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Evaluating older adult self-care capacity

In multiple settings, nurses have opportunities to observe patients' abilities to make decisions and live safely at home.

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It happens to every nurse: You observe an older patient who shows signs that he can't take care of himself or a patient's family asks you for advice about their loved one's capacity to live alone. Assessment of older adults' ability to provide self-care is a priority for healthcare professionals, incorporating health history, functional assessment, cognitive evaluation, psychological state, and socioeconomic factors. Determining an older patient's "capacity" to make decisions and live safely at home presents a serious and difficult challenge—one that nurses can assist with by assessing the ability to make executive decisions related to environmental safety, financial resources, and consequences of medical care.

In this article, we discuss your role as a nurse or NP in assessing the capacity of the older adult; specific tools useful in determining capacity assessments for those who are at risk for self-neglect, injury, exploitation, or abuse due to cognitive decline; and resources to aid patient care.

Capacity and competence

As healthcare professionals, we're often faced with the contradictory responsibilities of respecting patients' autonomy (self-determination) while protecting those patients who are incapable of protecting themselves. Two important terms—*capacity* and *competence*—are often used interchangeably but incorrectly. Each term is distinct with different meanings.

Capacity is a clinical concept referring to an individual's decision-making capability. It varies from day to day or according to specific tasks, such as managing medications or paying bills. Capacity is determined by a clinical assessment and doesn't usually require court action.

In contrast, *competence* is viewed as a legal term referring to a judge's ruling as to whether a person is capable of making his or her own decisions. Nurses are infrequently involved with determining competence.

However, we have great potential related to assessment of functional domains, including hygiene, the home environment, activities for independent/safe living,

medical self-care, and personal financial management. Ideally, capacity assessment involves multiple disciplines; however, nurses are often the healthcare professionals who make the first-line observations that are critical to protecting patients.

Four elements constitute decision-making abilities in a capacity assessment:

- understanding—the ability to comprehend and retain information
- appreciation—the ability to appreciate the consequences of decisions
- reasoning—the ability to make decisions based on values and beliefs
- expressing a choice—the ability to make a selection and communicate decisions.

Nurses often make the first-line observations that are critical to protecting patients.

Case study #1

An NP has been volunteering at the local low-income clinic for several months, caring for multiple patients with chronic diseases. Three times in the last year, the NP has seen Margaret, an 87-year-old female patient with a history of hypertension. The NP was able to help her with funding for her medications last year, but today her BP is extremely elevated. Margaret appears unkempt and anxious. When asked about adherence to her medications, Margaret admits to not having them filled because her son took her car away from her and she had no way to get to the pharmacy. When questioned about her family, Margaret states that her son and his girlfriend moved into her home 2 years ago and they moved Margaret into an apartment. She was okay with the change because they needed more room.

At first, her son helped pay her rent, but stopped after 3 months. She was evicted from the apartment because she had no income. Her son was unwilling to allow her back into the home because of her appearance and smell. She's been homeless for 9 months. After a thorough exam, the NP feels a need to assess Margaret for cognition.

The NP administers the Montreal Cognitive Assessment (MoCA), which indicates a deficit in thinking, memory, and recall. Margaret doesn't know the year, month, or date. She isn't sure about her age today but is able to state her date of birth. She's unable to draw a clock or answer most of the questions on the MoCA. She can't recall any words, even with cues. And she's unable to articulate a clear choice on where she wants to live. The NP is concerned that Margaret may have a cognitive impairment, but she's also concerned about potential exploitation by Margaret's son.

Two issues are brought to light in this case. The first is that Margaret is exhibiting signs of cognitive impairment and there's concern that she's being financially exploited by her son. She doesn't demonstrate capacity for self-care as evidenced by her lack of reason and understanding, and is unable to appreciate the seriousness of her situation, which may pose high risks for injury and further complications. Further, she's unable to appreciate the consequences of her decisions or express a choice specific to a decision.

Contacting Adult Protective Services is an interventional option. When you find evidence of a patient's declining cognition, you have an obligation to report or refer for further evaluation and/or treatment. Referring for further evaluation may include a meeting with family members, the healthcare team, or Adult Protective Services.

Cognitive impairment

Self-neglect by older adults increases their risk of hospitalization, long-term-care placement, and even an earlier

death. It's important for you to recognize when a patient can't perform the basic activities of daily living (ADLs) needed for independent living. These include getting out of bed, dressing, eating, taking medications, managing finances, and using the phone. When patients present with "red flags" of self-neglect or abuse, take extra time to evaluate for a decline in cognition (see *Red flags for cognitive decline*).

Consider a differential diagnosis when patients present with signs of self-neglect. A sudden onset of confusion and memory loss may indicate delirium, which is usually reversible. New medications, drug interactions, an acute illness such as a urinary tract infection, or a change in oxygenation may mimic signs of dementia in an older patient. Depression can also be mistaken for dementia, with reduced executive functioning, attention, memory, learning, psychomotor speed, and verbal processing.

Case study #2

Sixty-seven-year-old Sally is readmitted to the hospital with chronic obstructive pulmonary disease. The nurse recognizes Sally from being on his floor the previous month. She appears unkempt and confused compared with her last visit. As the nurse takes Sally's history, he reviews the medications she's currently taking. She confirms all the medications on the list from the previous month. The nurse asks Sally if she's still taking the antibiotic, which she should have completed. Sally replies that she's taking everything.

The nurse has a feeling that Sally may be confused. He asks her about the previous hospitalization and she tells him that it's been years since she was in the hospital. Further questions lead the nurse to ask about today's date, month, and year, which Sally can't answer with accuracy.

This is an example of a patient who needs further evaluation to rule out delirium related to medical conditions such as a urinary tract infection, dehydration, or poor oxygenation. Delirium may have a sudden onset, whereas dementia progresses slowly.

Patients experiencing cognitive decline to the point of affecting ADLs are said to have dementia. The National Institute on Aging describes Alzheimer disease as a progressive disease that eventually leads to the loss of the ability to perform ADLs. Patients with mild cognitive impairment may be able to live at home for a long period of time with very little change in their ability to perform ADLs. The process

Red flags for cognitive decline

Appearance

Weight loss; disheveled appearance; dirty; urine or feces odor; inappropriate clothing for the season

Home

Cluttered; unkempt; animal feces/urine on the floor; mail/bills stacked up; lack of food in the refrigerator; odd items left in the refrigerator, such as clothing or bills in the freezer

Executive decision-making/activities

A decrease in normal activities; getting lost while driving/walking; inability to make phone calls, including 911; sleep disturbances

Finances/possible exploitation

Forgetting to pay bills; not submitting a tax return; electricity turned off; giving money away to family members or strangers

Healthcare

Forgetting medical appointments; poor medication adherence; inability to give an accurate medical history; repeated hospital admissions

Psychological state

Answers yes to any of the following: feeling down, depressed, or hopeless, or having little interest or pleasure in doing things

Cognition

Memory changes, such as being unable to repeat three to five words after 1 minute or draw a clock with numbers and hands in the appropriate place; disorientation; inattention

for evaluating cognitive decline is multifaceted. The evaluation may involve assessing the patient's self-care, medical care, environment, and finances.

Assessment steps

Assessing older patients for self-care capacity includes appropriate communication, a health history, a physical assessment, a functional assessment, nutrition status, a medication assessment, and a cognitive/psychological assessment. Let's take a closer look.

Communication. Introduce yourself, speak clearly and slowly, sit at the patient's eye level, and allow sufficient time for the patient to answer.

Health history. This includes past medical history, current medical diagnoses, medications, hospitalizations, and history of psychological and mental health diagnoses and treatments.

Physical assessment. Perform a physical exam, including vision and hearing assessments.

Functional assessment. Assess the patient's ability to perform ADLs. Ask about each of these activities. Can they perform them independently or do they need assistance? (See *Functional assessment performance* for more information.)

Nutrition status. Poor nutrition in older adults can reflect illness, depression, dementia, or other problems with shopping or financial resources. Unintentional weight loss of greater than 5% in 6 months or a body mass index less than 20 is a red flag for poor nutrition and requires further evaluation.

Medication assessment. Allow time to review both prescription and over-the-counter medications. Explore if the patient takes medications as prescribed; if not, what are the reasons for not doing so? Explore how the patient remembers to take medications and other issues related to medications, such as forgetfulness, fear of being overmedicated, or lack of understanding.

Cognitive/psychological assessment. Assess for appearance, behavior, mood, motor activity, attention, executive functioning, language, memory, and orientation.

Functional assessment performance

Personal needs and hygiene

- Bathing and grooming
- Toileting
- Dressing
- Eating and adequate nutrition

Home environment

- Maintaining basic repairs
- Safe living conditions
- Physical structure of the home
- Maintaining appropriate heating and cooling
- Maintaining appropriate and safe storage of food
- Safe water supply

Activities for independent/safe living

- Shopping
- Cooking
- Cleaning
- Laundry
- Using the phone
- Arranging for transportation
- Dealing with mail

Medical self-care

- Medication management
- Refilling prescriptions
- Wound care
- Self-monitoring for illness
- Arranging medical appointments

Personal financial management

- Paying bills
- Managing bank statements
- Managing insurance
- Judgment with basic financial decisions
- Keeping financial records secure

Helpful tools

When taking a patient history, a simple question such as asking the patient's age can give you clues to the need for further assessment. If the patient can't give an

Capacity assessment tool examples

Tool	Description/domains assessed	Benefits/challenges
Clock	Visuospatial and executive function	Takes 1 to 2 minutes to administer; beneficial tool when added to other tests
		Incomplete tool to test for capacity on its own
Mini-Cog	Three-word registration, clock drawing, and three-word recall	Takes 3 minutes to administer; sensitivity: 0.91%, specificity: 0.86%
		Only has two components for evaluation of cognitive decline
MMSE	Attention, language, memory, orientation, visuospatial proficiency	Takes 6 to 10 minutes to administer; sensitivity: 81%, specificity: 89%
		Proprietary
Mattis Dementia Rating Scale-2	Attention, initiation/perseveration, construction, conceptualization, and memory	Takes 10 minutes to administer; Alzheimer disease sensitivity: 1.0, specificity: 0.68
		Proprietary; unable to differentiate mild cognitive impairment due to Parkinson disease
SLUMS Examination for Detecting Mild Cognitive Impairment	Attention, language, memory, orientation, visuospatial proficiency	Takes 10 minutes to administer
		Lower sensitivity than MoCA
MoCA	Attention, language, memory, orientation, visuospatial proficiency	Takes 10 minutes to administer; mild cognitive impairment sensitivity: 0.90; Alzheimer disease sensitivity: 1.0, specificity: 0.87
		Proprietary

accurate age, you may ask the current year, the current president, or information about the patient's health history. Answers may help determine the need for further evaluation. There are over 40 tools available to evaluate cognitive decline in patients, with variations in the amount of time it takes to complete the tests, differences in screening components, and costs (proprietary) to use the tool (see *Capacity assessment tool examples*).

To evaluate for cognitive impairment, you'll assess for cognitive or behavioral function deficits, including learning and information recall, reasoning or task completion, visuospatial proficiency, speech, reading and writing, behavior, and personality. One of the most well-known tools is the Mini-Mental State Exam (MMSE), which is composed of 20 questions. It includes orientation, memory, language, attention, and visuospatial components. Although the tool is widely used, it does cost.

For the patient in the hospital or clinic who presents with questionable cognitive ability, you may want to start with a quick test such as the clock test or Mini-Cog exam. The clock test may be combined with other tools for screening dementia. It takes only 1 to 2 minutes to complete, and the instructions are readily available online. The Mini-Cog exam takes approximately 5 minutes or less and assesses for executive function, memory, and visuospatial deficits.

Other well-known tools used to evaluate for cognitive decline are the Saint Louis University Mental Status (SLUMS) Examination for Detecting Mild Cognitive Impairment and the MoCA. Both take approximately 10 minutes to administer; however, depending on the situation, it can take much longer, and some patients

on the web

AARP: www.aarp.org

Alzheimer's Association: www.alz.org

Centers for Medicare and Medicaid Services: www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html

Meals on Wheels America: www.mealsonwheelsamerica.org

National Adult Protective Services Association: www.napsa-now.org

National Association of Area Agencies on Aging: www.n4a.org

National Council on Aging: www.ncoa.org

U.S. Department of Health and Human Services: www.hhs.gov/about/index.html

Veterans Affairs guide to long-term services and supports: www.va.gov/GERIATRICS/Guide/LongTermCare/index.asp

may not be able to complete the tests. An advantage of the MoCA is the specificity for mild cognitive impairment, tools for the blind, and availability in multiple languages.

It's important to remember that no single cutoff score on any test will categorize a patient as with or without capacity. Different types of decisions require different skills. When determining if a patient can make and execute decisions to live safely at home, multiple domains must be evaluated; no one test, or part of the assessment, is sufficient. However, your observation, assessment, and interaction with the patient are critically important to initiate a full assessment to protect him or her from abuse, neglect, or exploitation. Without you as a keen observer, red flags may be overlooked.

Case study #3

Bob is a 74-year-old male patient who's seen in the clinic by an NP for an annual exam. Bob takes only lisinopril and simvastatin. Besides hypertension, hyperlipidemia, and an occasional cold, Bob is fairly healthy. The NP notes that he's lost approximately 20 lb in the last year. His wife indicated at the last visit that Bob was losing his memory and today she says it's much worse. She states that he's still driving but has gotten lost several times and gone the wrong way on a road twice in the last month. The NP remembers that Bob didn't know the year but did know how old he was a year ago. He was able to complete a clock test with little effort.

While the NP questions Bob about his memory at this visit, he becomes agitated. He can't recall the year, day, or month. The NP administers the MoCA and Bob scores 17 out of 30 points, indicating cognitive impairment. Bob's wife sits quietly during the exam, but she admits to the NP that she can't answer several of the questions. She's concerned about her own memory. The NP considers that Bob is exhibiting signs of dementia and his wife may have mild cognitive impairment.

This patient and his wife require further assessment to ensure that they aren't in danger. With permission from Bob and his wife, the NP may meet with the couple and their children to arrange for help in the home. One area that should be addressed is decision-making with Bob's driving. There are multiple resources for the nurse, NP, older adults, and families to address declining self-care abilities (see *On the web*).

Your role

Nurses and NPs are often the first to observe a lack of self-care in patients. The RN at the bedside spends hours with patients and may be the initial person to observe red flags indicating a deficiency in capacity. Nurses who work in home health have the advantage of seeing changes in the home, such as hoarding, dangerous living environments, and disorganization. With advanced dementia, patients may have unusual items such as papers in the refrigerator, animal feces on the floor, and bills stacked on the table.

Advanced practice RNs serve both the patient and the community in multiple settings, including the clinic, home, and assisted living or long-term care. The

goals of the advanced practice RN when called on to determine patient capacity include decision-making, safe living conditions, the need for immediate or emergent medical attention, and recommendations for future medical care.

Well-being and safety

In almost every setting, you can make important observations about your patients' self-care abilities. Although the process of determining capacity can be complex and challenging, requiring multidiscipline input, the role of the nurse is crucial for our older patients' well-being and safety. ■

REFERENCES

Administration on Aging, Administration for Community Living, US Department of Health and Human Services. A profile of older Americans: 2015. www.acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2015-Profile.pdf.

Crowe S, Ewart L, Derman S. Something isn't right: the subtle changes of early deterioration. *Nursing made Incredibly Easy!* 2017;15(1):34-41.

Knight MJ, Baune BT. Cognitive dysfunction in major depressive disorder. *Curr Opin Psychiatry.* 2018;31(1):26-31.

Mitchell JC, Dick MB, Wood AE, Tapp AM, Ziegler R. The utility of the dementia severity rating scale in differentiating mild cognitive impairment and Alzheimer disease from controls. *Alzheimer Dis Assoc Disord.* 2015;29(3):222-228.

Norris D, Clark MS, Shipley S. The mental status examination. *Am Fam Physician.* 2016;94(8):635-641.

Roedl KJ, Wilson LS, Fine J. A systematic review and comparison of functional assessments of community-dwelling elderly patients. *J Am Assoc Nurse Pract.* 2016;28(3):160-169.

Stewart S, O'Riley A, Edelstein B, Gould C. A preliminary comparison of three cognitive screening instruments in long term care: the MMSE, SLUMS, and MoCA. *Clin Gerontol.* 2012;35(1):57-75.

Tsoi KK, Chan J, Hirai HW, Wong SY, Kwok TC. Cognitive tests to detect dementia: a systematic review and meta-analysis. *JAMA Intern Med.* 2015;175(9):1450-1458.

US Census Bureau. Age and sex of all people, family members, and unrelated individuals iterated by income-to-poverty ratio and race. 2017. www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-01.html.

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