INTRODUCTION

Pam Tripaldi’s father received a diagnosis of Alzheimer disease in 2007. Tripaldi served as her father’s primary caregiver for the final four years of his life, during which he received care at several different hospitals. During these hospitalizations, she encountered near-miss patient safety events in which staff did not recognize her father’s dementia. Tripaldi contacted the Pennsylvania Patient Safety Authority in 2015 and recounted examples of situations in which hospital staff either obtained inaccurate information from her father or failed to provide the assistance necessary to support her father in activities of daily living, such as feeding himself.

Tripaldi said, “If you asked my dad his name and date of birth—sure, he knew that. But they would ask him things like ‘Have you had surgery?’ and he would say no. Well yes he did, he had quadruple bypass surgery!” She also described situations in which her father did not get out of bed or did not eat, because the staff asked him if he wanted to or if he needed assistance and he would say no. “And sometimes I just couldn’t be upset with the staff, because I am not sure what information they were privy to because of HIPAA [Health Insurance Portability and Accountability Act].”

In looking for solutions to this problem, Tripaldi considered colored wristbands. “He wore a wristband for fall risk and another one for allergies.” Tripaldi asked, “Couldn’t he wear a wristband so that everyone would know that he had dementia?” Tripaldi blogs about this experience, communicates with other patients and family members with similar hospital experiences, and works with a chapter of the Alzheimer’s Association to raise awareness about the issue. Initially, she proposed using a purple wristband to identify patients with dementia, because that is the color for Alzheimer disease. After discovering that purple is the color used to indicate DNR (i.e., do not resuscitate), Tripaldi began to advocate for use of a black wristband because, “Alzheimer’s is a disease that is dark, fearful and lonely to the patient, family members and caregivers. It also brings to mind the POW and MIA flag, which like our loved ones, are lost but never forgotten.”

In response to this inquiry, Authority analysts queried the Authority’s Pennsylvania Patient Safety Reporting System (PA-PSRS) database for reports of events similar to those described by Tripaldi to determine what events had been reported for patients with dementia. Analysts were particularly interested to learn whether any reports mentioned use of colored wristbands to communicate a diagnosis of dementia, because the Authority has written about the risks involved in using colored wristbands to communicate clinical information, other than patient identification, and has suggested that hospitals limit the number and standardize the meanings of specific colors used for patient wristbands. The Authority has also warned of potential risk associated with the use of colored community wristbands (e.g., yellow Livestrong bracelets) not sanctioned for hospital use.

Authority analysis of events revealed similar instances in which inaccurate information or consent was obtained from patients with dementia or potentially unrecognized dementia. Risk reduction strategies targeted these failure modes include screening for dementia, assessing capacity, identifying and communicating with surrogate decision makers, and standardizing communication of a patient’s dementia diagnosis with all hospital staff. (Pa Patient Saf Advis 2016 Mar;13[1]:1-10.)

* The HIPAA Privacy Rule can be misinterpreted as prohibiting the communication of patient medical information between healthcare providers and hospital staff. The rule allows for disclosure of this information for treatment purposes, and requires that hospitals develop policies to identify staff that require access to this information and the minimum amount necessary to carry out their job duties and provide care to the patient. For more information please see: http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/minimum-necessaryrequirement/index.html
REVIEWS & ANALYSES

and dementia care guidelines. Other ideas to improve patient identification were gathered from interviewing hospital staff, family members of patients with dementia, and dementia advocacy groups.

Background
Dementia is a neurocognitive disorder characterized by an insidious onset and gradual decline in cognitive function that results in an inability to carry out activities of daily living independently. Multiple causes for dementia exist; the most prevalent form is Alzheimer disease, which comprises 60% to 80% of cases.4 See “Recognizing Dementia and Dementia Due to Alzheimer Disease.”

The prevalence of dementia increases with age, with estimates ranging from 1% to 2% of adults at age 65 up to 4% by age 85.4 The Alzheimer’s Association estimates that 270,000 adults age 65 or older received a diagnosis of Alzheimer disease alone in Pennsylvania in 2015, and there will be 320,000 by 2025. Nationally, this number was 5.1 million in 2015 and is expected to increase to 7.1 million by 2025. Because of the large number of aging baby boomers and extended life expectancy of the general population, this number is predicted to reach 13.8 million by 2050.5

Despite increasing prevalence of dementia, many individuals with this condition do not have a documented diagnosis. In fact, investigators estimate that physicians fail to recognize dementia in 19% to 67% of patients in the outpatient setting—particularly in patients in earlier stages of disease with milder forms of cognitive impairment.6-8 In these patients, cognitive deficits may not be detected, or when they are, they are incorrectly attributed to normal aging9 or mild cognitive impairment.9

Deficits in the cognitive domains of memory and learning (present in all cases of possible or probable Alzheimer disease, language, and complex attention can directly impede an individual’s ability to recall, communicate, or understand information necessary to participate in medical decision-making, especially in later stages of dementia.10-12 For these reasons, it is important to obtain information from a family member or other reliable informant when assessing or treating a patient with dementia.13-14

A diagnosis of dementia does not preclude a patient from actively participating in his or her own decision making and care; many are able to express values and preferences relevant to medical decisions. However, with advanced dementia, a shift to shared decision making (i.e., involving the patient and a family member or other surrogate), and ultimately delegated decision making (i.e., reliance on a surrogate decision maker) becomes necessary.11-12

METHODS
Pennsylvania Patient Safety Authority analysts identified events involving patients with dementia by querying the Authority’s PA-PSRS database for events containing the terms “dement” and “Alzheimer” (including misspellings) that were reported over a 10-year period, from January 2005 through December 2014. Analysts also queried the PA-PSRS database for events reported for patients age 65 or older that contained the term “poor historian” to identify events involving patients with possibly unrecognized

RECOGNIZING DEMENTIA AND DEMENTIA DUE TO ALZHEIMER DISEASE

According to the American Psychiatric Association, the following criteria must be present to establish a diagnosis of dementia (i.e., major neurocognitive disorder) and dementia due to Alzheimer disease.

Dementia
— Significant deficits are identified in one or more of the following cognitive domains: complex attention, executive function, language, memory and learning, perceptual-motor skills, or social cognition.
— Cognitive deficits impair the individual’s ability to carry out everyday activities independently (e.g., paying bills, managing medications).
— These deficits are not attributable solely to delirium or better explained by another mental disorder.

Dementia due to Alzheimer disease
— Criteria for dementia are met AND an Alzheimer disease genetic mutation is identified from family history or genetic testing.
— Cognitive decline occurs slowly over time, with deficits seen in memory and learning and at least one other cognitive domain.
— Cognitive function declines steadily over time, without extended plateaus.
— These cognitive deficits are not better explained by other physiologic or psychiatric causes (e.g., cerebrovascular disease, substance abuse, other mental disorders).

Keywords, Similar Events, and Failure Modes
Analysts identified 627 event reports that contained the keywords “historian,” “wrong,” “said,” “aware,” “consent,” “didn’t,” and “know.” Of these, 63 event report narratives described events similar to those described by Tripaldi; the majority were reported as errors related to procedures, treatments, or tests (n = 47). Five failure modes were identified through iterative thematic analysis of these 63 event report narratives (see Figure).

PA-PSRS Events
The following is an example of a patient safety event in which inaccurate information and informed consent was obtained from a patient who was not initially recognized as having dementia by members of the healthcare team.*

A [male older than 80 years] identified himself and stated that he was to get injections in his left lower back for left low back and leg pain. The surgical consent signed by the patient stated right low back, as well as paperwork in his chart. I notified the surgical resident who then changed the consent to the left side. Upon entrance to the operating room, I informed the attending surgeon of this situation and he said that the patient has dementia and his son signs his paperwork. The surgical resident called the patient’s physician to clarify, then returned to say that we would now be doing the patient’s right side.

The following two reports describe instances in which informed consent was obtained from patients with established diagnosis of dementia, without the input of family members.

When reviewing the chart of a [male older than 75 years] before doing a surgical procedure, I discovered that there was no consent. My managers called the unit and the consent was sent down to them from the floor. The patient was on contact isolation precautions, so I was unable to leave the room to look at the consent. My managers called into the room to say that it was okay to proceed. After the case ended I looked at the consent and found that it had been “signed” by the patient who has Parkinson’s and dementia and was not very responsive. His signature looked like a scribbled line on the paper. The consent was not signed by next of kin or any person capable of giving consent for the procedure.

A [female older than 90 years] with a history of dementia was scheduled for an interventional radiology (IR) procedure. The family left to get something to eat and returned to find the patient had been sent down to IR. The nurse taking care of patient called IR to report that the consent for the procedure had not yet been signed and was told that consent would be obtained in their department. The nurse was told that the patient needed to be sent down because the physician was there and ready to proceed. The family returned and was very upset. IR was called and told to stop until the family could come down. The consent was signed by the son. The family spoke with a patient representative about this near miss and concern about confused patients signing consents.

The following report describes an event in which information was obtained from a patient older than the age of 80 who was noted to be a “poor historian” but does not mention a diagnosis of dementia or Alzheimer disease. Though reported as an Incident without harm to the patient, this event involved a surgical procedure that
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A [male older than 80 years] is a poor historian who denied having hardware in his leg prior to surgery. During surgery to amputate the leg, the surgeon encountered an intramedullary rod. Orthopedic surgery was consulted and an x-ray was done to see the extent of the rod. Under the supervision of the orthopedic surgeon, the attending surgeon cut the rod. The surgery was completed without further incident.

Lack of Methods to Identify Patients with Dementia

Two hundred fifty-two event reports for patients with dementia or potentially unrecognized dementia (N = 3,710) described the use of colored wristbands to communicate fall risk. Five described using fall-risk signs, and three described using colored wristbands or gowns to communicate risk for wandering or elopement. Although cognitive impairment contributes risk for each of these events, no reports described the use of these methods to identify patients with dementia or other cognitive impairment, independent of these indications.

DISCUSSION

Events reported through PA-PSRS suggest that failing to communicate a patient’s dementia diagnosis to all members of the healthcare team is a valid concern in Pennsylvania hospitals. However, it is only one of the aforementioned five failure modes (see Figure), all of which are worthy of attention.

Failure to Recognize Preexisting Dementia

PA-PSRS event reports describe situations in which members of the healthcare team failed to recognize that a patient had dementia. Factors that may contribute

Note: Illustrated modes categorize 63 events in which hospital staff obtained inaccurate or incomplete information or consent from patients with dementia or potentially unrecognized dementia. Failure mode total exceeds event total because some events involved multiple failure modes.
to a missed diagnosis of dementia include the following:

Cognitive aging. Some cognitive changes are to be expected with normal aging. These changes are associated with structural and functional changes in the brain that occur over a person’s lifetime. The types and rates of these cognitive changes are influenced by a multitude of factors (e.g., genetics, educational level, health status) and vary widely among individuals.15-16 In general, as people age, gradual declines occur across all domains of cognitive functioning, and steeper declines are seen with advanced age. As a result, cognitive declines can be expected in the majority of the oldest members of society.15-16

Mild cognitive impairment. Mild cognitive impairment is an interim clinical diagnosis that bridges the gap between normal cognitive aging and dementia.21 It is diagnosed when a person’s cognitive function is impaired beyond what would normally be expected for their age and educational level, but this impairment does not interfere with instrumental activities of daily living. Once the ability to carry out these activities independently is impaired, criteria for dementia are met. People with mild cognitive impairment are at high risk for developing subsequent dementia.4,10,15

Education level and cognitive reserve. When asked why she thought hospital staff did not recognize her father as having dementia, Tripaldi said, “My father was a brilliant man, and he could hide it well.” Cognitive declines can be smaller and less noticeable among patients with higher educational levels and good baseline cognitive functioning.15-16 The theory of cognitive reserve suggests that higher levels of education, occupational complexity, reading ability, and IQ protects the brain, allowing it to function at a high level for a longer period of time and compensate for the pathologic changes that cause dementia. However, once a threshold of structural changes has been reached, symptoms become noticeable, and cognitive function usually declines rapidly.18-20

Protocols for screening and diagnosis. “You would never know my father had dementia, unless you were asking him specific screening questions,” Tripaldi said. A large number of tools exist to screen for cognitive impairment, but none are recognized as the gold standard for screening and diagnosis of dementia.22-23 The Mini-Mental State Examination (MMSE) has been widely researched and is the screening tool most commonly used by primary care providers and geriatric specialists. The MMSE takes 10 minutes to administer and is used to assess cognitive ability within five domains: orientation, registration, attention and calculation, recall, and language.23

The Clock Drawing Test (CDT) and the Mini-Cog are two brief screening tools that have become more widely used, either alone or in conjunction with the MMSE.23 The CDT takes about one minute to administer; the patient follows specific instructions to draw the face of a clock and cognitive impairment is identified through application of scoring criteria to elements in the patient’s drawing.24 The Mini-Cog takes about three minutes to administer and combines the CDT with a threethreeitem delayed word recall test.25-27

Failure to Assess Competence and Decision-Making Capacity

Analysis of PA-PSRS event reports suggests that in some events in which information or consent was obtained from patients with dementia, staff did not recognize impaired competence and decision-making capacity. Although it is important to preserve autonomy and agency through engaging patients with dementia in decision-making,28-29 it is also important to assess their capacity to do so.10,15 Competency is the legal term for this ability, and capacity is the clinical term.22 In Pennsylvania, “incapacitated adult” is the legal term used to describe a person “whose abilities to receive and evaluate information effectively and communicate decisions in any way are impaired to such a significant extent that they are partially or totally unable to manage their financial resources or to meet essential requirements for their physical health and safety.”31

Ideally a patient who is deemed competent would have the capacity to understand treatment options (including risks and benefits), make a decision, and explain the rationale or values that support their decision. In patients with memory impairment, this decision may be forgotten, but the patient may still be judged to have decision-making capacity if he or she makes the same decision when presented with the same information at another point in time.32

Drane outlined a sliding scale model to determine competence in patients with dementia. According to the model, awareness of one’s medical condition and assent (i.e., “going along with”) may be sufficient when a medical decision has low potential to result in harm. As the potential for harm increases, a deeper understanding or appreciation of risks and benefits, along with the ability to provide a rationalization for a decision, may be required.34

Failure to Identify a Reliable Historian or Surrogate Decision Maker

Events have been reported through PA-PSRS in which hospital staff have failed to identify a reliable historian or surrogate decision maker for a patient with dementia or other cognitive impairment. If a patient with dementia arrives unaccompanied, clinicians may struggle to identify the appropriate historian or surrogate decision maker even to determine whether one exists.
In the event that a patient with dementia is deemed to be an “incapacitated adult” and has not established a surrogate decision maker, Pennsylvania law allows for a court-appointed guardian. Any person concerned about the welfare of an incapacitated person may initiate this process. The orphan’s court will then appoint a guardian, giving preference to someone named by the incapacitated person. In urgent situations a temporary guardian may be appointed for a 72-hour period, with extensions for up to 20 days. In emergencies, healthcare providers may deliver necessary medical care without consent or guardianship, if it can be determined that a reasonable person would have consented to such treatment.

Failure to Contact a Reliable Historian or Surrogate Decision Maker

Tripaldi expressed frustration with “a lot of little things” that happened when she was not by her father’s side and hospital staff failed to contact her. “I tried to be there as much as I could. Nothing terrible happened, thank goodness. But I am sure there are people who have had things happen with disastrous results.”

Events have been reported through PA-PSRS in which a reliable historian or surrogate decision maker for a patient with dementia was known to exist but was not contacted by hospital staff. In some event reports it is unclear whether an attempt was made to contact this person, and in other reports attempts to contact the person were unsuccessful. Some events resulted in delayed or missed patient care. In other events care was provided, but family members or other members of the healthcare team raised concerns or questioned the appropriateness of proceeding without this communication.

Failure to Communicate the Patient’s Dementia Diagnosis, Competence, and Decision-Making Capacity

A review of event reports suggests that even in cases in which a patient’s dementia diagnosis is established and their competence and capacity for decision-making has been evaluated, information is not consistently communicated to members of the healthcare team. Ideally, this information would be communicated during patient hand-off, defined by Cohen and Hilligoss as “the exchange between health professionals of information about a patient accompanying either a transfer of control over, or of responsibility for, the patient.” But even when communicated during hand-off, this information may not be made known to other hospital staff.

THE ALZHEIMER’S/DEMENTIA HOSPITAL WRISTBAND PROJECT

Gary LeBlanc is the founder of the Alzheimer’s/Dementia Hospital Wristband Project. Like Tripaldi, LeBlanc served as primary caregiver to his father, who had Alzheimer disease. LeBlanc said, “One day I looked at my dad and realized, ‘My goodness, I know this man better than he knows himself.’ He didn’t know where he grew up, he didn’t know any of his brothers or sisters, he didn’t recognize any of his friends. And, when he went to the hospital, who were they asking for the answers to questions? Him!”

LeBlanc said, “There’s nothing that happens in the hospital that doesn’t involve a question. ‘How do you feel? What do you want for lunch?’ These questions are the root of all evil for people with dementia.”

In response, he developed the Wristband Project in collaboration with Bayfront Health of Brooksville hospital leadership and the local chapter of the Alzheimer’s Association (Brooksville, Florida). Like Tripaldi, LeBlanc originally wanted to use a purple wristband to identify patients with dementia, but learned that this could be confused with DNR in some hospitals. Hospital staff were also concerned with using wristbands to communicate a diagnosis, because of HIPAA privacy rules that prohibit sharing personal health information. Ultimately, the team decided to use the purple angel logo, a symbol used internationally to raise awareness of dementia and to recognize dementia-friendly communities.

Nurses screen patients for cognitive impairment upon admission using the Mini-Cog and place a dime-sized sticker with the purple angel logo on the identification wristband and a purple angel sign outside the room for patients who screen positive. “The purple angels do not say that this patient has a specific diagnosis,” LeBlanc said. “It is simply an ‘at-risk’ symbol that says that this patient has, or possibly has cognitive issues, and that all information provided by the patient needs to be verified.”

Margaret Gordon, chief quality officer and interim chief nursing officer at Bayfront Health of Brooksville, further clarifies: “The purple angel indicates cognitive impairment, but we do not use it for patients with delirium. We do not want staff to assume that an older person has dementia, when in fact they have delirium due to an acute cause that should be identified and corrected.”

Gordon reports success in improving care and preventing adverse events for patients with dementia since implementing the wristband project in 2013. When asked whether the wristbands were the key, she said, “The key is education.” LeBlanc and his team provide education to all hospital staff, both clinical and non-clinical, as well as volunteers and first responders. “We have raised awareness. But,” Gordon said, “only hospitals with a strong patient safety culture and a commitment to…"
improving care for patients with dementia may be able to maintain this awareness.”

LeBlanc echoes Gordon’s emphasis on education, “The truth of the matter is that the training is at the heart of this program. And with the number of individuals with dementia that we see coming in the future, we are going to have a major problem in five years if we don’t start preparing right now.” (For more information on the Alzheimer’s/Dementia Hospital Wristband Project, go to www.common-sensecaregiving.com.)

RISK REDUCTION STRATEGIES

The following strategies are suggested to hospitals seeking to improve care for patients with dementia and their family members:

Lay the Groundwork

— Assemble a multidisciplinary team to design improved care processes for patients with dementia. Suggested members include a physician and nurse with dementia expertise (i.e., specialization in geriatrics, neuroscience, or psychiatry), a social worker, and administrative staff.13,39-41

— Solicit input from patients with dementia and their family members to identify challenges and guide improvement efforts.37,42

— Form partnerships with dementia advocacy groups, such as local chapters of the Alzheimer’s Association, to identify resources and educational materials available for patients, their family members, and hospital staff.13,37

— Educate hospital staff (both clinical and non-clinical), volunteers, and first responders about dementia, including signs and symptoms, problems commonly faced in the healthcare setting, communication strategies, and resources available to support patients, their family members, and staff.13,37,41

Screen for Cognitive Impairment and Assess Capacity

— Screen all patients for cognitive impairment upon admission.34,37

— Refer patients who screen positive for cognitive impairment for further evaluation by a dementia specialist or team.39-41

— Assess patients with dementia for competency and capacity for decision making.13,39-41

Identify and Communicate with Surrogate Decision Makers

— Identify existing surrogate decision makers by communicating with patient family members and other care providers and reviewing all medical and legal documents.13

— Obtain informed consent from surrogate decision makers for patients deemed to lack competency or capacity for decision making.43

— Provide resources to help patients and families seeking to create advanced directives or designate surrogate decision makers. (The American Bar Association Commission on Law and Aging44 and the Alzheimer’s Association45 provide a comprehensive array of resources to assist patients with dementia and their family members with these tasks.)

— Consult hospital legal counsel and social work department for patients deemed to lack competency or capacity for decision making who do not have a designated surrogate decision maker.33,43-44

— Engage family members or surrogate decision makers in developing a plan of care for the patient with dementia.42

— Ask family members to verify all information provided by patients with dementia whenever possible.37

Standardize Communication with Hospital Staff

— Communicate the patient’s dementia diagnosis and all relevant information necessary to provide care for the patient, during each patient handoff (e.g., competency determination, assistance required with activities of daily living, contact information for the patient’s family member or designated surrogate decision maker).

— Consider using visual indicators that allow all hospital staff to readily identify patients with cognitive impairment and provide appropriate care.37

CONCLUSION

Dementia is a common condition in older adults that is often overlooked by clinicians and other hospital staff. Family members have expressed frustration and fear of adverse events that could result from this failure to recognize dementia and from obtaining inaccurate information or consent from patients with dementia. The Authority has received event reports through PA-PSRS and information through direct communication from family members of patients with dementia to suggest that such events do occur in Pennsylvania. Strategies to improve care and safeguard patients with dementia in the hospital include screening for dementia, assessing competency and capacity for decision making, identifying and communicating with surrogate decision makers, and standardizing communication of a patient’s dementia diagnosis with all hospital staff.

Acknowledgments

Edward Finley, BS, Pennsylvania Patient Safety Authority, contributed to the data collection and analysis for this article.
NOTES


LEARNING OBJECTIVES

— Identify strategies to improve care for hospitalized patients with dementia.

— Identify factors impacting the recognition and diagnosis of dementia.

— Recall the predominant failure modes for events involving patients with dementia, as identified in reports to the Pennsylvania Patient Safety Authority.

— Recognize assessment findings that correlate with diagnostic criteria for dementia.

— Distinguish between situations in which it may or may not be necessary to communicate with family members or surrogate decision makers for patients with dementia.

SELF-ASSESSMENT QUESTIONS

The following questions about this article may be useful for internal education and assessment. You may use the following examples or develop your own questions.

1. All of the following are risk-reduction strategies that a hospital can use to improve care for patients with dementia except:
   a. Solicit input from patients with dementia and their family members to identify challenges and guide improvement efforts.
   b. Screen all patients for cognitive impairment upon admission.
   c. Limit communication of a patient’s dementia diagnosis to clinical staff only.
   d. Obtain informed consent from surrogate decision makers for patients deemed to lack competency or capacity for decision making.

2. Each of the following statements regarding dementia is false except:
   a. The number of Pennsylvanians diagnosed with Alzheimer disease is expected to double between 2015 and 2025.
   b. Physicians may fail to recognize dementia in up to two-thirds of patients in the outpatient setting.
   c. The Mini-Mental State Examination is recognized as the gold standard for screening and diagnosis of dementia.
   d. The Health Insurance Portability and Accountability Act Privacy Rule prohibits the sharing of patient diagnoses with non-clinical hospital staff.

3. Complete the following sentence: The failure mode most frequently identified in events reported to the Authority involving patients with dementia was ________.
   a. failure to recognize preexisting dementia
   b. failure to assess competence and decision-making capacity
   c. failure to identify a reliable historian or surrogate decision maker
   d. failure to contact a reliable historian or surrogate decision maker
   e. failure to communicate a patient’s dementia diagnosis, competence, and decision-making capacity
An 87-year-old man is admitted with anemia and a possible gastrointestinal bleed. During the history and physical, the patient tells you that he is a retired mechanical engineer and his wife passed away two months ago. When assessing his orientation, you notice he pauses a long time before telling you the date and then laughs it off, saying “all the years run together when you’re my age!” Later, you notice a calendar on the wall behind you, within the patient’s direct line of sight—but you dismiss this as a coincidence. When reviewing his medication list, the patient tells you that he takes an aspirin, a multivitamin, and a “water pill.” When asked about timing and dosages, he tells you that he doesn’t really have a schedule and that he doesn’t feel like he really needs “all these pills.” Later, when looking at notes in the electronic health record from his most recent hospital stay two months ago, you read that his wife passed away three years ago, and that he was discharged on 10 medications, including metoprolol and omeprazole.

4. In the above scenario, which combination of assessment findings is MOST suggestive of dementia?
   a. Age older than 85 and high level of education
   b. Age older than 85 and deficits in memory
   c. Deficits in memory and high level of education
   d. Deficits in memory and inability to manage his medication regimen

A diagnosis of dementia is established for the patient described above, and he is deemed to have decision-making capacity; however, he asks that his son be included in any healthcare decisions. Three days into his hospital stay his hemoglobin drops to 7g/dL and the patient becomes lethargic and confused. The attending physician has decided that he requires an emergent transfusion because his hemoglobin continues to drop and he is symptomatic, but the patient is now unable to provide consent. The patient’s son cannot be reached by phone over multiple attempts.

5. Which of the following BEST describes the appropriate actions to be taken in this scenario?
   a. Transfuse the patient, despite the lack of consent.
   b. Delay the transfusion until the son can be reached to provide consent.
   c. Administer haloperidol to treat the patient’s superimposed delirium so that he can provide informed consent.
   d. Ask hospital legal counsel to contact the orphan’s court to establish temporary guardianship before transfusing the patient.

On the day of discharge for the patient described in the preceding scenarios, the day shift nurse is prepared to review the discharge instructions with the patient and his son before the end of her shift; however, the son is running late. The patient has a friend visiting—an older woman who hasn’t visited before. Just as the day shift nurse finishes giving report to the evening shift nurse, the son calls the unit to say that he is downstairs with the car, and asks if his father can just be sent down to the lobby.

6. Which of the following BEST describes the appropriate actions to be taken by the day shift nurse?
   a. Review the discharge instructions with the patient and tell him to make sure he gives his son the paper copy.
   b. Review the discharge instructions with the patient’s friend and ask her to convey the instructions to the patient’s son.
   c. Send the patient down to the lobby and ask the patient transporter to give a paper copy of the discharge instructions to the patient’s son and to tell him to call you if he has any questions.
   d. Ask the patient’s son to come to the unit so that the day shift nurse can review the discharge instructions with the patient and his son.
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