TOPIC: COGNITIVE IMPAIRMENT

1. **Cognitive impairment is a temporary or permanent change within the brain which affects a person's ability to think, reason and learn**. Temporary causes may include stress, medication, depression, vitamin deficiency, thyroid disease, alcohol, and head trauma. Permanent causes include severe head trauma, illness, brain disease and brain damage at birth.

2. Some disorders which may cause cognitive impairment include:

a. Depression - emotional sadness and withdrawal, usually caused by loss (of person, possession, health, choice, self-esteem).

b. Anxiety – persistent feelings of fear and nervousness.

c. Suspiciousness - distrust of others.

d. Delusion - false belief not supported by reality.

e. Paranoia – irrational feeling of being persecuted, suspiciousness, hostility.

f. Schizophrenia - suspiciousness, paranoia, and delusion resulting in inappropriate behavior.

g. Mental retardation – process which slows or stops a child's brain from maturing. Most common causes include difficult birth, Down's Syndrome, high fever, drug or alcohol abuse during pregnancy.

h. Dementia – progressive mental deterioration due to organic brain disease which causes structural changes within the brain. Alzheimer's Disease is the most common.

3. **Dementia causes progressive deterioration of memory, judgment, orientation, physical skills, language and communication.**

a. Behaviors common to residents with advanced dementia include sundowning, catastrophic reactions, wandering, pacing, pillaging, hoarding, agitation, anxiety, hallucinations, and delusions.

b. **Techniques used to reduce the effects of advanced dementia** and initiated only upon instruction from the nurse include: **1) Reality orientation** - helps resident remain aware of their environment, of time and of themselves. **2) Validation therapy** - helps resident improve dignity and self-worth by having their feelings and memories acknowledged. **3) Reminiscing** - allows resident to talk about past experiences, especially pleasant ones.

c. **Difficult behavior may result from too much stimulation, change in routine or environment, physical pain or discomfort, reactions to medications, and fatigue.** Responses to difficult behavior:

. 1) Remain calm. Speak slowly and clearly.

. 2) Avoid approaching the resident from side or back.

. 3) Try to calm the resident by holding hands, patting, singing, if appropriate.

. 4) Try to distract the resident's attention and redirect behavior.

. 5) Allow resident to express feelings if talking reduces agitation.

d. **Dementia resident needs assistance in the following areas**:

. 1) **Safety** (a) Monitor movement (wandering). (b) Do not move things around in room. (c) Watch for inappropriate use of objects (knives, forks, throwing things). (d) Check that clothing is worn properly (shoes tied, pants buttoned).

. 2) **Nutrition**(a) Assist resident to dining area when food is being served. (b) Have food ready to eat when placed in front of resident (seasoned, opened, cut, and buttered). (c) Allow resident more time to swallow and tell resident to swallow, if necessary. (d) Serve only one food at a time or serve finger foods, if appropriate. (e) Monitor food intake according to current nursing practices to assure adequate nutrition. (f) Check if resident is hiding food.

3) **Hydration**(a) Offer fluids more often and in smaller amounts to assure adequate hydration, if appropriate. (b) Listen for spoken cues that resident may be thirsty (using words like water, ocean, rain). (c) Watch for nonverbal signs that resident is thirsty (dry mouth, searching, smacking lips).

4) **Dressing**(a) Assist resident to choose appropriate clothing. Offer the resident a choice of two outfits. (b) Assist resident to dress properly. (c) Simplify dressing according to needs (snaps or Velcro instead of buttons).

5) **Bathing** (a) Prepare bathing area before bringing resident into room. (b) Explain procedure and allow resident to feel water to reduce anxiety. (c) Assist resident to bathe, as necessary, and check water temperature frequently since resident may be unable to tell

you if water turns too hot or too cold.

6) **Elimination**

(a) Take resident to bathroom frequently. (b) Provide perineal care as needed.

4. LNA's role:

a. Focus on what the resident can do. Do "with" and not "for" the resident.

b. Treat each resident as an adult, with respect and dignity.

c. Speak and move slowly. Never rush the resident.

d. Be consistent in approach, **do not force care**. Remain calm and speak softly if a resident becomes agitated. If resident is agitated, stop and try again later. **Never argue with the resident**.

e. Check resident frequently and always explain who you are and what you are doing.

f. Encourage daily exercise.

g. Give resident only one short, simple direction at a time and give resident extra time to process information and to respond.

h. Use eye contact and appropriate body language. The resident can sense impatience.

i. Watch resident's facial expressions and body language for feelings and moods.

j. Learn each resident's past routines and patterns.

k. Understand that all behavior has meaning. Try to discover that meaning.

l. Understand that wandering may be necessary for some residents.

ADDITIONAL DEFININTIONS:

Orientation – being aware of person, place and time **Sundowning** - increased confusion and restlessness in late afternoon, evening, and night **Catastrophic Reactions** – being abnormally overwhelmed by stimuli; easily startled **Pillage** – take what does not belong to you **Hoard** – to accumulate and hide **Agitation** – being overly excited **Anxiety** – worry or uneasiness about what may happen **Hallucination** – hearing, smelling or seeing things that are not there