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Dementia Management

Techniques for Staging and Intervention

Learning Outcomes

After this course, participants will be able to:

- Identify at least three stages of dementia including related behaviors and abilities.
- Identify at least two standardized assessments used to accurately stage residents with dementia.
- Identify at least four treatment interventions and activity adaptations for patients with dementia.
- Discuss at least two appropriate documentation strategies to reflect skilled intervention.

Cognition

Cognition

- Definition – The process of thinking, perceiving and learning
- Specific cognitive functions include
  - Decision-making
  - Judgment
  - Spatial orientation
  - Thinking/reasoning
  - Verbal communication
  - Memory

Memory

- Definition – Ability to retain and retrieve previously learned information
- Long-term Memory
  - Procedural Memory – Memory for how to do things; accessed without conscious control
  - Declarative Memory – Consciously available memories
    - Episodic memory – Personal experiences/events
    - Semantic memory – General factual info

Normal Age-Related Changes

- ↑ sensitivity to distractions
- More difficulty concentrating
- Less efficient processing & storage of new information
- ↓ ability to shift attention among many objects (multi-tasking)
- Slowing down of free recall (proper nouns/ names/places)
- ↓ ability to recall information immediately when & where needed
- Brain function slows down just as muscles and all other bodily functions slow down
- Research shows we lose 1% of our capacity each year after age 30

Normal Aging and Memory

Preserved Memory Functions

- Procedural memory
- Episodic memory
- Semantic memory

Declining Memory Functions

- Learning new information
- Recalling new information

Cognitive Decline in the Elderly

- Age-associated Memory Impairment (AAMI)
  - General degradation of memory which results from aging
- Mild Cognitive Impairment (MCI)
  - Bridge or transition between normal cognitive aging and dementia
  - 10-20% of patients with MCI progress to dementia within 12 months

Etgen et al., 2011

Dementia

Dementia

- Progressive decline in cognition along with a short- and long-term memory loss due to brain damage/disease

ICD-9-CM, 2013

- Impairment in memory and at least 1 domain of cognitive functioning that represents a decrease from previous functional level & results in an impairment in daily activities

Buffington, Lipski, & Westfall, 2013

CONTINUED

Background

- Estimated 5 million Americans suffer from dementia
  - More than 15 million provide caregiving
- Costly to treat ($215 B in 2010)
- Caregiving is the most costly aspect of dementia care

(AHRQ, 2014)

CONTINUED

Background (Alzheimer's Association, 2015)

- In the US 1 in 9 persons over 65 have AD
  - 16 million by 2050
- Estimated 75% of persons with AD are admitted to a SNF
- AD is the 6th leading cause of death in the US
  - Only disease in the Top 10 that cannot be prevented or cured

CONTINUED

Types of Dementia (Alzheimer's Association, 2016)

- Alzheimer's Disease
  - Most common type (60-80% of cases)
  - Slow progressive decline in cognition and function
  - Neuronal cell death in parietal and temporal lobes and presence of plaques and tangles
  - Affects 5.4 million people

CONTINUED

Alzheimer's Disease (alzheimersnewstoday.com)

- 44 million people worldwide have Alzheimer's disease or a related form of dementia
- In the U.S., 5.5 million people have Alzheimer's disease
  - 5.3 million are 65 and older
- About two-thirds of Americans with Alzheimer's disease are women
- Prevalence doubles every five years beyond the age of 65
- Someone in the U.S. develops Alzheimer's disease every 66 seconds
- Sixth-leading cause of death in the U.S.
- Typical life expectancy after an Alzheimer's diagnosis is 4-8 years
- Global cost estimated to be $605 billion

CONTINUED

Types of Dementia

(Association for Frontotemporal Degeneration, 2016)

- Frontotemporal lobar degeneration
  - Pick's disease
  - Young age 50-60
  - Changes in behavior and language
  - Memory preserved
  - Atrophy of the cortical regions of frontal and temporal lobes
  - Affects 50,000-60,000 persons

CONTINUED

Types of Dementia (Alzheimer's Association, 2015)

- Lewy Body disease
  - Impaired executive function, perception, memory
  - Fluctuating cognitive function
  - Visual hallucinations
  - Autonomic nervous system issues
  - Parkinson's like motor function
  - Lewy bodies in neurons and glia
  - 3rd most common after AD and vascular

CONTINUED

Types of Dementia (Alzheimer's Association, 2016)

- Korsakoff syndrome
  - Caused by substance abuse or medications
  - Marked severe memory loss, confabulation, spared social cognition
  - Thiamine deficiency

CONTINUED

Types of Dementia (Alzheimer's Association, 2016)

- Vascular dementia and disease
  - Previously known as multi-infarct dementia
  - Symptoms vary depending on area of brain affected
  - Impaired judgement and decision making
  - 2nd most common after AD

CONTINUED

Types of Dementia

(AIDS Education and Training Center National Resource Center, 2016)

- HIV Associated
  - Cognitive, motor, and behavioral impairments
    - Concentration, attention, memory, executive function, apathy and social withdrawal, unsteadiness, clumsiness
  - Demyelination in frontal cortex.

CONTINUED

Types of Dementia

(National Institutes of Health Genetics Home Reference, 2016)

- Prion Disease
  - Creutzfeldt-Jakob is the most common
  - Rapidly fatal disorder
  - Motor symptoms like ataxia and myoclonus
  - Neuronal cell death caused by prion proteins in the brain
  - 350 new cases each year

CONTINUED

Types of Dementia (Alzheimer's Association, 2016)

- Parkinson's Disease
  - Motor symptoms
  - Cognitive symptoms similar to Lewy Body
  - Loss of dopamine producing cells in the substantia nigra
  - 50-80% of the 1 million with PD have cognitive decline

CONTINUED

Types of Dementia (Alzheimer's Association, 2016)

- Huntington's Disease
  - Onset between 30 and 50 years
  - Involuntary movement
  - Changes in personality, mood, and other cognitive functions
  - Loss of brain cells in striatum (cortex and basal ganglia)
  - 30,000 (1 in every 10,000)

CONTINUED

Types of Dementia

- Multiple etiologies
  - Referred to as mixed or multi-factorial dementia
  - Classified by presence of more than 1 type of cognitive disease excluding substance abuse with co-existing AD and vascular disease being the most common

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Modifiable Risk Factors

- Cardiovascular risk factors
- Metabolic factors
- Endocrine factors
- Lifestyle factors

Etgen et al., 2011; Kirk-Sanchez & McGough, 2014

Key Points

- MCI/dementia influenced by modifiable risk factors
- Associated w/ classic cardiovascular risk factors
- CRF newly discovered risk factor—no treatment related to cognitive decline yet determined
- Substitution therapy generally not recommended (e.g., Vit B12, Vit D, testosterone, estrogen, etc.)
- Mediterranean diet & physical activity recommended
- Stop smoking; low alcohol consumption

Etgen et al., 2011

Risk Factors for Dementia

- Heredity
- Down syndrome
- Health problems
- Environmental factors
- Brain trauma

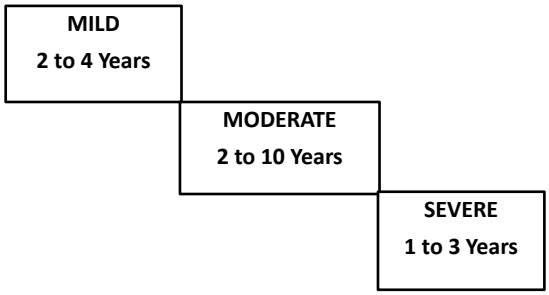
Stages of Dementia

Mild/Early
First Stage

Moderate/
Middle
Second Stage
Third Stage

Severe/Late/
End Stage
Third Stage
Fourth Stage

These are general patterns that do not apply to everyone. Stages may vary in length and symptoms may overlap between stages.



From "Keepsake: A Program on Memory, Aging & Alzheimer's"

Early Dementia

- Appear more apathetic, with less sparkle
- Lose interest in hobbies, activities
- Unwilling to try new things
- Unable to adapt to change
- Show poor judgment and make poor decisions
- Slower to grasp complex ideas and take longer with routine jobs

Early Dementia

- Blame others for “stealing” lost items
- Become more self-centered and less concerned with others and their feelings
- Become more forgetful of details of recent events
- More likely to repeat themselves or lose the thread of their conversation
- More irritable or upset if they fail at something
- Have difficulty handling money

Early Dementia

- Looks “normal”
- Good speech/language/social skills
- Immediate memory relatively intact
- No changes in posture and/or gait
- Knowledge of past, present and future
- Believes still has responsibilities
- Doesn’t believe needs assistance

Early Dementia

- Wandering
- Exit-seeking, eloper or runaway
- Delusions, suspiciousness, anxiety
- Tearfulness, depression and catastrophic outbursts
- ADL relatively intact

Early Dementia

- Problems coming up with the right word or name
- Trouble remembering names when introduced to new people
- Challenges performing tasks in social or work settings.
- Forgetting material that one has just read
- Losing or misplacing a valuable object
- Increasing trouble with planning or organizing

Middle Dementia

- Very forgetful of recent events; memory for the distant past generally seems better, but some details may be forgotten or confused
- Confused regarding time and place
- Become lost if away from familiar surroundings
- Forget names of family or friends, or confuse one family member with another
- Forget saucepans and kettles on the stove; may leave gas unlit

Middle Dementia

- Wander around streets, perhaps at night, sometimes becoming lost
- Behave inappropriately, for example going outdoors in nightwear
- See or hear things that are not there
- Become very repetitive
- Neglectful of hygiene or eating
- Become angry, upset, distressed or frustrated

Middle Dementia

- Looks “unfinished”
- Ambivalent about social graces
- Noticeable speech/language deficits
- Difficulty using common objects
- Changes in posture, gait, balance, vision
- Knowledge past and immediate present
- Gives up previous “responsibilities”
- Unconcerned about whereabouts
- No longer able to think abstractly

Middle Dementia

- Wandering, self-stimulation
- Becoming sensory oriented
- Searching for things/persons
- Repetitive “tasks”
- Delusions, suspiciousness, anxiety
- Catastrophic outbursts
- Resistance to care, ADL simplification
- Social “butterfly”

Middle Dementia

- Forgetfulness of events or about one's own personal history
- Feeling moody or withdrawn, especially in socially or mentally challenging situations
- Being unable to recall their own address or telephone number or the high school or college from which they graduated
- Confusion about where they are or what day it is
- The need for help choosing proper clothing for the season or the occasion
- Trouble controlling bladder and bowels in some individuals
- Changes in sleep patterns, such as sleeping during the day and becoming restless at night
- An increased risk of wandering and becoming lost
- Personality and behavioral changes, including suspiciousness and delusions or compulsive, repetitive behavior like hand-wringing or tissue shredding

Late/End Stage Dementia

- Unable to remember, for even a few minutes, that they have had, for example, a meal
- Lose ability to understand or use speech
- Incontinent
- Show no recognition of friends and family
- Need help with eating, washing, bathing, using the toilet, dressing
- Fail to recognize everyday objects

Late/End Stage Dementia

- Disturbed at night
- Restless, perhaps looking for a long-dead relative
- Aggressive, especially when feeling threatened or closed in
- Have difficulty walking, eventually perhaps becoming confined to a wheelchair
- Have uncontrolled movements
- Immobility will become permanent; in the final weeks or months the person will be bedridden

Late/End Stage Dementia

- Looks “abnormal”
- Severe speech/comprehension deficits
- Severe difficulty using common objects
- Appears “lost in thought”
- Difficult to get and keep attention
- Significant posture, gait and/or balance deficits
- Downward restricted gaze

Late/End Stage Dementia

- Need round-the-clock assistance with daily activities and personal care
- Lose awareness of recent experiences as well as of their surroundings
- Experience changes in physical abilities, including the ability to walk, sit and, eventually, swallow
- Have increasing difficulty communicating
- Become vulnerable to infections, especially pneumonia

Reasons for Referral

- Unsafe gait pattern
- Swallowing issues
- Positioning or restraint concerns
- Weight loss without medical cause
- Postural guarding; signs of balance disorders
- Need to modify the environment to prevent falls
- Contractures or decreasing ROM
- Patient unable to participate in activities
- Caregiver does not understand cueing
- Need to establish an ADL routine
- Patient unable to communicate needs

CONTINUED

Why use a staging tool?

- To enhance the quality of life
- To identify a patient's baseline
- To develop appropriate intervention strategies
- To modify/adapt the environment
- To train caregivers
- To provide reassurance

CONTINUED

Staging Tools

- Mini-Mental State Examination
- FROMJE
- Global Deterioration Scale
- Brief Cognitive Rating Scale
- Functional Assessment Staging
- Brief Interview for Mental Status
- Short Blessed Test
- St. Louis University Mental Status Examination
- Test Your Memory
- Brief Cognitive Assessment Tool
- Self-Administered Gerocognitive Examination

Behaviors

BPSD

- Behavioral and psychological symptoms of dementia
  - Symptoms of disturbed perception, thought content, mood or behavior that frequently occur in patients with dementia.
- As many 76% of residents have BPSD
- Labels used to describe include agitated, aggressive, and disruptive

(AHRQ, 2014)

CONTINUED

Caregiver Burden

- AD is the 12th most burdensome disease
- Caregivers report symptoms like decline in emotional well-being, physical health, depression
- Post acute care cost projected to increase from $236 billion in 2016 to over $1 trillion in 2050

CONTINUED

Caregiver Strategies

- Support groups led by professionals that address depression, burden (Chien et al, 2011)
- Attending support group report higher QOL (Bartfay & Bartfay, 2013)
- Limited evidence for internet-based support group (Marziali & Garcia, 2011)
- Skill training DVD with periodic phone calls from a practitioner reduced stress (Gallagher-Thompson et al., 2010)
- Reframing distressing beliefs (Eggenberger, Heimerl, & Bennett, 2013)

Caregiver Strategies

- Mindfulness-based interventions improve mental health (Oken at al., 2010; Whitebird et al., 2013)
- A telephone-based intervention improved interactions with staff (Davies et al., 2011)
- Home monitoring systems did nothing to help with caregiver worry, did not improve caregiver sleep (Rowe et al., 2010)
- The strongest evidence for caregivers came from interventions targeted at communication skills, use of memory aids, and mindfulness to reduce stress

Theoretical Frameworks

Four theoretical frameworks to explain etiology of behavioral disorders

- Biologic/genetic
  - Due to symptoms of dementia
- Behavioral
  - Relationship between patients and environment
- Reduced stress threshold
  - Lower threshold to stimuli
- Unmet needs

(Cohen-Mansfield, 2013)

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Theory of Retrogenesis

(ret-roh-JEN-uh-sis) *n*. The loss of mental abilities in old age in the opposite order in which they are gained in childhood, especially as exhibited by Alzheimer's patients

CONTINUED

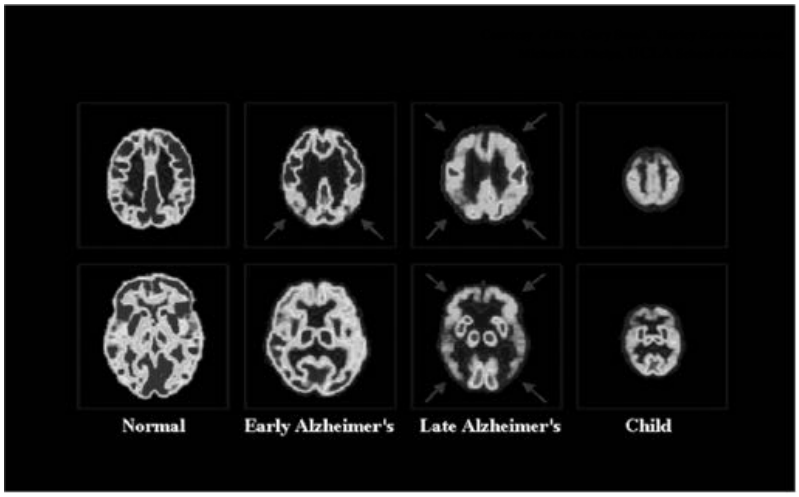
Theory of Retrogenesis

Brain Development

- Begins first in the primary motor area
- One of the last brain structures to be myelinated is the hippocampus

Alzheimer's Degeneration

- Brain damage begins in the hippocampus
- The primary motor area is finally affected in late stages of AD



Basic Needs

- Physiological
- Safety/security
- Belonging and love
- Esteem

Care Models Addressing Behaviors

- Progressively Lowered Stress Threshold Model (Hall & Buckwalter, 1987)
  - Six principles of care
  - Modify the environment
  - Unconditional positive regard
  - Use anxiety as a gauge
  - Listen for behaviors
  - Support loss and enhance safety
  - Provide caregiver education

Care Models Addressing Behaviors

- Need-Driven Dementia-Compromised Behavior Model (Algase et al., 1996)
  - Background factors
  - Dementia compromised functioning
  - Poor health status
  - Demographic and psychosocial variables
  - Proximal factors
  - Unmet physiologic and psychological needs
  - Disturbing environmental factors
  - Uncomfortable social surroundings

Responses to Stress

Typical Stress Relievers

- Go for walk
- Talk on the phone
- Take a bath
- Put on comfortable clothes
- Go shopping
- Exercise
- Read a book
- Sex

Dementia Behaviors

- Wandering
- Asking same thing over and over
- Taking off clothes
- Rummaging
- Pacing
- Inappropriate sexual behavior

Behaviors and Dementia

- "Behavioral symptoms related to dementia are defined as verbal, vocal or motor activities that are considered to be aggressive, excessive or lack adherence to social standards."
- Behaviors result from interactions between the resident, the caregiver and the setting
- 56-66% of residents in LTC facilities exhibit behavioral symptoms related to dementia

Boustani et al, 2005

CONTINUED

Disruptive Behaviors

- Inappropriate, repetitive or dangerous behaviors which are disruptive to the living and working environment in the NH
- Most common disruptive behaviors
  - Wandering
  - Aggression
  - Agitation

Ahn & Horgas, 2013

CONTINUED

Behaviors

- ALL behavior has meaning and is indicating something
- Behavior is a form of communication
- Look at every behavior as unmet need
- Behaviors are considered a problem when
  - Safety or well-being of patient or others is compromised
  - A trigger or cause cannot be identified

Common Behaviors

- Anger/agitation
- Sleep problems
- Paranoia/delusions
- Resistance to ADL
- Continence difficulty
- Getting lost/ wandering
- Sundowning
- Catastrophic reactions
- Rummaging
- Repetitive actions
- Crying out
- Inappropriate social and sexual behavior

Causes of Problematic Behaviors

- Environmental
- Physiological
- Psychological
- Medication induced
- Communication
- Task-related
- Pain

Addressing Problematic Behaviors

- Prevent the incidence of agitation and aggressive behaviors
- Respond to episodes to reduce severity, duration, caregiver distress
- Interventions may be
  - Patient focused: directly intervene with patients
  - Caregiver focused: intervene through caregivers and environment

Addressing Problematic Behaviors

- Staff nurses under-identify behavior changes and the need for additional physical assessment
- The Serial Trial Intervention (STI) can be initiated to determine the cause of a behavior change and address it

Kovach et al., 2012

Addressing Problematic Behaviors

- Observe the behavior and try to determine cause
- Behaviors may be indicative of needs that should be addressed
- Could be due to inability to manage stress
  - Change in routine/caregiver/environment
  - Demands that exceed ability
  - Multiple and competing stimuli
  - Pain/illness/discomfort
  - Medication side effects

Interventions/ Treatment Strategies

CONTINUED

Fall Management

- Incidence of falls with AD is around 60% (twice that of normal elderly)

(Shaw et al., 2003).

- Embed physical training focused on improving gait, strength, balance, and flexibility in occupation-based intervention

(Hauer et al., 2006; Oliver et al., 2007)

- Close supervision and participation in activity-based intervention

(Detweiler et al., 2005)

CONTINUED

Fall Management

- Unrestricted daytime access to the wander gardens decreased falls (Detweiler et al., 2009)
- Environmental modification should be used with a multi-faceted intervention
- Strong evidence for wander guards (Tchalla et al., 2013)
- Evidence for music is limited

CONTINUED

Dementia-Specific Fall Risk Factors Assessment

General

- ☐ New admission or transfer to another unit
- ☐ Falls within last 30 days
- ☐ No trauma
- ☐ Injury _____
- ☐ Bladder or bowel incontinence
- ☐ Low body mass
- ☐ Seizures
- ☐ Episode of acute illness

Mobility

- ☐ Ambulatory and active
- ☐ Ambulatory but weak or debilitated
- ☐ Using assistive device
- ☐ Unable to use assistive device properly
- ☐ Non-ambulatory
- ☐ Self-propelled wheelchair
- ☐ Relies on proprioception for balance

Cognition

- ☐ Depression
- ☐ GDS Stage 6
- ☐ GDS Stage 7
- ☐ Change in cognitive level on GDS
- ☐ Poor reasoning or judgement
- ☐ Unable to recognize ambulation deficits
- ☐ Unable to tolerate wearing eyeglasses
- ☐ Unable to tolerate wearing hearing aids
- ☐ Unable to verbally communicate needs
- ☐ Unable to comprehend bed or chair alarm

Neuromotor Changes

- ☐ Rigidity present
- ☐ _____Arms
- ☐ _____Legs
- ☐ _____Neck
- ☐ _____Trunk
- ☐ Rigidity induced by bed/chair alarm sound
- ☐ Decreased grip strength
- ☐ Loss of protective reflexes
- ☐ Impaired balance recovery
- ☐ Impaired protective extension

CONTINUED

Altered Gait and Balance

- ☐ Start hesitancy and freezing
- ☐ Shuffling
- ☐ Scissoring
- ☐ Non-continual walk with hesitation
- ☐ Deviated from straight path
- ☐ Difficulty making turns
- ☐ Feet scrape ground surface
- ☐ Unable to step over obstacle
- ☐ Unable to navigate around obstacles
- ☐ Reduced walking speed
- ☐ Unsteady standing balance
- ☐ Uses furniture for walking or balance
- ☐ Postural sway ____forward ____backward ____left side ____right side
- ☐ Unstable rising from seated position
- ☐ Unstable getting out of bed
- ☐ Unstable sitting balance
- ☐ Unable to sit up
- ☐ Unable to perform unassisted transfers
- ☐ Feet slide away during transfers

Vision Changes

- ☐ Decreased depth perception
- ☐ Decreased peripheral vision
- ☐ Visual neglect ____left ____right

Behavior Changes

- ☐ Self-stimulating wandering
- ☐ Restless pacing
- ☐ Resistive to ADL care
- ☐ Anxiety, agitation
- ☐ Sleep disturbance

Agitation

- Do not fight, scream or scold
- If possible leave the room (tell person you'll be back)
- Do not turn your back on the person
- Simple, firm, clear language
- Do not try to reason
- Keep your hands in view
- Avoid exaggerated gestures
- Stand to one side and slightly sideways

Agitation

- Stay out of personal space
- Use soft eye contact
- Appear non-confrontational
- Tell person gently what you want him/her to do
- Do not restrain from wandering, go with them
- Ask others to leave the room
- Reassure family members

Wandering Strategies

- Illusions
- Visual cliffing
- Deterrents
- Message
- Camouflage
- Diversions

Pain in the Elderly

- 50-80% of NH patients are reported to be in pain (Achterberg et al, 2013; Ahn & Horgas, 2013; Patel et al., 2013; Takai et al., 2010)
- Pain is positively correlated with ↑ aggression and agitation scores (Ahn & Horgas, 2013)
- Analgesics were significantly less often prescribed and/or used for patients with dementia (Hoffman et al., 2014; Takai et al., 2010)

CONTINUED

Pain Management Protocol

- Ensure all comfort needs are met
- Look for treatable conditions
- Look for other potential sources of the unusual behavior
- Try non-drug comfort strategies
- Begin an analgesic trial
- Use a pain rating/assessment tool

CONTINUED

Pain Behaviors

(American Geriatric Society Panel)

1. Facial expressions
   - Slight frown/sad, grimacing, wrinkled forehead, closed eyes, rapid blinking
2. Verbalizations/vocalizations
   - Sighing/moaning/groaning, grunting/chanting, calling out, noisy breathing, asking for help, verbally abusive
3. Body movements
   - Rigid/tense, fidgeting, ↑ pacing, rocking, gait/mobility changes

Achterberg et al., 2013

Pain Behaviors

(American Geriatric Society Panel)

4. Changes in interpersonal interactions
   - Aggressive/combative/resisting care, ↓ social interactions, socially inappropriate/disruptive, withdrawn
5. Changes in activity patterns or routines
   - Refusing food/appetite change, ↑ rest periods, sleep pattern change, cessation of common routine, ↑ wandering
6. Mental status changes
   - Crying/tears, ↑ confusion, irritability,/distress

Achterberg et al., 2013

Pain Assessment in Advanced Dementia Scale (PAINAD)

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling, or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	

Total ____

Scoring:

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool

CONTINUED

Barriers to Pain Management

- Poor or absent communication
- Psychotropic meds to deal with behavior
- Lack of knowledge for pain assessment & management
- Reluctance to change/increase meds

CONTINUED

Multi-Sensory Interventions

- Transcutaneous Electrical Nerve Stimulation (TENS)
  - Most often used for pain control
  - Positive short-term benefits on sleep disturbances and behavioral symptoms, evaluated immediately after treatment or at six-week follow-up

(Johnson, 2008; Cameron, Lonergan, & Lee, 2009)

Factors Affecting Communication

- Family/staff stress and frustration
- Environment
- Time
- Distractions in the environment
- Medications
- As dementia progresses, the ability to correctly interpret communication decreases
- Depression and anxiety

Challenges in Communication

- Word-finding difficulty
- Repetition
- Unable to read and/or understand written communication
- Revert back to their native language
- Lose ability to speak in sentences
- Loss of ability to understand
- Unable to use words

Communication Strategies

- Avoid arguing or reasoning
- Ask closed-ended questions
- Observe non-verbals
- Allow time to respond
- Be ready to repeat
- Use short sentences
- Speak slowly, clearly, audibly
- Use the person's name
- Use gestures/visual cues

Communication Strategies

- Communication skills vary
- Assume most of the conversation
- Grade the conversation
- Be an active listener
- Avoid shouting
- Use adult language
- Use eye contact
- Use touch

Using History to Guide Treatment

- What do they like to do?
- What is their history?
- Strengths and limitations?
- Environment -- what contributes to successful engagement and what hinders it?
- Relevant life experiences, values, interests?

Intervention

- Promotion
- Modification
- Remediation
- Maintenance
- Prevention

Activity Requirements

- Gross motor
- Repetitive
- Uses familiar motions
- Involves 1 or 2 steps
- Observable effect on the environment
- Non-competitive
- Involves few or no rules

Meaningful Activity

Every activity must . . .

- Have a purpose that is obvious to the participant
- Be voluntary
- Be pleasurable
- Be socially and age appropriate
- Be failure proof

CONTINUED

Considerations When Adapting Activities (Warchol, Copeland, & Ebell, 2002)

- Attention span
- Environmental scanning
- Awareness of purpose/goal
- Communication
- Physical attributes
- Quality of work
- Problem solving
- Sequencing
- Social factors
- Environment
- Ability to initiate
- Ability to choose
- New learning ability
- Direction following
- Response time

CONTINUED

Activities by Stage

- Early stage of dementia
  - Activities that focus on the whole task
- Mid-stage of dementia
  - Activities that focus on the individual steps of the activity
- Late stages of dementia
  - Activities that focus on the sensory part of the activity

Successful Activities

1. Assess cognitive function
2. Learn about past habits and interests
3. Choose activities based on past interests
4. Adapt the activity to match physical and cognitive abilities
5. Assess success of the activity

General Treatment Approaches

- Determine spared skills
- Provide resident with activity choices
- Structure treatment with simple activities
- Establish programs to follow post-discharge
- External memory aides
- Determine effective cueing methods

Skilled Interventions – PT
Gait

- Use of assistive device:
- Assess resident's cognitive/physical ability to use an assistive device
  - Rolling walker vs. standard walker
  - Cane vs. hand-held assist
  - Is this a new device?
  - Ability to learn to use new device
  - Ability to re-learn to use current device
  - Is this the least restrictive device?

Skilled Interventions – PT
Gait

- Visual and proprioceptive/tactile cues
  - Demonstrate task; provide tactile cues
  - Tactile cues to trunk/hips/LEs
- Safe environment
  - Proper footwear during gait
  - Lighting/nightlights
  - Remove environmental hazards
  - Properly maintain assistive device
  - Visual cues

Skilled Interventions – PT
Bed Mobility/Transfers

- Visual cues
- Safe environment
  - Appropriate bathroom equipment
  - Rearrange room for safety
- Appropriate equipment
- Adapt environment
- Maintain assistive device

Skilled Interventions – PT
Balance

- Postural response training
  - Ankle strategies
  - Hip strategies
  - Stepping strategies
- Training strategies
  - Progressive therapeutic tasks
  - Visual/proprioceptive/tactile cues
  - Demonstrate task while providing cues

Skilled Interventions – PT Education

- Balance status upon discharge
- Use of assistive device and strategies for transfers and gait
- Fall risk
- Proper “getting up from a fall” techniques
- General safety issues

Treatment Considerations by Stage Early PT

- Tendency to forget where objects have been placed
- Reliance on routine
- Poor concentration

CONTINUED

Treatment Considerations by Stage Middle PT

- Deterioration of judgment
- Exhibits wandering
- Impaired learning

CONTINUED

Treatment Considerations by Stage Late PT

- Unaware of surroundings
- Non-ambulatory without assistance
- Cannot learn new tasks
- Requires environmental adaptation

Treatment Approach By Stage

Mobility: Early Stage

- Teach resident in use of:
  - Assistive devices
  - Environmental cues
  - Previously learned and new sequences
  - Secondary effects and hazards
  - New equipment
  - Safety precautions
  - Routine maintenance of equipment
  - Pacing with respect to time constraints

Treatment Approach By Stage

Mobility: Middle Stage

- Compensate by:
  - Walking with supervision
  - Allowing additional time to perform task (2-3 times longer)
  - Incorporating repetitive training into previously learned tasks
  - Using repetitive sequence to facilitate long-term learning
  - Using a consistent routine and sequence and incorporating counting when applicable
  - Using demonstration, striking visual cues and verbal cues
  - Teaching resident to use grab bars and other safety items
  - Reduce distraction from interesting objects by removing them from view

Treatment Approach By Stage

- Mobility: Late Stage
  - Ambulation program and related safety issues
  - Fall prevention strategies
  - Sitting schedule and recommended method
  - Use color contrast to distinguish between floors and furniture
  - Contracture management program
  - Use strengths/abilities (e.g., grasping objects for support to assist with transfers)

Documentation

CONTINUED

Advocacy Model of Care

- Restoration
- Compensation
- Adaptation/Maintenance

CONTINUED

Documentation

- Medicare Requirements
  - Diagnosis coding (ICD-10) w/ correct onset date
  - Prior level of function
  - Medical necessity
  - Rationale/Justification for treatment
  - Supportive nursing documentation

CONTINUED

Skilled Intervention

- Activity analysis
- Task segmentation
- Environmental adaptation to increase safety and functional independence with least amount of supervision in least restrictive environment (describe the specific adaptation)
- Techniques to compensate for decreased vision (describe the techniques and resident's response)

CONTINUED

Skilled Interventions

- Compensatory techniques
- Cueing hierarchy
- Analysis of resident response
- Analysis of ability to generalize and/or transfer learned skills
- Functional maintenance or restorative program

Skilled Intervention

- Type and amount of cueing required to complete a task
- Adaptive/assistive equipment utilized including resident's response
- Staff and/or family/caregiver education and training with resident

Goals

- Resident or caregiver centered, not the "therapist will assess"
- Avoid non-skilled words like "maintain," "tolerate" or "participate"
- Goals must be functional, measurable, objective
- Appropriate to language, cognitive, functional and motor abilities

Sample Goals

Functional Mobility

- Ambulate 50 ft w/o falls or loss of balance when changing from even to uneven surfaces w/ 25% VCs regarding surface change
- Resident will safely utilize handrail w/ 25% verbal and tactile cues w/ no episodes of balance loss when ambulating from bedroom to dining room
- Self-correct during dynamic standing balance activities w/ center of mass over base of support 3 out of 5 times to reduce fall risk
- Roll bilaterally using bedrails and max (A) in order for staff to complete hygiene tasks

IDT Techniques

Interdisciplinary Treatment Techniques

- Establish simple routine
  - Short simple phrases for instruction
  - Concrete, not abstract
  - Consistent with sequence of tasks/instruction
  - Predictable routine

Interdisciplinary Treatment Techniques

- Task segmentation
  - Simplify tasks
  - One-step commands
  - Hand-over-hand guidance
  - Familiar area
  - Allow for slower reaction time
  - Repeat commands
  - Limit adaptive equipment

CONTINUED

General Behavior Management Strategies

- Keep tasks simple
- Be flexible
- Provide soothing activities
- Tolerate wandering or pacing
- Get into the person's reality
- Validate the person's feelings
- Keep a calm demeanor
- Distract with meaningful activity
- Use routines, keep environment and approach consistent and familiar

CONTINUED

Interdisciplinary Treatment Techniques

- Provide one-step commands
- Speak slowly
- Repeat and rephrase sentences
- Utilize gestures with speech
- Praise and encourage patient often
- Limit distractions/structure environment
- Eye contact
- Avoid open-ended questions, offer choices
- Demonstrate the activity

Interdisciplinary Treatment Techniques

- Encourage automatic responses
- Activities performed with, not “for” patient
- Use other senses
- Topic maintenance
- Label objects
- Educate staff and family

Cueing Strategies

- Cues should be short and provide clear direction (Padilla, 2011)
- Verbal prompts along with positive reinforcement improve performance (Coyne & Hoskins, 1997)
- Demonstrate the activity
- Series of pictures that symbolize activity
- Provide tactile stimulation along with verbal instruction

Cueing Strategies

- Use hand signals, pictures, facial expressions
- Provide familiar visual and auditory stimuli
- Provide cues when changing topic
- Use of redirections
- Hand-over-hand technique
- Utilize multi-modality cueing

Principles of Care

- Acknowledge abilities and disabilities
- Increase cues to assist performance
- Demonstrate the activity
- Familiar activities are most successful
  - Tap into overlearned skills
- Decrease environment distractions
- Interrupt stereotypic behavior
- Get patient's attention
  - Allow ample processing time

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