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Dementia supportive care Initial assessment

Mental Health Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

78-year-old woman with established dementia. Care stage: At the first supervised assessment.

Medical history: Dementia is established and family support is needed for daily activities. The current assessment distinguishes gradual functional needs from any new acute change. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The person wishes to participate in decisions and prefers permission before others are involved. Assess support, work/study function, substance use and practical access without stigma.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Caregiver reports increasing help needed with washing and orientation.

Objective findings and required checks: Memory difficulty and dependence in daily tasks; assess new changes for reversible causes.

Physical examination and investigations: Review baseline function, behaviour, sensory needs, medicines and caregiver strain.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Dementia supportive care: Progressive cognitive impairment affects memory, function and communication, with individual variation.

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Medical / surgical management

Use familiar routines, supported communication, safe activity and individualized caregiver assistance.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed cognitive medicine	Manage selected dementia symptoms	Monitor tolerability and benefit
medication review	Reduce avoidable sedating or anticholinergic burden	Changes require the treating team.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Caregiver reports increasing help needed with washing and orientation. Memory difficulty and dependence in daily tasks; assess new changes for reversible causes. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize communication difficulty affecting expression of needs; daily self-care needs exceed current ability; vulnerability to a fall or accidental injury; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Use familiar routines, supported communication, safe activity and individualized caregiver assistance. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met

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using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask the person or caregiver which communication methods work best. Assess: Assess comprehension, expression and the need for qualified interpretation or aids.	Communication difficulty affecting expression of needs. Possible factors: speech, cognition, sensory or language barriers. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Communicates an essential need using an agreed method. Longer-term: Before the clinically approved transition or agreed follow-up: Patient and caregivers demonstrate the communication approach for continuing care.	1. Establish a reliable yes/no or supported communication method. Rationale: A shared method enables participation and reduces frustration. 2. Use qualified interpretation, visual aids or specialist support as indicated. Rationale: Appropriate aids improve accuracy and informed participation. 3. Allow time and verify meaning without completing responses prematurely. Rationale: Respectful pacing supports autonomy and clearer assessment. 4. Use familiar routines, supported communication, safe activity and individualized caregiver assistance. Rationale: Progressive cognitive impairment affects memory, function and communication, with individual variation. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about falls, dizziness, vision and usual walking aids. Assess: Assess gait, medicines, cognition and environmental risks.	Vulnerability to a fall or accidental injury. Possible factors: unsteady mobility, dizziness or environmental hazards. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Transfers and essential activity occur without a fall during the care period. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates safe use of assistance and identifies home hazards.	1. Individualize fall precautions and keep necessary items and the call bell accessible. Rationale: Accessible support reduces unsafe unassisted movement. 2. Supervise transfers according to assessed need and check footwear and aids. Rationale: Correct assistance and equipment improve stability. 3. Review reversible contributors with the team, including postural symptoms and medicines. Rationale: Addressing causes improves safety beyond environmental measures.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: After the first indicated intervention, at the documented review time:	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach communication, home safety, routine support and caregiver respite options. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach communication, home safety, routine support and caregiver respite options.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Sudden confusion, fever, injury or abrupt behavioural change needs assessment for delirium or other acute illness.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Progressive cognitive impairment affects memory, function and communication, with individual variation.

- Priority concerns: Communication difficulty affecting expression of needs; Daily self-care needs exceed current ability; Vulnerability to a fall or accidental injury; Learning needs about the condition and care plan.

- Sudden confusion, fever, injury or abrupt behavioural change needs assessment for delirium or other acute illness.

- Teach communication, home safety, routine support and caregiver respite options.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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