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מַכְסֵן בְּחַקְדֵּיָה לְגַהֲרָטוֹלוֹגִיה
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BROOKDALE INSTITUTE OF GERONTOLOGY
AND ADULT HUMAN DEVELOPMENT IN ISRAEL

COGNITIVE IMPAIRMENT AND THE QUALITY
OF CARE IN LONG-TERM CARE INSTITUTIONS

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Arnold Rosin
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Robert Schwartz

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Cognitive impairment and the quality of care in long-term care institutions

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Abstract - This study sought to determine whether cognitively impaired elderly in long-term care institutions receive a lower quality of care than do the non-impaired. The quality of care for each of 136 elderly in nine units for independent, frail and nursing residents was examined through the tracer method. On the basis of the MSQ test and an assessment by the ward nurse, a composite scale for measuring cognitive impairment was developed. Sixty-one percent of the elderly were found to suffer moderate to severe cognitive impairment. The cognitively impaired patients were found to receive poorer nursing care and staff were unaware of the existence of a greater proportion of their medical problems, compared with the non-impaired. The findings suggest that the lower quality care provided to the cognitively impaired is related to their greater behavioral and social problems such as aggressiveness and apathy. Staff members are apparently less inclined to have contact with patients displaying such problems. Changes of referral policies and training programs for institutional staff on the care of the cognitively impaired elderly are necessary in order to improve care for this group.

Key words: differential quality of care; cognitive impairment - consequences; cognitive impairment - elderly; composite cognitive impairment scale; cognitive impairment - nurse assessment.

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A large proportion of the elderly in nursing homes in many countries, suffer from cognitive impairment ranging from moderate memory loss to severe dementia (1, 2). Cognitively impaired patients are found not only in special psychogeriatric units, but also in the general wards of institutions.

Many cognitively impaired patients suffer from a complex of physical illnesses and require considerable nursing care (3). Because of the coincidental dementia, confusion and communication difficulties, however, they may be unable to make known their needs to the staff. Staff may be inclined to dismiss or pass them by because of their bizarre behavior, lack of communication ability, or personal doubts about the value of treating such demented patients. It might be expected, therefore, that differences will appear between the care given to cognitively impaired and those cognitively normal old people who suffer similar degrees of physical disability. Indeed, it has been suggested that cognitively impaired elderly receive lower quality care than do the non-impaired but this contention has yet to be supported by quantitative data (4, 5, 6).

The present paper examines a) whether the quality of care for medical and nursing problems in institutions dif-

fers between residents with and without cognitive impairment, and b) the usefulness and reliability of a field methodology that employs ward nurses to gather data on cognitive impairment among elderly patients.

The data for this paper were obtained from an in-depth study of the quality of institutional care in Israel (7).

Methods

Data collection

The study was conducted in nine long-term care units. Four were in private and five in public institutions. Two of the units were for independent elderly, three for frail elderly and four were nursing units. Previous to sampling, government surveyors were asked to classify the units as "good" or "poor" based on their familiarity with them. Five of the units were thus implicitly assessed as "good" and four as "poor". A multidisciplinary team collected data from medical and nursing examinations and interviews with staff and 136 residents (a 36% sample of the patient population).

Elderly patients were interviewed and examined by a research physician, nurse, oral epidemiologist and occupational therapist regarding selected conditions characterising their state of health and

behavioral activities. These conditions were referred to as "tracers". The ward nurse, the treating physician and the social worker (or matron) of the unit were asked to describe each sampled resident with regard to the tracer conditions and care given. Medical and social records were reviewed by the research team. Similarly, the physician, nurse, social worker and director of the institution were questioned about responsibility, regulations, policy and work organization. On-site observations were made regarding staff-resident relationships and institutional facilities.

The tracers

The tracer method uses a set of well-defined and often-occurring problems which provide information on specific facets of a care delivery system. The methodological assumption is that the care provided for tracer problems is an indicator of the quality of care provided for other problems, and thus the quality of the entire system can be deduced (8).

Eight tracers reflecting medical and nursing problems were selected (Table 1). Using Kessner's criteria, a problem was defined as a tracer if it had a high prevalence, a significant functional impact, a definite diagnosis, standard manage-

ment, and the likelihood that proper care would positively influence the patient's condition.

Sampled patients were scored on the quality of care afforded them, based on: 1) staff awareness (physician, nurse, social worker) of the existence of specific problems, and 2) provision of treatment for these tracer problems.

Two quality of care indices were constructed for the medical and nursing domains: awareness indices – the number of problems of which the staff was aware expressed as a percentage of the resident's total number of problems as defined by the research team, and treatment indices – the number of treated problems expressed as a percentage of the resident's total number of problems.

Measurement of cognitive impairment

Evaluation of the cognitive status of elderly patients was based on two sources. The Mental Status Questionnaire (MSQ) (9) was translated and modified after pilot testing. Further, a set of eight questions was put to the ward nurse concern-

ing each patient. The questions elicited the nurses' perceptions of time and space orientation among the patients, identification of familiar persons, and ability to comprehend and to speak coherently.

Three scales based on different sources of information were constructed for the test population:

1) MSQ: classified into three categories; no impairment with scores ranging from 0–2; moderate, 3–7; and severe, 8–10 points. This follows the original scale.

2) Nurse assessments: classified into three categories denoting no impairment, moderate impairment and severe impairment.

3) A combination of the above scales, or a composite scale, in which all residents were included.

Examination of the degree of overlap in those cases (112) for which both the MSQ and the nurse assessment were obtained revealed that almost all cases in which the nurse indicated moderate or severe impairment were also scored as impaired according to the MSQ. The reverse did not hold true: in many cases

patients scored as moderately or even severely impaired according to the MSQ were not considered as such by the responsible nurse. This underestimation on the part of the nurse is likely due to the fact that not all aspects of cognitive impairment as measured by the MSQ are expressed in a resident's everyday behaviour. At this point in the analysis, five cases for which there was no MSQ assessment and which the nurse evaluated as non-impaired were dropped, leaving 129 cases in the composite measure.

Those elderly who could be tested by the MSQ were scored accordingly. Those who could not be tested by the MSQ because of refusal, deafness, language problems or confusion were scored according to the nurse's assessment. The scoring combined moderate and severe impairment into one category, allowing a final classification of patients as impaired or not impaired.

Behavior was assessed according to ward nurse reports that evaluated degree of cooperation, aggression, depression and apathy (always, sometimes or never).

Results

Prevalence of cognitive impairment

Comparison of the measures of cognitive impairment (Table 2) indicates that the MSQ scores showed a higher prevalence of moderate impairment (42%) than the nurse's assessment (19%). Both types of assessment, however, registered a similar prevalence of severe impairment. Sixteen percent of the sample population were unable to respond to the MSQ test. These residents were graded according to the nurse's assessment and are included in the composite measure upon which the following analysis is based.

According to the composite measure 61% of the sample test population suffered from some degree of cognitive impairment (Table 3). There was little difference in age between impaired and non-impaired elderly. More than 90% of those of Asian-African origin were impaired, compared to 52% of those of European-American origin (following a common division of the Israeli Jewish population according to country of origin, with Israel-born elderly subsumed under Europe-America). The group with cognitive impairment had an average 5.6 years of schooling as opposed to 11.2 for the non-impaired.

Table 1. Quality of care tracers and treatment indicators

Problem	Medical tracers		Nursing tracers	
	Treatment	Problem	Treatment	Problem
Hypertension	blood pressure measurements at least every 2 months	mobility problems	receives help in getting around	
Visual problems	visit to ophthalmologist or optometrist in past year	difficulty in brushing teeth	receives help in brushing teeth satisfactory oral hygiene	
Hearing problems	visit to audiologist or been treated for hearing problems by a doctor in the past year	difficulty washing	receives help in washing satisfactory state of cleanliness	
Oral health problems	oral check-up during past year denture repair	difficulty dressing	receives help in getting dressed satisfactory clothing condition	

Table 2. Prevalence of cognitive impairment by different measures

Cognitive status	MSQ (n = 112)	Nurse assessment (n = 134) ^a	Composite measure (n = 129) ^b
No impairment	45.1	66.3	no impairment
Moderate impairment	41.9	19.0	impairment
Severe impairment	13.0	14.1	
Total	100.0	100.0	100.0

^a In two cases no nurse assessment was obtained.

^b To avoid a false negative bias, five cases for which there was no MSQ assessment and which the nurse evaluated as non impaired, were dropped.

Table 3. Cognitive impairment, by sex, age, origin, and years of schooling

Cognitive status	Sex (%)		Age (average)	Origin (%)		Years of schooling (average)	Total
	Male (n=32)	Female (n=97)		Asia/Africa (n=24)	Europe/America (n=102)		
No impairment	36.2	40.2	82.8	7.6	47.8	11.2	39.2
Impairment	63.8	59.8	81.1	92.4	52.2	5.6	60.8
Significance according to Chi-square test	NS	NS		p<0.01		p<0.01	

Table 4. Cognitive impairment¹, by type and quality of ward²

Cognitive status	Nursing wards			Independent and frail wards			Total	
	Good (n=15)	Poor (n=21)	Total (n=36)	Good (n=56)	Poor (n=37)	Total (n=93)	Good (n=71)	Poor (n=58)
No impairment	15.5	0	6.5	66.7	29.4	51.7	55.9	18.9
Impairment	84.5	100.0	93.5	33.3	70.6	48.3	44.1	81.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

¹ By composite measure.² As assessed by government surveyors

Table 5. Selected aspects of affective and social functioning by cognitive impairment (%)

	Cognitive status			Significance (χ ² test)
	Impaired (n=78)	Non-impaired (n=51)	Total (n=129)	
<i>Affective functioning</i>				
Not cooperative				
always, sometimes	47.7	13.4	34.2	
never	52.2	86.6	65.8	p<0.01
Aggressive				
always, sometimes	57.5	17.2	36.6	
never	42.5	82.8	63.3	p<0.01
<i>Social functioning</i>				
Apathetic				
always, sometimes	37.9	8.1	26.0	
never	62.1	91.9	74.0	p<0.01
Depressed				
always, sometimes	50.5	33.8	43.5	
never	49.5	66.2	56.5	NS

The prevalence of cognitive impairment was examined in terms of the type of unit and with regard to the grading of ward quality—good or poor—as assessed by government surveyors (Table 4). Ninety-four percent of nursing ward patients showed cognitive impairment; in wards of poor quality this figure rose to 100%. Almost half of the patients in frail or independent wards suffered from some mental impairment, with an even higher figure of 70% in the poorer quality wards.

Behavioral problems as reflected in lack of cooperation, aggression, apathy and depression according to ward nurse assessment, were significantly more

prevalent among the cognitively impaired (Table 5). Approximately half of the cognitively impaired were non-cooperative, in contrast to only 13% of the non-impaired; 58% of the former were aggressive compared to 17% of the latter. Poor social functioning as exhibited through apathy occurred in 38% of the cognitively impaired versus only 8% of the non-impaired. Depression was found in 51% and 34% of the impaired and non-impaired, respectively.

Health status

The frequencies of nursing problems were significantly higher among impaired

than among non-impaired elderly (Table 6). For example, difficulty in washing was noted in 85% of the cognitively impaired compared to 45% of the non-impaired ($p<0.01$). Regarding medical problems, no significant differences were found between the two groups in regard to hypertension and visual or hearing difficulties, but oral health problems were noted in 90% of the group with cognitive impairment compared to 70% among the others. The differences remain even when controlling for type of ward (independent/frail or nursing), quality of ward, age, sex, or country of origin.

Quality of care

As noted, the relationship between the level of quality of care and cognitive impairment of the patients was examined for each tracer along two dimensions of quality: 1) staff awareness of the problem, and 2) the extent to which each problem was treated. Employing summary indices of quality (Table 7), staff was aware of the medical disabilities (as defined by the research team) of 48% of the non-impaired, as against 31% of the cognitively impaired ($p<0.01$). By contrast, awareness of nursing problems was higher for cognitively impaired patients than for non-impaired (91% vs. 82%, $p<0.05$).

The table also shows that summary indices for the treatment of both medical disabilities and nursing problems were higher for non-impaired (40% and 73%, respectively) than for the impaired (21% and 39%; $p<0.01$). When controlling for staff awareness, summary treatment indices remained significantly lower for the cognitively impaired.

Tables 8 and 9 present data on differences in awareness and treatment for each individual tracer. The staff had a higher awareness of oral health problems among the non-impaired elderly, 50% as compared to 5% of the impaired (Table 8). Difficulty in dressing was a problem of which the staff was more aware in cognitively impaired patients. Differences in awareness for other problems were not significant.

As seen in Table 9, there is a consistent tendency towards a higher rate of care provision to non-impaired than to impaired elderly. However, this tendency is significant only with regard to visual problems.

Table 6. Prevalence of medical and nursing problems by cognitive status¹

	Cognitive status	
	Impaired (n=78)	Non-impaired (n=51)
<i>Medical problems</i>		
Hypertension	37.5	43.7
Visual problems	61.8	64.6
Hearing problems	50.8	59.2
Oral health problems	90.2**	70.3**
<i>Nursing problems</i>		
Mobility problems	69.3**	40.6**
Difficulty brushing teeth	55.3**	23.0**
Difficulty washing	85.0**	44.8**
Difficulty dressing	47.6**	18.9**
Average number problems	5.51**	3.90**
Average number nursing problems	2.49**	1.02**

** p<0.01 according to χ^2 test.

¹ For criteria for determining the existence of medical and nursing problems see Fleishman et al. (7).

Regression analysis on the four summary indices of quality showed that (even when controlling for ward type and ward quality) cognitive impairment had a negative influence on awareness of medical problems and treatment of nursing problems (Table 10). It did not significantly affect treatment of medical problems and had a positive influence on awareness of nursing problems. When controlling for cognitive impairment, quality and ward type continue to affect the quality of care indices. Wards which were assessed as "good" tended to score higher on the treatment indices for both medical and nursing problems. Only the summary index for awareness of medical problems was influenced by ward type. There was greater awareness of medical problems in nursing wards than in independent/frail wards.

Discussion

The MSQ test was used to assess the cognitive status of the residents, but 16% of the elderly were not able to respond. In assessing the relationship between cognitive impairment and quality of institutional care, it is important that all the subjects be examined, including the severely demented. The use of a nurse's assessment of confusion as well as the standard mental status questionnaire provided us with a useful "composite" tool for the examination of the study population.

Cognitive impairment was found in almost two-thirds of a sample of elderly in homes that provided different levels of

care. This rate is similar to that found in a survey of Part 3 welfare homes in London, in which 31% of the residents were found to suffer from severe dementia and 36% from moderate dementia (10). The mean age of 81 was also similar in both surveys. These figures reflect a situation in which residential homes necessarily supply nursing and medical services because of the growing numbers of elderly admitted due to disability or chronic disease. Increasing rates of falls, mental disorders, and organic diseases are to be expected as the residents become older and frailer.

Among residents of Asian-African origin, 90% showed some sign of cognitive impairment compared to 52% of European-American elderly. Similar findings emerged in a survey of elderly in the Israeli town of Bnei Brak by Zilberstein et al. (11). Kramer et al. (12) raise the possibility that low cognitive impairment scores may sometimes reflect low levels of education in people who are not cognitively impaired. However, Folstein et al. (13) demonstrated that low scores on the Mini Mental Status Examination do not directly reflect education levels.

In Israel, higher proportions of Asian-African elderly report the presence of a modified extended family than do elderly of European-American origin. Consequently, they also report higher rates of instrumental aid from their children (14). The cultural tendency among Asian-African families to care for elderly relatives at home until a dementing illness makes institutionalization unavoidable, may explain the higher cognitive impairment

scores found among institutionalized Asian-African elderly. Such differential rates of late institutionalization according to origin are confirmed by Bergman et al. (15). They report rates in Israel of 28.2 per 1,000 Asian-African elderly and 37.6 per 1,000 European-American elderly.

A central finding of this study was the higher prevalence of cognitive impairment in poor quality wards when compared with good wards. This difference remained even when controlling for type of ward. High concentrations of cognitively impaired elderly in poor wards suggests the influence of referral policies in this direction. In addition, living in a poor quality ward for an extended period might exacerbate tendencies towards cognitive impairment. Because of their deficient staffing, these wards are even less capable of providing the special attention required by cognitively im-

Table 7. Summary indices of awareness and treatment of medical and nursing problems by cognitive status¹

Summary indices	Cognitive status	
	Impaired (n=78)	Non-impaired (n=51)
<i>Awareness indices</i>		
Medical problems	30.86**	47.75**
Nursing problems	90.60*	81.73*
<i>Treatment indices</i>		
Medical problems	21.48**	39.76**
Nursing problems	39.21**	72.71**

* p<0.05 according to χ^2 test.

** p<0.01 according to χ^2 test.

¹ Percentages calculated from total number of residents suffering from respective problems.

Table 8. Staff awareness of medical and nursing problems, by cognitive status¹

Staff awareness of	Cognitive status	
	Impaired (n=78)	Non-impaired (n=51)
<i>Medical problems</i>		
Hypertension	47.8	63.9
Visual problems	38.9	29.3
Hearing problems	42.3	39.3
Oral health problems	5.4**	49.7**
<i>Nursing problems</i>		
Difficulty walking	86.0	85.4
Difficulty brushing teeth	84.0	57.5
Difficulty washing	100.0	92.0
Difficulty dressing	96.0**	67.3**

** p<0.01 according to χ^2 test.

¹ Percentages calculated from total number of residents suffering from respective problems.

Table 9. Treatment of medical and nursing problems, By cognitive status¹

Treatment indicators ²	Cognitive status	
	Impaired (n=78)	non-impaired (n=51)
<i>Care for medical problems</i>		
Adequate surveillance of blood pressure status	47.1	45.4
Existence of care for visual problems	39.2*	64.7*
Existence of care for hearing problems	11.4	32.8
Existence of oral health care	3.8	5.4
<i>Care for nursing problems</i>		
Receives help in walking	55.6	61.8
Satisfactory oral hygiene	38.5	66.2
Satisfactory clothing	56.8	80.6
Satisfactory cleanliness	42.3	66.1

* p < 0.05 according to χ^2 test.

¹ Percentages calculated from total number of residents suffering from respective problems.

² For detailed definitions of treatment indicators see Fleishman et al. (7)

paired patients. Indeed, the regression analysis confirms that both impaired and non-impaired residents received poorer medical and nursing treatment in poor quality wards when compared with good wards.

A second important finding is that the cognitively impaired received poorer care than cognitively normal residents. Regression analysis demonstrated that the poorer care provided to cognitively impaired was not solely due to their tendency to reside in poor quality wards. Even when controlling for ward quality, and ward type, cognitively impaired elderly were found to receive poorer nursing treatment than did the non-impaired, and this despite the fact that the staff were not less aware of the existence of

these problems amongst the cognitively impaired.

The reason for the lesser degree of nursing treatment provided to cognitively impaired patients may have been their lack of ability to demand care from the staff, or the latter's reluctance to deal with them. Many of the cognitively impaired elderly exhibited abnormal affective and social functioning; they also tended to suffer from more physical disabilities. Mann et al. (10) emphasize that the cognitively impaired are more likely to exhibit problem behaviors such as aggression and wandering. It follows that staff are less likely to extend willing assistance to persons who are aggressive or uncooperative.

Staff were less aware of the existence of the medical problems of the cognitively impaired and this remained even when controlling for ward quality and ward type. This finding too can be related to staff's greater reluctance to attend to the cognitively impaired and may also be connected with the difficulties which the cognitively impaired have in communicating their medical needs. The contrasting finding that, when controlling for ward type and ward quality, staff were not less aware that the nursing problems of the cognitively impaired might be due to their being more easily discernable. Nurses are constantly exposed to these problems, the care of which constitutes an essential part of the nurse's role.

It should be noted that no staff member interviewed during the study had received adequate training in dealing with cognitively impaired patients. This stand-

ing problem is aggravated by a chronic shortage of nursing manpower in institutions for the elderly (16). Poor quality wards tend to suffer more from staffing shortages than do good wards. Staff training, together with simple occupational activity, should make life more tolerable and meaningful for such patients (17).

Further compounding the situation, the governmental referral system tends to direct a higher proportion of cognitively impaired elderly to poorer quality wards, perhaps in order to preserve the higher levels of care in better quality wards. This policy reinforces the negative relationship between cognitive impairment and quality of care. The situation is aggravated by the fact that government regulations and reimbursement policies do not include any specific provisions for the care of cognitively impaired residents despite their obvious need for special attention.

Given a situation in which there is a demonstrable care-giving discrimination against the cognitively impaired elderly, certain actions are indicated. First, periodic assessment of the cognitive status of institutionalized elderly should be carried out. This, together with a continuing reassessment of the medical, nursing and psychosocial problems of elderly residents, will serve to heighten staff awareness of the problems in need of treatment. Second, training plans should be instituted for staff members that will emphasize the special needs of the cognitively impaired elderly, the means of treatment, and the improvement of relations with such elderly. Third, referral and admission policies should seek a more uniform distribution of cognitively impaired elderly between good and poor wards, avoiding any policy of concentration.

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Table 10. Effect of cognitive impairment, ward quality¹ and ward type on quality of care indices (regression analysis)

Variables	b	Significance
<i>Awareness of medical problems</i>		
Cognitive impairment	22.65	0.001
Ward quality	5.55	0.359
Ward type R ² - 0.13	20.15	0.004
<i>Awareness of nursing problems</i>		
Cognitive impairment	10.36	0.041
Ward quality	6.01	0.148
Ward type R ² - 0.06	-0.13	0.977
<i>Treatment for medical problems</i>		
Cognitive impairment	7.48	0.258
Ward quality	20.81	0.001
Ward type R ² - 0.17	8.55	0.203
<i>Treatment for nursing problems</i>		
Cognitive impairment	23.63	0.009
Ward quality	34.20	0.000
Ward type R ² - 0.31	2.77	0.721

¹ As assessed by government surveyors.

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ג'וינט ישראל
מכון בראקדייל לגנטולוגיה
והלפלהות אדם וחברה בישראל

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מוגבלות קוגניטיבית ואיכות הטיפול במוסדות לטיפול ממושך

רחל פליישמן
ארנולד רוזין
אדרייאן תומר
רוברט שורץ

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Cognitive impairment and the quality of

Fleishman, Rachel



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חובן בראונדיל: הספריה

עמ' ה' ללחוזר עד הספר יש

המכון

ברוקדייל בנו-ופועל במוסג'ם וחברה. הוא נוסד ב-1974 בארצות הברית (בברוקה, קליפורניה, ארצות הברית) ופועלת כחברה ציבורית.

המייצאים והשלטניים מושג ערך נקי של המכוון או נקי ל双重性。

מוגבלות קוגניטיבית וaicות הטיפול
במוסדות לטיפול ממושך

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**המרכז הרפואי "שער צדק", ירושלים

במימון המוסד לביטוח לאומי

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תקציר

המטרה של מחקר זה הייתה לבדוק, האם איכות הטיפול הניתן לחוליים המוגבלים מבחן קוגניטיבית במוסדות לטיפול ממושך נמוכה מזו שמקבלים הבלתי-מוגבלים. באמצעות שיטת המסמנים הוערכה איכות הטיפול ב- 136 קשישים - עצמאיים, תשושי נפש וסיעודיים - בתשע יחידות. על סמך מבחן התמצאות MSQ והערכתה של אחوت המחלקה פותח סולם למדידת רמת המוגבלות הקוגניטיבית. 816 מון הקשישים סבלו מוגבלות קוגניטיבית ביןונית עד חמורה. נמצא, שחוליים אלה קיבלו טיפול סיודי פחות טוב ושיעור הביעות הרפואיות שלהם שהסגל לא היה מודע להן היה רב יותר מזה של החולים הלא-מוגבלים. מון הממצאים עולה, שאיכות הטיפול הירודה יותר הניתנת למוגבלים אלה קשורה בתופעות ההתנהגות החרייגות שלהם, כמו תוקפנות ואדרישות. נראה, שאנשי הסגל נוטים פחות להתייחס לחוליים עם בעיות כאלה. כדי לשפר את הטיפול בקבוצת חוליים אלה, יש הכרח לכלול שינויים במדיניות החפניות ולתכנן לسان הعبادים במוסדות תכניות הכשרה לטיפול בקשישים עם מוגבלות קוגניטיבית.