### Purpose:
To provide an effective Prescreening process that assures that residents seeking admission for Alzheimer’s and related dementia care are properly placed to their benefit as well as to the benefit of others residing on this (secure) unit.

### Protocol:
All potential residents for the Dementia/Secure Unit will receive a preadmission assessment by the necessary designated professionals to assure a safe and appropriate living environment for all residents of the unit.

1. At the time of the initial interview/inquiry with the legal representative, the Admissions Representative will explain the Admission criteria and process. Arrangements will be made at a future date for the coordination of a preadmission visit by a nurse and social worker.

2. The responsible party/legal representative will be provided with a list of required medical tests and records from the resident’s physician.

3. The following records and information will be required prior to acceptance of the resident with Alzheimer’s Disease or a related dementia:
   a. History and Physical performed by a physician with in the last 5 days.
   b. Laboratory tests to include: CBC, chemistry profile, thyroid profile, serology, B-12, folate, and thiamine levels.
   c. Any psychiatric evaluations performed within the last five years.
   d. Chest X-ray, CAT scan, or MRI to rule out organic disease or a neurological workup.

4. The Psycho-social assessment of the caregiver will include:
   a. Background and health
   b. Social support network
   c. Environmental adequacy
   d. Financial situation
   e. Goals of care

5. Residents accepted must be medically stable with no suicidal or homicidal tendencies or deemed to be a danger to him/her, others, or the property.
6. Age limit is 55 and on with special cases reviewed by the Admissions team as part of the morning Administration meeting.

7. Families/guardian and/pr RP are required to assist in the case of a medical emergency

8. Residents accepted to the Dementia Unit will be limited to those whose needs are appropriate for the level of care for that unit. When the resident’s needs cannot be met or are not appropriate for the secured special care dementia unit, the resident will be transferred to another unit.

9. Consultants available to the unit will include: psychiatrist, gerontologist, neurologist, and others specialized in the field of dementia.

Adjustment to the Facility

When institutional care becomes a necessity, it is often behavioral symptoms that contribute to the decision to seek nursing facility placement. In addition, the placement may be influenced by events such as the illness or death of a spouse or care giving, (Surveyor Guidebook on Dementia, 1992). It is essential that the receiving facility be prepared to facilitate the resident adjustment to the new environment, in light of a variety of factors that may impact on the resident’s acclamation to their new home.

1. Review all pertinent information regarding the resident’s history and physical, prior living arrangements, psychosocial assessment of the resident and the caregiver, and goals of care (as applicable, as identified by the responsible party). A Geri-psych review will be required pre and post admission. A Geri-psych evaluation will be requested within one week of admission to the facility.

2. The Global Deterioration Scale will be administered at the time of admission, Quarterly and/or when there is a significant change in status. Other tools such as the “Mini mental State” examination may also be used as a supplemental assessment.

3. Secondary diagnoses will be identified and the physician will work with the interdisciplinary team to determine if pain could be a potential contributor to behaviors. A pain assessment will be conducted at the time of admission and throughout the course of stay to rule out pain as a potential contributor of behavioral issues. Interventions will be directed to the resident specific care plan.

4. The primary physician will be requested to visit within the first 72 hours, unless the resident has been followed by the primary physician prior to admission to the facility, and has been recently examined.

5. Primary care assignments will be coordinated for new residents. Assignments will be modified during the first 72 hours as a means to introduce the resident to the new environment and new care givers.

6. The use of psychoactive medications to treat behavioral symptoms will be based on a thorough analysis of the benefits in treating symptoms versus the potential adverse effects of the drugs. The rule of thumb will be to go low and go slow. Monitoring must be provided throughout the course of administration. Pharmacy will review the medication profile prior to the initial care plan.

7. New family and resident orientations will be provided within the first week. Orientation will include an introduction to primary care givers, and members of the interdisciplinary team. Reference materials and support group information will be provided to Family/RP members.
8. Responsible parties will be invited to a preliminary care plan meeting. The staff will work with the family/RP to establish normal routines, and assist in the resident acclimation to the new environment. Care plans will be implemented to address clinical, behavioral, and environmental needs and issues. Caregiver education and support will be conducted in response to changing conditions and the need to modify the plan of care over time.

9. Activities will work with the new resident and provide opportunities for interactive quality time, success, enhanced feelings of self esteem for the resident, and opportunities for joy and pleasure.

10. Family/RP will be encouraged to assist with the transition to the new environment

11. Activities will be coordinated such as: Sensory stimulation, arts and crafts specific to the age and stage of the resident, music and exercise, organized games, grooming groups, support groups, and special needs programs such as “New Resident Adjustment Group”.

12. New or worsening dementias will be evaluated by:
   a. Check vital signs and blood glucose levels.
   b. Review medication records for the addition of meds, discontinuation of meds, change in doses, allergies, and change in the route of administration. Ask pharmacy to review polypharmacy and potential Food/Drug interactions.
   c. Review the chart for changes in function e.g. bowel and bladder habits. Sleep patterns, intake, mobility, or any recent fall or injury.
   d. Check for pain to include observations for guarding of the body, resistance to care, new neurological deficits or shifts to the level of conscientiousness, new asymmetries or swelling.
   e. Skin integrity with observation for swelling, bruises, redness, rashes, or dyscrasias.
   f. Check joints as well as range of motion. Observe for limitations, tenderness, and signs of fractures or a history of fracture. Check to see if there has been a recent history of a fall or an injury.
   g. Examine the abdomen for distention. Enlarged bladder, catheter problems, signs of a UTI, diminished bowel sounds. Check for recent bowel movement; check current bowel pattern.
   h. Check labs.
   i. Check for recent environmental changes such as a change in room, roommate, remodeling, noise pollution, and overall comfort.
   j. Check for changes in the social system. Is there a change in family visits, recent personal loss, or a shift in activities?
   k. Check for signs of depression and sadness, crying, anxiety, withdrawal from normal activities, sleep problems, fatigue, decreased energy/lethargy, difficulty concentrating, slow3d or slurred speech.
   l. Check respiratory status. Observe for signs and symptoms of respiratory distress, Shortness of breath, wheezes or rhonchi, congestion, productive or non productive cough.
   m. Check secondary diagnoses and previous medical history.
   n. Check for signs of infection or the onset of acute illness.
Preadmission Checklist
For Individuals with Alzheimer’s disease and Related Dementias

☐ Pfeiffer Short Portable Mental Status Questionnaire (Score at least 5-7)

☐ To be obtained from Physician:
   ☐ Current History and Physical
   ☐ Any psychiatric evaluations within the last five years
   ☐ Chest X-ray report
   ☐ CAT scan, MRI, or Neurological Report (Circle the one that applies)
   ☐ Lab Reports: (CBC, Chemistry Profile, Thyroid Profile, Serology, B-12, Folate, Thiamin)
   ☐ Physician orders for care (#3008)

☐ Functional Assessment of ADL’s
   ☐ Psychosocial Assessment of the resident
      a) Description of memory loss
      b) Review of present symptoms
      c) List current prescriptions and over the counter medications
      d) Review of current medical problems
      e) History of family dementia and/or vascular disease
      f) History of hospitalizations and surgeries/medical procedures
      g) Description of current health habits including diet, alcohol, smoking, and sleep patterns
      h) Any history of head injury
      i) Functional ADL assessment
      j) Any other pertinent history
      k) Pfeiffer SPMSQ

☐ Psychosocial Assessment of the Caregiver
   a) Background and health
   b) Social support network
   c) Environmental adequacy
   d) Financial situation
   e) Goals of care

☐ Advance Directives
   a) Appointment of surrogate/DPOA/Legal Guardian
   b) Living Will
   c) DNRO

Signature of person completing checklist: ___________________________________________

Date: __________-____