The Impact of Dementia on Residents' Needs, CNA Workload, and Staffing

How are staffing needs in healthcare settings determined? In hospitals, to plan patient care administrators use a Patient Classification System. This is a method for determining how serious the patient's medical condition is, what level of nursing care the patient needs, and how many nurses must be on duty to ensure that patients get the care they need. The severity of a patient's medical condition and needs is referred to as acuity. When our loved elders become too frail to remain at home, we move them not to a hospital but to a long-term-care home. Still, residents of these homes are there because of declining health. They need care. Perhaps not the kind of care that calls for medical specialists and hi-tech equipment to be on hand. But they do need attention paid to their declining physical and cognitive health. Long-term-care homes use census as the basis for staffing. Acuity doesn't have the same imperative in these homes that it does in hospitals. It should. It must. My hope is that this essay will help persuade all who are concerned about the quality of life of those living and working in long-term care homes to advocate for staffing based on the cognitive acuity of residents.

The list below gives a picture of what the care challenges are in long-term-care homes when residents show symptoms of memory loss or other cognitive problems. (According to the CDC, this is nearly half the residents of nursing homes. The Alzheimer's Association has put this at two-thirds.) The ramifications of these symptoms for aides' workloads should be evident. These symptoms and their impact on workload serve as a rationale for using residents' cognitive acuity, rather than census alone, as the basis for staffing in long-term care homes.

One reason legislators don't pay more attention to staffing levels might be that they don't appreciate, in a visceral way, the symptoms of progressive dementia and how these symptoms affect aides' workload. Do administrators really comprehend what an aide's work day is like? Do state regulators realize how much time it takes just to assist with ADLs when a person shows symptoms of dementia? Or are they 'cognitively impaired' when it comes to understanding a workload impacted by cognitive loss. For example: CNAs are expected to encourage persons with dementia to function at their highest level, to do as much for themselves as the can and want to do. But a resident living with dementia who wants to dress herself might take twenty minutes to do this, needing an aide nearby to cue or assist as required. A Cognitive Acuity Assessment tool could, I believe, help administrators, families and legislators understand staffing needs in a concrete way.

A Cognitive Acuity Assessment tool is a descriptive list of the symptoms of dementia. This list isn't meant to be a discouraging forecast for those who, thanks to the support they have, may not show severe symptoms. The better the care a person has, the more a person diagnosed with dementia can retain functionality, with fewer and less severe behavioral symptoms. But insofar as persons do experience serious consequences of dementia, those who regulate care homes need to appreciate residents' needs, and staff accordingly. Below is what I think this tool might look like. If you are an aide working in a memory-care community, or a home care aide, or someone caring for a family member at home, these symptoms are familiar to you. They are your constant companions. I'm not sure they're as familiar to those who set long-term care staffing standards. If they were, we would have better staffing. These symptoms create behavioral challenges aides must and want to respond to effectively and compassionately, so our residents will feel secure, content, at home.

Those living with dementia may not exhibit every symptom mentioned; frequency and severity may vary greatly among persons and even in an individual from day to day or over months. But insofar as these symptoms are present at all, they have a substantial impact a CNA's workload.

1. Independent in ADLs but needs extended time to toilet, wash, dress and groom, eat.
2. Needs verbal or visual cues for washing, dressing, eating, toileting, grooming.
3. Needs assistance to complete the above tasks.
4. May have impaired hearing.
5. May have impaired vision.
6. May have gait or balance problems.
7. Uses cane, walker or wheelchair.
8. Is at risk for falls. Has fallen numerous times.
9. Forgets to use cane or walker.
10. One-person assist. Can't stand unaided for toileting, grooming, transferring.
11. Two-person assist. Cannot support self standing, cannot assist in transfers.
12. Difficulty using or comprehending speech.
13. Is losing words, including recall of names.
14. No longer uses words. Doesn't respond to words.
15. Has difficulty communicating needs and emotional states either verbally or by gestures.
16. Has significant short-term memory loss.
17. Asks for absent or long-dead family members.
18. Is repetitive in asking questions or expressing wishes.
19. Is incontinent, unaware of toileting needs.
20. Handles feces.
21. Becomes easily agitated, may yell.
22. Is argumentative.
23. Loses 'filters.' May use uncharacteristic profanity or insults.
24. May undress in public.
25. Is impatient when it's necessary to wait.
26. Can become physically combative.
27. Paces, wanders.
28. Attempts elopement.
29. Has sleep problems, insomnia.
30. Rummages (through drawers, etc.).
31. "Shops," i.e. takes things belonging to others.
32. Hoards or hides food, other possessions.
33. May crave food after eating a meal, denies having eaten.
34. Unable to follow multi-step instructions.
35. Can become 'stuck' in repetitive behavior.
36. Has difficulty initiating, sequencing or ceasing actions.
37. Has difficulty way-finding.
38. Has poor sense of time
39. Sundowns.
40. Recognizes changes in cognitive abilities yet denies any change.
41. No longer initiates conversation.
42. Unable to participate in games, crafts.

43. No longer comprehends what he//she reads.
44. Cannot participate in physical exercises.
45. Resists socializing, is more withdrawn.
46. Is subject to depression.
47. Is subject to manic episodes.
48. Has delusions or hallucinations.
49. Is prone to anxiety.
50. Seeks sexual or intimate physical contact with others against their wishes.

As dementia progresses in an individual and in the long-term care community, the amount of time a CNA needs to spend with residents increases. The number of CNAs needed on a shift increases accordingly.

As a CNA I beg you: please ensure that long-term care communities will have the staffing they need to ensure the well-being of residents and staff alike.