6.4: Applying the Nursing Process

This section outlines the steps of the nursing process when providing care for adults with cognitive impairments.

Assessment

Nurses provide care for older adults in a wide variety of settings including acute care facilities, clinics, adult day care facilities, retirement communities, long-term care facilities, private homes, and community-based residential facilities (CBRF). It is vital for nurses to notice any signs of changing mental status based on the patient’s baseline. Any new or sudden changes that indicate possible delirium should be urgently reported to the health care provider for further assessment of potential underlying health conditions. See the following hyperlink to view a delirium evaluation tool used by hospitals.

Note

View the Delirium Evaluation Bundle shared by the Agency for Healthcare Research and Quality (AHRQ).

When assessing an adult patient with a previously diagnosed cognitive impairment, there are several assessments to include on admission. Their medical history should be reviewed and a medication reconciliation completed. A general survey provides a quick, overall assessment of the way an individual interacts with their environment and their overall mobility status. A comprehensive neurological assessment should be performed to establish a patient’s baseline neurological status. After a baseline status is determined, routine focused neurological assessments are performed to monitor for changes, such as asking the patient to state their name, place, and the date, as appropriate.
Note

Read more information about performing a neurological exam in the "Neurological Assessment" chapter of the Open RN Nursing Skills textbook.

Additional assessments include functional status and the patient’s ability to perform activities of daily living (ADLs). A decline in the ability to perform self-care and maintain ADLs can affect the individual’s well-being. Functional declines can bring about feelings of inadequacy and lead to depression. The ability to live independently relies on maintenance of self-care skills, including bathing, dressing, and toileting. Other factors that must be considered include the ability to adequately handle finances; maintain a clean, safe environment; and to shop and prepare meals. When deficits in these areas occur, resources should be recommended to assist the individual to meet these needs.

Cognitive changes including disorientation, poor judgment, loss of language skill, and memory impairment should be assessed objectively using standardized tools. Common standardized tools used to assess a patient’s mental status include the Mini Mental State Exam (MMSE) and the Mini-Cog. See Figure 12 for an image of one of the questions included on the MMSE.

Cultural Considerations

Nurses provide culturally competent care for all individuals. Being aware of personal biases related to ageism and cognitive impairments is necessary when providing care for older adults experiencing confusion, memory deficits, and impaired judgment. Ageism is the stereotyping and discrimination against individuals or groups on the basis of their age. Ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs. Ageism is widely prevalent and stems from the assumption that all members of a group (i.e., older adults) are the same. Ageism has harmful effects on the health of older adults; research has shown that older adults with negative attitudes about aging may live 7.5 years less than those with positive attitudes. Some of this prejudice arises from observable biological declines and may be distorted by awareness of disorders such as dementia, which may be mistakenly thought to reflect normal aging. Socially ingrained ageism can become self-fulfilling by promoting stereotypes of social isolation, physical and cognitive decline, lack of physical activity, and economic burden in older adults.

[1] [2]
These biases in health care personnel, patients, and family members can prevent early recognition and treatment of health problems like dementia, delirium, and depression.

Diagnoses

Commonly used NANDA-I nursing diagnoses for older adults experiencing cognitive impairment include the following:

- Self-Care Deficit
- Risk for Injury
- Impaired Memory
- Impaired Coping
- Social Isolation

A common NANDA-I diagnosis related to cognitive impairment caused by dementia is *Self-Care Deficit*, defined as, “The inability to independently perform or complete cleansing activities; to put on or remove clothing; to eat; or to perform tasks associated with bowel and bladder elimination.” An associated condition with this nursing diagnosis is “Alteration in cognitive functioning.”

An example of a related PES statement is, “Self-Care Deficit related to altered cognitive functioning as evidenced by impaired ability to access the bathroom, to put clothing on lower extremities, and to maintain appearance.”

Outcome Identification

An example of an overall goal for an older adult experiencing cognitive impairment due to dementia is, “The patient will perform self-care activities within the level of their own ability daily.”

An example of a SMART expected outcome for a patient with cognitive impairment resulting in *Self Care Deficit* is, “The patient will remain free of body odor during their hospital stay.”

Planning Interventions

There are many nursing interventions that can be implemented for older adults with impaired cognitive function based on their individual needs. Interventions focus on maintaining safety, meeting physical and psychological needs, and promoting quality of life. As always, refer to an evidence-based nursing care planning resource when customizing interventions for specific patients. For interventions targeted for common symptoms of dementia, see the “Alzheimer’s Disease” section in this chapter. See Table 6.4 for general nursing interventions to implement for patients with cognitive impairments.

Table 6.4 General Nursing Interventions for Cognitive Impairments

**Therapeutic Communication:** Provide nursing care in a timely manner with an attitude of caring and compassion while maintaining the dignity of the individual. Establish a therapeutic relationship based on trust by sitting at the level of the patient and engaging in eye contact.
**Reminiscence Therapy:** Allow individuals opportunities to share their past experiences and stories. This allows expression of personal identity and supports the individual’s coping and self-esteem.

**Touch:** When appropriate, touch provides comfort for individuals. It provides sensory stimulation to avoid sensory deprivation and demonstrates caring and warmth. It is important to assess the individual’s reaction to touch before implementing therapeutic gentle touch.

**Reality Orientation:** This technique provides awareness of person, place, and time for those who are cognitively able. It restores a sense of reality, decreases confusion and disorientation, and promotes a healing environment. Older adults experiencing a change in environment or stressful situation benefit from the use of environmental cues for orientation, such as clocks, calendars, and whiteboards noting who is providing care and when they will return.

**Validation Therapy:** This technique is used for older adults who are confused. The focus is on the emotional aspect of their communication. This therapy avoids reorientation to time and place, even when incorrect. It does not reinforce incorrect perception but focuses on validating their feelings. [5]

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**Implementing Interventions**

When implementing interventions for patients with cognitive impairments, patient safety receives priority. Implement fall precautions, wandering precautions, and environmental safety precautions as appropriate.

**Evaluation**

It is important to routinely evaluate the effectiveness of customized interventions for patients with cognitive impairments. Review the SMART outcomes established for each specific patient to determine if interventions are effectively promoting safety while also maintaining their physiological and psychological needs and promoting quality of life. Modify the care plan when needed to meet these outcome criteria.

2. "InterlockingPentagons.svg" by Jfdwolff[2] is licensed under [CC BY-SA 3.0](https://creativecommons.org/licenses/by-sa/3.0/)

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