explain to her what will happen next.

She tells Mrs. Kemp that she will wrap a blood pressure cuff around her upper arm and that the cuff will squeeze her arm for a few moments while her blood pressure is measured. As the cuff inflates, Mrs. Kemp begins to squirm and asks Mr. Kemp to take her home. The nurse gently strokes Mrs. Kemp's hand while watching the blood pressure monitor and making conversation. Afterward, she removes the cuff and pauses to allow Mrs. Kemp a few moments to rest. She then shows Mrs. Kemp the pulse oximeter, explaining that it's used to check the amount of oxygen in her blood, and asks Mrs. Kemp to extend the finger to which she'd prefer it be attached. With her husband's encouragement, Mrs. Kemp extends her index finger. The nurse then asks Mrs. Kemp to take some deep breaths "like this" and demonstrates as she auscultates Mrs. Kemp's lungs. The nurse notes bilateral wheezing and decreased breath sounds in the left lower lobe. She records an initial pulse oximetry reading of 92% with a respiratory rate of 24 breaths per minute and a temperature of 100.8°F. A chest X-ray verifies that Mrs. Kemp has community-acquired pneumonia and she is admitted to a general medical unit.

Understanding that deviating too far from the normal routine may cause patients with dementia to become confused and fearful, the nurse on the general medical unit conducts a short interview with Mrs. Kemp and her husband to learn about the patient's daily routine, abilities, needs, interests, and personal preferences (for meal choices, time to bathe, music selection, and favorite TV programs). Although it's unclear how long Mrs. Kemp will be in the hospital, the nurse suggests that Mr. Kemp may want to bring in one or two family photos and Mrs. Kemp's favorite blanket or shawl, as familiar objects may help her acclimate to the new environment.

In developing the person-centered care plan, the nurse completes, with the help of Mrs. Kemp and her husband, the "All About Me" board,[15] a large laminated board that hangs in the patient's room, providing the interprofessional health care team with helpful information about patient preferences (what matters to the patient, one of the age-friendly 4Ms) and any sensory impairments she has (she wears eyeglasses for reading, for example). As a reminder to the patient, the board also includes the names of the nurse and nursing assistant.

The nurse has a conversation with Mr. Kemp to determine the level of involvement he and any other family members may be willing or able to have in assisting with Mrs. Kemp's care needs. Interviews conducted with family caregivers during the hospitalization of a family member with dementia suggest that a partnership in care between family members and hospital staff often benefits both patients and family caregivers.[16]

ADVANCE DIRECTIVES

Advance directives offer an additional opportunity for patients with dementia and family members to clarify their values and preferences. Mr. Kemp had been asked at his wife's admission whether Mrs. Kemp had advance directives. She did not, but he had not had a chance to ask for assistance in completing the documents. Upon completion of the "All About Me" board, the nurse has an opportunity to raise the subject again with the couple. Because of the progressive nature of dementia, it's recommended that the full health care team be involved early in the course of illness to pursue advance care planning. During the early and moderate stages of Alzheimer's disease, for example, the patient may still be able to participate in decision making.[17] Although Mrs. Kemp's memory

Federally Funded Resources

National responses to the rising number of patients with dementia and the knowledge deficits observed among caregivers include the Geriatrics Workforce Enhancement Program (GWEP) grants funded by the Health Resources and Services Administration (see https://bhw.hrsa.gov/grants/geriatrics)[11] and the Age-Friendly Health Systems initiative launched in 2017 by the John A. Hartford Foundation in partnership with the Institute for Healthcare Improvement, the American Hospital Association, and the Catholic Health Association of the United States to improve the quality of care of older adults across the continuum of care (see *Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults*, available at www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx).[10] In 2015, 44 institutions in the United States were awarded GWEP grants and charged with improving the care of older adults by increasing geriatric competencies of health care professionals.[12] Additional funding was also available to address issues specific to Alzheimer's disease and other dementias.

is declining, engaging her in advance directive discussions is important to ensure that her health care preferences are shared and the care issues that matter to her are addressed. To help the couple better understand their choices, the nurse arranges for them to meet with all members of the health care team as they complete the necessary documents.

COMMUNICATING WITH PATIENTS WHO HAVE DEMENTIA

Effective communication strategies are essential in providing person-centered care to patients with dementia (see *Effective Strategies for Communicating with Patients Who Have Dementia*). Such patients may have a reduced ability to understand information they receive or to retrieve and express information that will aid health care providers in caring for them. When caring for patients with dementia, nurses should assess the patient's language abilities and communication patterns and try to gather information from family members and caregivers that will help all staff communicate with the patient. Such information may include the following[18]:

- how to interpret unclear verbalizations
- patient needs that can be anticipated
- names of family members and close friends
- typical daily routines, including toileting, eating, sleeping, and favorite activities
- situations that trigger upset and calming interventions
- sources of comfort and reassurance

Verbal communication. When communicating verbally with patients who have dementia, speak in a calm voice and allow for pauses between ideas. Give patients enough time to respond so they don't feel hurried or rushed. As much as possible, phrase questions in a way that permits a yes–no response. Take care to avoid corrective speech. For example, if patients aren't oriented to date or place, gently incorporate the information into conversation rather than overtly correcting them.[19]

Managing short-term memory problems. As dementia progresses, short-term memory declines, so it's important for health care providers to reintroduce themselves at the start of each encounter. To ease transitions, explain each step in a process or activity. For example, if helping a patient move from the bed to a chair, the nurse might say, "Mr. Jones, I'm going to help you move to the chair so you can eat lunch. First, I'll raise the head of your bed. Then, if you move to the edge of the bed, I can help you stand up and walk over." Another helpful strategy is to use short questions to offer limited choices, for example, "Do you want to wear socks or slippers today?" or "Would you like water or orange juice with your breakfast?"

Avoiding 'elderspeak.' When addressing older adults, some people use terms of endearment, such as sweetie, honey, or dear. Some care providers talk to older adults using a singsong voice or baby talk to cajole them into cooperating as if they were a young child. Although it may be well intentioned, this type of communication, called "elderspeak," is widely understood to be ageist and disrespectful, and has been shown to increase resistance to care in patients with dementia.[20]

Nonverbal communication. Although both verbal and nonverbal communication can be used effectively when caring for patients with dementia, as the disease progresses and the patient's expressive ability deteriorates, nonverbal communication may become increasingly important. Nonverbal practices that aid communication include approaching patients from the front, establishing eye contact, and using a gentle touch.

Behavioral communication of unmet needs. All behavior has meaning. As such, behavior can be understood as a form of communication that may need to be addressed.[14] The patient may signal unmet needs (for pain management, toileting, thirst, or hunger, for example) by such nonverbal behaviors as repeated vocalizations, changes in vocal tone, or pace of speech.[18] Behaviors such as calling out, refusing to move, being combative, or wandering need to be recognized as communication. Rather than interpreting these behaviors as a barrier to providing care, health care providers should attempt to determine the unmet physical or psychosocial need they may signal and how to intervene appropriately. Is the patient anxious or lonely? Is a change of position needed? Would a short walk be helpful? When patients are anxious, the three R's—repeat, reassure, and redirect—can reorient them and reduce the need for medical management.[21]

The Person-Centered Care Philosophy

The abrupt transition from a familiar routine to the fast-paced, often hectic, and unfamiliar environment of a hospital can cause undue stress in patients with dementia. Person-centered care, which is the basis of the 2018 dementia care practice recommendations from the Alzheimer's Association,[14] relies on six principles that go beyond the provision of usual care and assessment, highlighting the importance of supporting patients' personal preferences, as well as their unique abilities and interests. These principles are[14]:

- Know the likes, dislikes, values, beliefs, and abilities of the person.
- Recognize behavior as communication; accept the person's perspective and feelings.
- Identify and support opportunities for meaningful experiences and interactions that incorporate the person's preferences.
- Build caring relationships in which you demonstrate respect by "doing with" rather than "doing for" the person.
- Create and maintain a supportive community that incorporates the person, family members, and staff in care.
- Regularly evaluate care practices and programs, sharing findings with other health care team members and making changes as needed.

The Progressively Lowered Stress Threshold (PLST) model for dementia care stresses the importance of rapidly assessing and responding to unmet needs. Key principles include reducing environmental stimuli, maintaining a consistent routine, monitoring possible causes of problematic behavior, and intervening before behaviors become problematic.[22] Because stress thresholds among people may vary widely, it's important to observe all patients and learn to identify their unique triggers.

Anticipating behavioral triggers. The nurse and nursing assistant reintroduce themselves to Mrs. Kemp on their third consecutive day working with her. As indicated on the "All About Me" board, Mrs. Kemp prefers to be addressed as Mrs. Kemp, so both are careful to address her as such. After attending occupational therapy, Mrs. Kemp seems agitated and tries to remove her sweatpants. The nurse gently strokes her arm and asks her, "Mrs. Kemp, would you like to use the bathroom?" She nods that she would. "First, I'll help you stand up from the chair," the nurse tells her. "Then I'll walk with you to the bathroom."

Mrs. Kemp has mild-to-moderate Alzheimer's disease, but her family has reported that when she's tired, she becomes agitated and refuses to participate in any activity, even moving from the chair to the bed to go to sleep. After dinner, the nursing assistant notices that Mrs. Kemp is becoming agitated, so she uses the nonverbal strategies of gently wrapping Mrs. Kemp in her shawl and stroking her arm. By engaging Mrs. Kemp in this way, the nursing assistant helps to calm her and prepares her to transition to the evening bedtime ritual. Since the family has told the nursing assistant that Mrs. Kemp becomes tired by 8 PM, she helps Mrs. Kemp bathe and prepares her for bed at 7:30 PM, thereby preventing Mrs. Kemp from becoming overtired, which can trigger her agitation.

It may be both challenging and time consuming to determine what the behavior of a patient with dementia is expressing. But recognizing that behavior often communicates a need can be the first step toward determining and addressing that need and delivering person-centered care. Some acute behavioral changes, such as agitation, inattention, lethargy, or some combination thereof, may indicate delirium and should be assessed as such.[23]

Effective Strategies for Communicating with Patients Who Have Dementia

Verbal strategies.
- Avoid elderspeak.
- Call patients by their preferred names.
- Introduce yourself with each patient encounter.
- To smooth transitions, narrate actions, saying what you are doing and why.
- Provide choices.

Nonverbal strategies.
- Approach patients from the front at eye level.
- Use a gentle touch to get the patient's attention or provide a transition from one activity to the next.

Attention to behavior.
- Avoid triggers that are known to upset or agitate the patient.
- Take time to explore what the person wants or needs.

DELIRIUM ASSESSMENT AND PREVENTION

Mentation, one of the 4Ms, focuses on identification and management of dementia, delirium, and depression. Both advanced age and dementia are among the leading risk factors for delirium.[23] Recognizing delirium in a patient with dementia is challenging, but thorough documentation of a comprehensive baseline assessment can help nurses identify acute changes. Family members are often the first to notice changes in a patient's behavior. When family members comment that a patient seems out of sorts, nurses should consider the possibility that the patient is showing signs of delirium.

Assessment tools for delirium include the widely used Confusion Assessment Method (CAM), a comprehensive observational interview developed in 1990[23]; the Nursing Delirium Screening Scale (NuDESC), a five-item observational scale developed in 2005[24]; and the 3D CAM, a three-minute assessment for CAM criteria developed in 2014[25]—all of which have been validated for assessing delirium in hospitalized patients.[26]

Key features of delirium include
- acute and fluctuating course.
- inattention.
- disorganized thinking.
- altered level of consciousness, which can present as hyperactive, hypoactive, lethargic, or some combination thereof.

Common causes of delirium include
- medications.
- infections.
- urinary retention.
- constipation or fecal impaction.
- dehydration.
- metabolic disturbances.
- hypoxia.
- pain.
- immobility.
- sleep deprivation.

The following strategies minimize the risk of delirium[27]:
- Maintain a routine, including wake and sleep times.
- Reorient patients with dementia as needed, using a calendar and clock.

- Ensure sensory aids (such as eyeglasses and hearing aids) are used.
- Avoid physical restraint.
- Minimize overstimulation.

The Hospital Elder Life Program (HELP) can also aid in preventing functional decline and delirium in older adults while reducing costs.[28,29] HELP is a comprehensive evidence-based program that has been implemented in more than 200 sites worldwide.[30] Upon hospitalization of an adult age 70 or older, the interdisciplinary HELP team screens the adult for six delirium risk factors (sleep deprivation, dehydration, cognition, vision, hearing, and immobility) and develops a targeted intervention plan that is updated as the patient's needs change.[28] Many interventions are performed by trained volunteers and no special unit is required.

OPTIMIZING FUNCTION IN PATIENTS WITH DEMENTIA

People with dementia who are hospitalized are sometimes assumed to have limited function and discouraged from participating in activities; this in turn increases their risk of functional decline. To optimize function in hospitalized patients with dementia, encourage participation in stimulating activities and ADLs while promoting safe mobility, incorporate the PLST model for care, and ensure that all sensory aids and assistive devices (such as glasses, hearing aids, and dentures) are available, in good repair, and being used.

Sensory stimulation. Excessive noise levels can disorient patients with dementia. Bed coordinators on hospital units often place patients who require close monitoring near the nurses' station, but the noise level in that location may frighten patients with dementia and increase their confusion. Such patients may benefit from being located farther away from the nurses' station and having health care providers respond to call lights in person rather than through the speaker. Mrs. Kemp is located away from the nurses' station, but she enjoys the frequent visits of the nurse and nursing assistant, which provide her with an opportunity to socialize while also allowing them to closely monitor her for any acute behavioral changes.

To promote appropriate sensory stimulation, nurses can introduce activity kits, such as sewing cards, word search puzzles, adult coloring books, and towel folding. Because Mrs. Kemp uses her glasses for reading, they are kept at her bedside along with her family photos and a water pitcher.

Participation in ADLs. Encourage patients to participate as much as possible in performing basic care.[14] For example, to help patients brush their teeth, nurses can stand behind them and place a hand over theirs while narrating the activity and allowing the patients to do what they can.

Such person-centered care approaches can also be used to assist patients during mealtimes. In addition to using the hand-over-hand technique, simplify the presentation of the food; offer smaller and more frequent meals; limit distractions; demonstrate the use of utensils; and provide cues, such as, "Why don't you take another bite of the spinach."

Promoting safe mobility. Mobility, one of the 4Ms, supports What Matters (another 4M), because maintaining mobility enables older adults to engage in what matters to them.[10] In 2007, the Centers for Medicare and Medicaid Services sought to improve quality and decrease costs by declaring falls with injury one of eight events for which they would no longer reimburse hospitals.[31] This policy, however, had the unintended consequence of restricting mobility for older adults, who were often confined to beds and chairs with alarms.

Assisting with ambulation, minimizing the amount of time spent in a chair or bed, scheduling active range-of-motion exercises, and regular toileting are effective ways to maintain the preadmission functional status of hospitalized patients with dementia. In addition to helping Mrs. Kemp with these activities, the nurse enrolls her in the hospital's mobility program, which promotes safe ambulation. To create a safe environment for mobility, environmental hazards must be minimized so the patient has a properly lit, clear pathway to the bathroom, which is identified with large-print signage or a picture.

MEDICATION USAGE

Medication, one of the 4Ms, needs to be carefully considered in older adults, especially those with dementia. The age-friendly model stresses the importance of avoiding medications that could potentially affect any of the other 4Ms: What Matters, Mentation, and Mobility. The American Geriatrics Society's updated Beers Criteria cautions that benzodiazepines; antipsychotics; barbiturates; antidepressants; nonbenzodiazepine, benzodiazepine receptor agonist hypnotics ("Z drugs"); and highly anticholinergic medications, such as first-generation antihistamines, are potentially inappropriate in most older adults.[32]

TRANSITIONS OF CARE

Following the acute hospitalization of a patient with dementia, a smooth transition to the next phase of care—whether it's to home, an assisted living facility, or a nursing home—requires discharge planning that takes into account the needs of the patient and the family. Ideally, discharge planning needs are addressed on admission, as poor discharge planning may increase length of stay or result in hospital readmission or subsequent ED visits. Mrs. Kemp's discharge-to-home plan will include orders for home health care services. To support Mr. and Mrs. Kemp during the transition, a hospital social worker arranges a family care conference for the couple and their two daughters. When in-person family meetings pose challenges,

Table 1. Online Resources for Providers and Caregivers of Older Adults with Dementia

Sponsoring Group	Available Resources
AARP • www.aarp.org/ppi/initiatives/home-alone-alliance • www.aarp.org/caregiving	• Family caregiving videos on special diets, incontinence, wound care, mobility, and managing medications (available in English and Spanish). • *Prepare to Care: A Caregiving Planning Guide for Families*, caregiver stories, community resources and tools, tips for care at home, financial and legal resources, caregiver preparation, and health system navigation.
"All About Me Board" Template[15] www.ncbi.nlm.nih.gov/core/lw/2.0/html/tileshop_pmc/tileshop_pmc_inline.html?title=Click%20on%20image%20to%20zoom&p=PMC3&id=3930328_nihms553196f1.jpg	The "All About Me" board is signage in the hospital room that provides the health care team with information on patient history, preferences, family information, and sensory impairments, while reminding patients of the names of their nurse and nursing assistant.
Alzheimer's Association www.alz.org/professionals/professional-providers/dementia_care_practice_recommendations	2018 Dementia Care Practice Recommendations (10 articles available for free download).
American College of Emergency Physicians www.acep.org/globalassets/sites/geda/documnets/geda-criteria-final_1.17.2019.pdf	Geriatric ED accreditation criteria for levels 1, 2, and 3.
Family Caregiver Alliance www.caregiver.org	Information, support, and resources for caregivers of adults with any chronic condition (free; registration required).
Function Focused Care www.functionfocusedcare.org	Videos, tips, tools, modules, and handouts on improving the functioning of older adults in any setting.
Hartford Institute for Geriatric Nursing https://consultgeri.org	Click on Tools, then Try This: Series, then Dementia Series, Issue #D10, "Working with Families of Hospitalized Older Adults with Dementia," for the tool, Information for the Hospital Team About a Patient with Memory Problems.
Health Resources and Services Administration Collaborative Action Team Training for Community Health–Older Adult Network (CATCH-ON) • http://catch-on.org • https://bhw.hrsa.gov/grants/geriatrics/alzheimers-curriculum	• Online modules and resources for older adults, their families, and health care professionals (some videos available in Spanish). • Training curriculum for Alzheimer's disease and related dementias.
Hospital Elder Life Program (HELP) for Prevention of Delirium • www.hospitalelderlifeprogram.org • www.hospitalelderlifeprogram.org/news/mobility-change-package-and-toolkit	• Interactive training for clinicians, families, and patients; tools for assessing delirium (registration required). • Mobility Change Package and Toolkit, a framework and step-by-step guide to help health care teams initiate a mobility program at the patient's institution.
Institute for Healthcare Improvement • www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx • www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Age_Friendly_What_Matters_to_Older_Adults_Toolkit.pdf	• *Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults*, available for download. • *"What Matters" to Older Adults? A Toolkit for Health Systems to Design Better Care with Older Adults*, available for download.
National Institute on Aging • www.nia.nih.gov/health/alzheimers-disease-research-centers • www.nia.nih.gov/health/going-hospital-tips-dementia-caregivers	• Information on Alzheimer's disease research centers, available by state. • Tips for dementia caregivers on going to the hospital.

Table 1. Continued

Sponsoring Group	Available Resources
Nurses Improving Care for Healthsystem Elders (NICHE) https://nicheprogram.org/resources/need-to-knows	Resources available without membership for caregivers and older adults.
Nursing Home Toolkit www.nursinghometoolkit.com/toolkitoverview.html	Resources to help health care staff address behavioral and psychological symptoms of distress using nonpharmacological strategies and a person-centered care approach.
Savvy Caregiver Training www.hcinteractive.com/SavvyCaregiver	The Savvy Caregiver is a six-week curriculum designed to help caregivers develop knowledge, skills, and attitudes to maintain the caregiving role.

teleconferencing can provide everyone in the family an opportunity to be included in the planning.

During the family care conference, the social worker may refer the family to the state's Area Agency on Aging (see https://eldercare.acl.gov/Public/Index.aspx), which may help the family identify resources and support for which they're eligible. These may include Meals on Wheels, homemaker services, and respite or adult day programs that provide structured activities and meals.

ASSESSING CAREGIVER CAPACITY

In addition to ensuring that the needs of the patient with dementia are met upon discharge, it is critical for the health care team to assess family caregivers for their capacity to continue in the caregiver role. While caregivers often report that caregiving provides meaning, strengthens relationships, and enables them to learn new skills,[33] the negative health effects of caregiving, particularly for patients with dementia, are well established and can include stress, depression, and poor general health.[34,35]

Another factor to consider when assessing caregiver capacity is that caregivers are often assigned nursing tasks for which they have no technical training.[36] The addition of required nursing tasks and medication management, and the patient's increased need for follow-up appointments, can intensify the stress and complexity of caregiving. The Preparedness for Caregiving Scale (available at https://consultgeri.org/try-this/general-assessment/issue-28.pdf) is an eight-item self-report tool that allows caregivers to indicate their level of preparedness across several domains and identify any specific areas in which they would like to feel better prepared. Based on their level of preparedness, caregivers may consider enrolling in the Tele-Savvy Education Program for Dementia Caregivers (available at www.nia.nih.gov/alzheimers/clinical-trials/tele-savvy-education-program-dementia-caregivers). This clinical trial, which continues through November 2020, takes the form of an online educational course based on the Savvy Caregiver program, an in-person six-week training designed to help caregivers develop the knowledge, skills, and attitudes necessary to maintain the caregiving role.[37]

Each member of the health care team and family caregivers play an important role in the transition to the next phase of care. The care team should ensure that family caregivers receive printed copies of all discharge instructions.

Integrating person-centered care principles throughout the hospital stay, thorough discharge planning that informs family caregivers about any required nursing tasks and medication changes, the family care conference, care coordination with the local department on aging, and a careful assessment of caregiver capacity are all essential elements in smoothing the transition to the next phase of care for patients with dementia. For a list of online resources, see Table 1.[15] ▼

For 60 additional continuing nursing education activities on the topic of dementia, go to www.nursingcenter.com/ce.

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