Caring for the Resident with Dementia
Learner's Guide

Goal:
In this lesson you will learn about Alzheimer’s disease and other causes of dementia, how to identify dementia, and the stages in the progression of Alzheimer’s disease. Then, you will learn some specific interventions to use when caring for a resident with dementia or memory loss.

Objectives:
At the end of this training session, you will have learned how to:
1. Explain the causes of Alzheimer’s disease and other diseases that can cause memory loss.
2. Identify the stages of Alzheimer’s disease and the behaviors associated with each stage.
3. Identify specific interventions to use when caring for a resident with memory loss.
4. Discuss a specific resident in your long term care community so that interventions can be incorporated into the resident’s plan of care.

Take Note: Review your organization’s policies, procedures, and protocols for working with residents with dementia. Pay special attention to your Resident Elopement Policy.

Related Topics: Prevention of falls.
Promoting self-care.
Lowering your stress level.
Elder abuse, neglect, and misappropriation of resident’s belongings.
Resident’s rights.

Learning Strategies:
To complete this lesson, follow these steps:
1. Read the materials provided in each unit of this lesson.
2. Complete the practice exercise or question for each unit.
3. Complete each activity unless instructed otherwise.
4. Read the lesson review.
5. Complete the final content assessment.

After completing all of these steps, print two copies of the completed activity forms. Give one copy to your education coordinator and keep one for yourself.
Introduction:
There are over 4.5 million Americans that have some form of dementia. Dementia is characterized by a general gradual loss of memory, reasoning, judgment, and abstract thinking in persons who earlier in life did not have this problem. It is estimated that $100 billion per year is spent on medical bills, long term care, and loss of productivity. By 2050, an estimated 16 million Americans will be plagued by this disease. Alzheimer’s disease is the most common cause of memory loss. Increasing age is the greatest risk factor for Alzheimer’s disease. One in 10 individuals over 65 and nearly half of those over 85 are affected.

More than 7 out of 10 people with Alzheimer’s disease live at home, where almost 75 percent of their care is provided by family and friends. The remainder is “paid” care costing an average of $19,000 per year. Families pay almost all of that out of pocket.

Half of all nursing home residents have Alzheimer’s disease or a related disorder. The average cost for nursing home care is $42,000 per year but can exceed $70,000 per year in some areas of the country. The average lifetime cost of care for an individual with Alzheimer’s is $174,000.

This training session will acquaint the staff in the long term care environment with general information about Alzheimer’s disease and other forms of dementia. About 50% of all persons in long term care communities have a diagnosis of dementia. Eventually, 80-90% of older adults will have some memory loss. The material presented will discuss specific interventions that staff can use with these residents. This lesson will also dispel some myths about Alzheimer’s disease.

Unit 1:
Goal:
This unit will introduce you to the causes of memory loss and symptoms of Alzheimer’s disease. You will also learn ways you can recognize dementia and the predictable stages of the disease.

The diseases that can cause memory loss:
Dementia means severe loss of a person’s ability to think, including problems with memory, reasoning, judgment, and abstract thinking in a person who did not previously have this problem. Memory loss is a major problem in the aging population. Alzheimer’s disease may be one reason for dementia, and accounts for two-thirds to three-fourths of dementias. Other causes of dementia include:

- Vascular dementia (also known as strokes or mini-strokes).
- Brain tumors.
- Metabolic problems.
- Viral infections.
- Drug interactions.
- Substance abuse.
- Psychological problems.
- Parkinson’s disease.

Because several types of dementia are reversible, it is important that treatable causes are diagnosed and treated. A person who is experiencing memory loss should have a complete physical examination to obtain a reliable diagnosis and to rule out all other causes which may be causing the memory problems.

Alzheimer’s disease is very common in older adults. It is the fourth leading cause of death in adults after heart disease, cancer, and stroke. Dr. Alois Alzheimer first described it in 1907. Alzheimer’s disease is a progressive, degenerative disorder involving the cortex and hippocampus of the brain. Destruction of brain tissue leaves holes in the tissue similar to those in Swiss cheese. Nerve fibers become twisted. The chemicals needed to transmit messages in the brain diminish. Research has concentrated on several theories of cause.

**Identification of Dementia**

One day there may be a test for this disease that can accurately diagnose the exact causes of dementia prior to death. When the cause is discovered, a cure or delay in progression may possibly be developed.

Since many types of dementia are correctable, it is important to diagnose the cause of memory loss. Persons worried about dementia often experience age-associated memory changes, which may include:

- Increased forgetfulness.
- More time is required for learning new information.
- Decreased ability to retrieve information.
- Decreased speed in processing information.

Diagnosing dementia should take place over a period of time since many physical and other conditions can temporarily impair thinking ability. Many reversible conditions require tests for a diagnosis. A thorough history, physical exam, and diagnostic work-up should be done before assuming that the person with memory loss has Alzheimer’s disease.

Although Alzheimer’s disease can only be positively diagnosed on autopsy, this diagnosis is given after a thorough physical exam when there is decline in two or more areas causing problems with work or social functioning, and when all other causes of dementia have been ruled out.

(September 2007)

Kansas Association of Homes and Services for the Aging
The stages of Alzheimer's disease and the behaviors associated with each stage

There are several ways to stage Alzheimer's disease, which is predictable in its progression. However, Alzheimer's disease can co-exist with other kinds of memory loss. We will look at four stages to this disease.

**Early stage:** The duration of this stage is 0-4 years. The onset is subtle. The family may have interpreted the symptoms as normal age-associated changes. Characteristics of this stage are:

- Loss of short-term (recent) memory with intact long-term memory.
- Ability to perform known tasks but hesitation in performing new tasks.
- Declining interest in life (less closeness to loved ones, less spontaneity).
- Difficulty identifying people.
- Indifference to courtesies and rituals.
- Vague, uncertain, indecisive behavior.
- Nouns are often forgotten.
- Somatic complaints—constipation, insomnia, sleep pattern changes, decrease energy.
- Mood changes and short aggressive outbursts.

**Middle stage:** The duration of this stage is 4-10 years. There is obvious loss of recent memory with a shortened attention span and increased difficulty finding words. The person is unable to think abstractly, reason, or use sound judgment. He or she can not handle finances or a checkbook. Characteristics of this stage are:

- Significant decline in memory, recall, retention.
- Slowed response to questions.
- Disorientation to time (often day and night are confused).
- Complaints of neglect.
- Misplacing of important papers, forgetting of responsibilities, and appointments.
- Inability to follow simple directions.
- Neglect of physical health and hygiene.

**Later stage:** The duration of this phase is 3-5 years. The characteristics of this stage are:

- Disorientation to place and time.
- Misidentification of people. (A person will not recognize himself or herself in a mirror or in photographs. This phenomenon is called mirror sign).
- Deterioration of motor abilities.
- Major communication problems (denial, confabulations, and nonverbal language).
- Catastrophic reactions (violent reactions to inability to perform simple tasks).

(September 2007)
Kansas Association of Homes and Services for the Aging
**Final or terminal stage:** The duration is 1-2 years. Severe deterioration of the person’s abilities occurs. Characteristics include:

- Incontinence.
- Lack of verbal communication.
- Physical deterioration. (The person forgets how to chew and swallow, which results in aspiration pneumonia, the most common cause of death. Seizures and coma are not uncommon.
- Total dependence on caregivers for all needs.

Early in the course of Alzheimer’s disease, the person may be aware of memory and function problems. The person may deny the problem and cope with changes by writing down information, simplifying life, and staying in familiar surrounds. Depression is common early in this disease. Anger, agitation, and anxiety can become very evident in the middle and later stages. On average, persons with Alzheimer’s disease live from 8-10 years after being diagnosed, though the disease can last for as many as 20 years.

**Dispelling Myths about Alzheimer's Disease:**

**Myth 1:** Memory loss is a natural part of aging.

Reality: In the past people believed memory loss was a normal part of aging, often regarding even Alzheimer’s as a natural age-related decline. Experts now recognize severe memory loss as a symptom of a serious illness. Whether memory naturally declines to some extent remains an open question. Many people feel that their memory becomes less sharp as they grow older, but determining whether there is any scientific basis for this belief is a research challenge still being addressed.

**Myth 2:** Alzheimer’s disease is not fatal.

Reality: Alzheimer’s disease is a fatal disease. It begins with the destruction of cells in regions of the brain that are important for memory. However, the eventual loss of cells in other regions of the brain leads to the failure of other essential systems in the body. Also, because many people with Alzheimer’s have other illnesses common in older age, the actual cause of death may be no single factor.

**Myth 3:** Drinking out of aluminum cans or cooking in aluminum pots and pans can lead to Alzheimer’s disease.

Reality: Based on current research, getting rid of aluminum cans, pots and pans will not protect you from Alzheimer’s disease. The exact role (if any) of aluminum in Alzheimer’s disease is still being researched and debated. However, most researchers believe that not enough evidence exists to consider aluminum a risk factor for Alzheimer’s disease or a cause of dementia.
Myth 4: Aspartame causes memory loss.
Reality: Several studies have been conducted on aspartame's effect on cognitive function in both animals and humans. These studies found no scientific evidence of a link between aspartame and memory loss. Aspartame was approved by the U.S. Food and Drug Administration (FDA) in 1996 for use in all foods and beverages.

Myth 5: There are therapies available to stop the progression of Alzheimer's disease.
Reality: At this time, there is no medical treatment to cure or stop the progression of Alzheimer's disease. FDA-approved drugs may temporarily improve or stabilize memory and thinking skills in some individuals.

Unit 1: Practice Activity
Assign the list of the characteristics of Alzheimer's disease below to the correct stage at which it generally occurs.

<table>
<thead>
<tr>
<th>Stages:</th>
<th>Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early stage</td>
<td>a. Incontinence</td>
</tr>
<tr>
<td>Middle stage</td>
<td>b. Loss of short term memory</td>
</tr>
<tr>
<td>Later stage</td>
<td>c. Deterioration of motor abilities</td>
</tr>
<tr>
<td>Final or terminal stage</td>
<td>d. Complaints of neglect</td>
</tr>
</tbody>
</table>

Unit 2:
Goal:
Learn general guidelines to use when caring for a resident with dementia and specific intervention strategies related to hyperactivity, pacing, wandering, incontinence, communication, depression, aggressive behavior, delusions, and hallucinations.

Specific interventions to use when caring for a resident with memory loss:
Today, there are many excellent video tapes on care of the person with memory loss. Some of these video tapes deal with specific problems such as nutrition, aggressive behaviors, wandering, accident prevention, delusions, and hallucinations. These behaviors are common reasons why care givers seek the help of long-term care facilities. Many long-term care communities have special programs to deal with memory loss. Your goals should be to:

- Promote high quality of life with dignity and respect.
- Maintain high levels of functional activities for as long as possible.
- Help them accept their intellectual level.
- Maintain a safe environment.
- Individualize care, taking into consideration pre-dementia personality and values.
Some general suggestions in giving care include:

**General Guidelines:**
- Be flexible and adjust expectations to reflect the resident's ability.
- Observe the resident's facial and body movements for emotions like frustration or joy. Also, pain can be assessed in this way.
- Treat the person like an adult in the way you act and talk.
- Encourage a sense of humor.

**Choosing Activities:**
- Build on past learned skills.
- Avoid complicated, new activities. Trying to teach new things may lead to frustration, anger, and anxiety, and could result in catastrophic reactions.
- Keep activities simple. Repetitive activities work best.
- Break activities into separate steps. For example, brushing teeth: Take the resident to the sink. Find the toothbrush. Open the toothpaste. Apply Tooth paste to the brush. Raise the toothbrush to the mouth and begin the brushing movement, and so on.
- Play quiet music from the resident's era.
- Limit activities to 20 minutes. Attention span can be quite short.
- Choose meaningful activities.
- Allow the resident simple choices about participation in activities.

There are “windows of opportunity” when even the most seriously afflicted can tell you about their memories and emotions. Be sensitive to these opportunities, listen to the resident, and value him or her as a person.

There are many things you can do to facilitate daily routine care. Repetition and familiarity work well with people with memory loss.

**Tips to Facilitate Daily Routine Care:**

**General Guidelines:**
- Maintain a consistent daily routine.
- Provide appropriate sensory stimulation. Both over-stimulation and under-stimulation are harmful to the person with memory loss. Clocks, calendars, pictures, and signs may be useful.
- Provide regular periods of rest and activity. When he or she is too tired, life becomes overwhelming for the person with memory loss.
- Minimize disorientation as much as possible. Personal reminders of activities and routines are vital in establishing a rhythm for the day and helping the person feel safe. Familiar items, photographs, and objects of memory can be comforting. Avoid busy crowded areas.
- Assist the person to stay as involved as possible in hobbies and interests.
Reminiscence therapy is generally very useful. However, be aware that sometimes this can bring back painful memories.

- Identify the tasks that the resident needs help with to prevent anxiety and frustration.
- Validate the resident’s feelings.

**Environmental Guidelines:**
Provide a safe environment. This can be a big challenge.

- Remove items that could be dangerous including sharp objects, poisonous plants or fluids residents might drink, or medications.
- Have a minimum of furniture if this is what the resident is used to.
- Place non-skid strips in areas where the resident may walk, especially when getting out of bed.
- Fall management measures should be instituted for those at risk for falls.

**Physical Guidelines:**

- Attend to physical problems promptly in order to decrease pain and confusion. Nonverbal signs of discomfort or other changes in behavior are often the first clues to physical problems.
- Administer medications as prescribed for anxiety, depression, and agitation to help the resident to cope.

**Specific interventions to provide safety, minimize frustration, exhaustion, and debilitation:**

**Hyperactivity, pacing, and wandering**

**General Guidelines:**

- Schedule daily exercise. The amount needs to be adjusted to the individual. Some residents can walk most of the day. For others, one long walk a day is sufficient.
- Identify residents as wanderers and develop a system of identification such as bracelets, photographs, and written physical descriptions.
- Anticipate the person’s needs (such as toileting, hunger, thirst, or reassurance) to prevent further frustration,
- Provide consistent staffing.
- Determine triggering events and decrease them as much as possible. Sometimes bathing can be a challenge. Eating or holding something can provide a distraction.

**Environmental Guidelines:**

- Use an alarm system so that when residents leave a designated area, staff are alerted.
- Install drawer and closet childproof safety locks.
• “STOP” signs may be helpful when placed in areas where people are prone to wander.
• Have a safe outdoor area for residents.
• Prepare “rummaging boxes” with items of interest for that person.
• Put up screens or curtains over doorways to hide them.
• A small light in the bathroom may help to allay fears of the dark as well as providing light for safety.

**Eating issues:**
Eating habits change during the course of the disease. Early on, the resident may have an increased appetite, may not know when to stop eating, or may forget to eat. In the final stages, the resident forgets how to chew and swallow. These tips are helpful in maintaining the nutritional status of the resident:

• Follow a mealtime schedule.
• Avoid foods that are too hot.
• Avoid hard foods and those difficult to chew (nuts, carrots, popcorn, hard candy).
• Offer only one or two choices on the plate at a time.
• Thicken liquids or choose semisolid foods to reduce the chances of aspiration.
• Encourage the resident to feed himself or herself as long as possible. Finger foods are often helpful, especially if the person is usually on the move.
• Use appropriate adaptive equipment.
• Remind the resident how to use utensils. At times you may have to put the person through the motions to get him/her started.
• Prompt the resident to drink fluids to prevent dehydration.
• Place the resident in a sitting position to decrease swallowing problems.

**Incontinence:**
Assess bowel and bladder function on an ongoing basis and change management plans with the progression of the disease. Specific interventions for Alzheimer’s disease include:

• Orient residents to the location of the bathroom. Large signs with a picture of a toilet may help, as will physically assisting them to the bathroom in later stages.
• Have a toileting routine to keep residents as dry as possible.
• Choose the appropriate incontinence products for the resident’s needs and body size.
• Sometimes replacing the door of the bathroom with a curtain makes it easier for the resident to get to the bathroom.
Communication:
Residents with Alzheimer’s disease have major problems with speech and language. This is very frustrating to both the resident and the family. There are some helpful interventions you can try.

- Treat the person with dignity and respect as an adult.
- Use short sentences and speak clearly.
- Use simple language.
- Avoid hoping that the person will remember what was said a few minutes earlier.
- Always face the person while speaking. Avoid startling the person with loud noises or by touching him or her from behind.
- Remember that many people still maintain a sense of humor.
- Remember that people with dementia are very sensitive to the emotions of those around them.

Depression:
There is a cause and a purpose for all the behaviors of the person with Alzheimer’s disease. The factors are both internal and external.

Internal factors:
- Fear as the person realizes he or she is losing control.
- Frustration with tasks that exceed the person’s ability.
- Impaired perceptions and lack of understanding by staff and family.
- Fatigue.
- Effects of medication.

External factors:
- Unfamiliar physical environment.
- Use of restraints.
- Nature and degree of environmental stimulation.
- Interaction with staff and others in the long-term care environment.

Some typical aggressive behaviors include hitting, slapping, and screaming, pacing, or verbal abuse toward nearby persons. The goal of care is to offer a non-threatening and safe environment. Some interventions can help. Strategies to use are:

- Allow the person to feel a sense of control.
- Enhance situations or stimuli that bring comfort.
- Use a calm voice.
- Avoid arguments, attempts at reasoning, and confrontation.
- Divert or distract the person. Offer to go on a walk, eat a snack, or do an activity.

(September 2007)
Kansas Association of Homes and Services for the Aging
Delusions and hallucinations:
Both of these occurrences are common with dementia. Some interventions may be helpful.
- Communicate with the care team about these problems.
- Be sure that the person is wearing his or her glasses and hearing aids. This will decrease misinterpretation of the environment.
- Be sure there is adequate lighting.
- Offer calm reassurance.
- Validate the resident’s feelings.
- Discuss a specific resident in your long-term care organization so that interventions can be incorporated into the resident’s plan of care (see activity).

Unit 2: Practice Activity
Is the following question true or false? Circle your answer.

A constant daily routine is beneficial to residents with dementia.
True    False

Lesson Summary
Dementia is a devastating disease, of which Alzheimer’s is one type. It is characterized by a general gradual loss of memory, reasoning, judgment, and abstract thinking in a person who earlier in life did not have problems with these. Often their physical bodies are remarkably healthy. Victims slowly lose contact with reality and those they loved. As caregivers, there are many useful approaches that we can use to make the lives of a person with memory loss more comfortable.

To continue with this lesson, please complete the following individual or group activities:
Caring for the Resident with Dementia

Individual/Group Activity:

Activity 1
Directions: Identify a resident(s) in your organization that has the following problems due to dementia. In Unit 1q, you learned the stages of Alzheimer’s disease and the behaviors associated with each stage. If the identified resident has Alzheimer’s, which stage is he/she in? If you are working individually, hand in your answers to your education coordinator. If you are working in a group, discuss your answers with your group.

- The resident who wanders.
- The resident who is combative.
- The resident who refuses to let you take care of him or her.
- The resident who won’t eat at mealtime.
- The resident who is continent if taken to the bathroom, but incontinent if not taken to the bathroom. Does not understand where the toilet is.
- The resident who asks you the same thing over and over again.
- The resident who is disruptive in activities.
Activity 2

**Directions:** In Activity 1, you identified a resident or residents that had certain problems due to dementia. List interventions that have worked/not worked and indicate one intervention that you will try based on this lesson. **This part is very important**—how are you using person-centered care with this resident? If you are working individually, hand in your answers to your education coordinator. If you are working in a group, discuss your answers with your group.

- The resident who wanders.
- The resident who is combative.
- The resident who refuses to let you take care of him/her.
- The resident who won’t eat at mealtime.
- The resident who is continent if taken to the bathroom, but incontinent if not taken to the bathroom. Does not understand where the toilet is.
- The resident who asks you the same thing over and over again.
- The resident who is disruptive in activities.

(September 2007)
Kansas Association of Homes and Services for the Aging
Lesson Assessment

Directions: Circle the correct answer.

1. Approximately what percentage of nursing home residents have Alzheimer’s disease? (Unit 1).
   a) 10%.
   b) 25%.
   c) 30%.
   d) 50%.

2. The most common symptom during the first stage of Alzheimer’s disease is: (Unit 1).
   a) Confusion.
   b) Wandering.
   c) Hearing loss.
   d) Memory loss.

3. All of the following are behaviors exhibited in the second stage of Alzheimer’s disease except (Unit 1).
   a) Hearing loss.
   b) Forgetfulness.
   c) Disorientation.
   d) Inability to follow simple directions.

4. One behavior exhibited in the third stage is (Unit 1).
   a) Modesty.
   b) Wandering.
   c) Hearing loss.
   d) Decreased appetite.

5. When approaching a resident with Alzheimer’s disease, it is best to do it calmly and slowly in order to avoid (Unit 2).
   a. A catastrophic reaction.
   b. The resident ignoring you.
   c. The resident not seeing you.
   d. The resident not hearing you.

6. When the resident is unable to recognize himself or herself anymore, this is called (Unit 1).
   a. Self-sign.
   b. Mirror sign.
   c. Loss of identity.
   d. Not identifying self.
7. Behaviors exhibited in the fourth stage of Alzheimer's disease include all of the following except (Unit 1).
   a. Weight gain.
   b. Incontinence.
   c. Inability to walk.
   d. Susceptibility to infections.

8. When assisting the person with Alzheimer's disease at mealtimes, all of the following are acceptable except (Unit 2).
   a. Offering all foods at once.
   b. Reminding the person to eat.
   c. A calm and quiet environment.
   d. Using plastic bowls and cups.

9. To help the resident with Alzheimer's disease with elimination you should: (Unit 2).
   a. Insert a catheter.
   b. Increase fluid intake at night.
   c. Make the resident wear adult diapers.
   d. Set up a toileting schedule during the day.

10. Methods to decrease wandering include all of the following except (Unit 2).
    a. Restraining the resident.
    b. Putting up a screen to hide the door.
    c. Hanging a sign on the door that says, “STOP”.
    d. Putting the resident in slippers during the day.

11. If the resident does wander outside, you would first do which of the following (Unit 2).
    a. Call the family.
    b. Call the police.
    c. Force him or her back into the building.
    d. Walk with the resident and try to distract him or her.

12. If a resident becomes agitated, one of the most common reasons is (Unit 2).
    a. The resident is angry with you.
    b. The resident needs to be medicated.
    c. The resident needs to eat something.
    d. The resident needs to go to the bathroom.
Caring for the Resident with Dementia
Presenter’s Guide

**Purpose**
There are over 4.5 million Americans that have some form of dementia. Dementia is characterized by a general gradual loss of memory, reasoning, judgment, and abstract thinking in persons who earlier in life did not have this problem. It is estimated that $100 billion per year is spent on medical bills, long-term care, and loss of productivity. By 2050, an estimated 16 million Americans will be plagued by this disease. Alzheimer’s disease is the most common cause of memory loss. Increasing age is the greatest risk factor for Alzheimer’s. One in 10 individuals over 65 and nearly half of those over 85 are affected.

Half of all nursing home residents have Alzheimer’s disease or a related disorder. The average cost for nursing home care is $42,000 per year but can exceed $70,000 per year in some areas of the country. The average lifetime cost of care for an individual with Alzheimer’s is $174,000.

This training session will acquaint the staff in the long-term care community with general information about Alzheimer’s disease and other forms of dementia. About 50% of all persons in long-term communities have a diagnosis of dementia. Eventually, 80-90% of older adults will have some memory loss. The material presented will discuss specific interventions that staff can use with those residents. The lesson will also dispel some myths about Alzheimer’s disease.

**Objectives:**
At the end of this training session, the participant should be able to:

- Explain the causes of Alzheimer’s disease and other diseases that can cause memory loss.
- Identify the stages of Alzheimer’s disease and the behaviors associated with each stage.
- Identify specific interventions to use when caring for a resident with memory loss.
- Discuss a specific resident in your long-term care organization so that interventions can be incorporated into the resident’s plan of care.

**Related topics:** Prevention of falls.
- Promoting Self-care
- Lowering your stress level.
- Elder abuse, neglect, and misappropriation of resident belongings.

(September 2007)
Kansas Association of Homes and Services for the Aging
**Learning Activities:**

To complete this session, the participants should:

- Read the materials provided in each unit of this lesson.
- Attend a lecture/discussion about memory loss (given a designated staff member or guest speaker) and/or read the *Caring for a Resident with Dementia Learner’s Guide.*
- View a video tape that discusses dementia (optional).
- Complete the Lesson Assessment.
- Complete the Group Activity and hand in to Education Coordinator.
- Review your organization’s policies, procedures and resources for working with residents with dementia.

After completing all of these steps, the participant should print two copies of the completed activity forms. One copy is to be submitted to the education coordinator, the other copy is retained by the participant.

**Overheads:**

- Other Causes of Dementia.
- Age-associated memory changes.
- (a-d) Stages of Alzheimer’s disease.
- Myths.
- (a & b) General suggestions for care.
- (a & b) Tips for daily care.
- (a-d) Interventions for hyperactivity; eating; incontinence; communication.
- Depression.
- Aggressive behavior.
- Delusions and hallucinations.

**Answers to Lesson Assessment**

1. **Answer:** d.
   
   **Rationale:** 50% of nursing home residents are diagnosed as having Alzheimer’s disease. This figure will most likely increase in the future due to the growing aging population, as well as physicians who are becoming more knowledgeable about the disease and less reluctant to make the diagnosis.

2. **Answer:** d.
   
   **Rationale:** Wandering and confusion are signs exhibited in the third stage of the disease. The most common sign is short-term memory loss. Some people with Alzheimer’s don’t lose their long-term memory until the last stage. Hearing loss is not a sign of Alzheimer’s disease.
3. **Answer: a.**  
*Rationale:* Hearing loss is not a symptom of Alzheimer's disease. The person with the disease may have this problem, but it is related to aging, not the disease. All of the other behaviors are exhibited in the second stage.

4. **Answer: b.**  
*Rationale:* Wandering is very characteristic of the third stage of the disease. The person usually exhibits an increase in appetite called hyperorality. Also, he or she may lose all sense of modesty and behave in inappropriate ways, such as masturbating or undressing in public.

5. **Answer: a.**  
*Rationale:* The key to working with a person with Alzheimer’s disease is using a calm and quiet manner so as not to startle or frighten the person. If a catastrophic reaction still occurs, it may be due to too much stimulation and you may need to either remove the person from the situation, or come back a few minutes later and try something else. DO NOT ARGUE WITH THE PERSON! This will only cause more agitation.

6. **Answer: b.**  
*Rationale:* The resident will begin to forget some people even in the second stage, but will still remember family members and him or herself. In the third stage, the resident will begin to forget family members, which is understandably very difficult for the family. And finally, he or she will not recognize their own face in the mirror or in pictures.

7. **Answer: a.**  
*Rationale:* In the fourth or “terminal” stage, the resident will continue to lose ability to meet personal needs like toileting, feeding, and so forth. He or she will lose the ability to understand how to feed him or herself, or even why eating is necessary. Therefore, the resident will experience weight loss, not weight gain.

8. **Answer: a.**  
*Rationale:* A person with Alzheimer's disease will do poorly in an environment with a lot of stimulation, because he or she cannot process all of the stimulation and focus on what needs to be done. Offering multiple foods will confuse the person with too many choices. Offer foods one at a time, and offer snacks between meals.

9. **Answer: d.**
Rationale: Having the resident go to the bathroom on a routine basis will prevent incontinent episodes and continue to encourage independence. The resident can either be taken to the bathroom every two hours, or at meal times and bedtime. Decreasing fluid at night will decrease incontinent episodes. A catheter should be a last resort but may be necessary in the fourth stage if the person develops a skin breakdown.

10. Answer: a:
   Rationale: Once the person becomes familiar with their surroundings, the wandering may decrease. Restraints should not be used with a resident who has dementia and wanders. Wandering usually occurs in the first three months in the long-term care community because it is an unfamiliar environment. The other interventions are things staff can do to decrease wandering.

11. Answer: d.
   Rationale: Most persons with Alzheimer’s disease will realize they are not in familiar surroundings once they go outside the building. Trying to force a resident back into the building will only frighten him or her more. Walking with the person and discussing other things, such as when the next meal is, will redirect him or her. Actions like gently taking the resident’s arm, walking together, and talking calmly will begin to calm the resident. Then you can probably turn him or her around and return to the building.

12. Answer: d.
   Rationale: A common reason the person with Alzheimer’s becomes agitated is because he or she needs to go to the bathroom. The resident becomes agitated because they do not know where the bathroom is, or how to get there, and does not know how to ask for assistance. By regularly toileting the resident, caregivers can decrease agitation.
More Information:
The following are resources you can have your staff read for more information about dementia, or they can be used if staff are presenting an in-service.

Articles


(September 2007)
Kansas Association of Homes and Services for the Aging
Books


Kansas Association of Homes and Services for the Aging
As people with dementia lose their powers or reasoning, judgment, perception and language, they often become anxious, bored, frustrated, angry, suspicious and depressed. It is from these emotional states that the challenging behaviors of dementia arise. This video series explains how to understand these behaviors by identifying the forces that trigger the uncomfortable emotions. A logical step-by-step explanation in simple, easy to understand language leads to an effective approach to preventing emotionally troubled behavior. In this video series you will learn to understand:

- The “inner world” of dementia.
- Positive and negative triggers.
- How to create an individual plan of care.

*Alzheimer’s disease: Inside looking out.* (18 minutes). $145 purchase, $45 rental. It is available from Terra Nova Films at tnf@terranova.org or 800-779-8491.
Several individuals in the early stages of Alzheimer’s, talk about how important it is for them to remain a respected participant in the decisions that affect their lives, from diagnosis to planning for end of life choices.

*Dealing with Alzheimer’s disease: A common sense approach to communication.* (20 minutes). $149 purchase $45 rental. It is available from Terra Nova Films at tnf@terranova.org or 800-779-8491.

Teaches the “do’s and don’ts” of successfully communicating with someone who has Alzheimer’s disease.

*Dementia with dignity.* (60 minutes). $169 purchase $55 rental. It is available from Terra Nova Films at www.terranova.org or 800-779-8491.

This dementia training video stands out because of its clear language, real-life situations, and practical approach. It shows that quality of life for persons with dementia can be greatly enhanced when caregivers:

- Understand the unpredictable effects of dementia.
- Learn how to communicate and respond to the specialized needs of the person behind the illness.
- Strengthen and encourage use of the person’s remaining skills to increase self-pride and autonomy.


Since it’s rarely possible to change the behaviors of residents who can’t understand or remember, those caring for people with Alzheimer’s must modify their expectations, and lean to intervene only when truly necessary. This sensitive and realistic video demonstrates practical ways of dealing with behaviors such as wandering, angry outburst, and delusions. Designed primarily for nursing home staff, it will be valuable for family caregivers as well.


This practical video shows both professional and family caregivers how to break down ADLS into simple tasks with people with dementia can perform without direct assistance. Lean how to help individuals with Alzheimer’s disease regain control over their lives.

*he’s doing this to spite me.* (22 minutes). $179 purchase $50 rental. It is available from Terra Nova Films at tnf@terranova.org or 800-779-8491.

(September 2007)

Kansas Association of Homes and Services for the Aging
Those who are close to someone who has dementia often find it hard to deal with the erratic and difficult behaviors that result from the disease. They may interpret these behaviors as intentional. This combined with the stress of care giving and a lack of understanding the effects of this disease may cause the caregiver to respond with frustration, impatience, and even anger. Three caregivers openly share their experiences and frustrations as they interact with their loved one who has dementia. These scenes are integrated with comments and guidance from professionals in the field of dementia care. The result is a video that teaches caregivers how to reframe the care giving dynamic into one that is more comfortable and productive for both the caregiver and the care receiver.

*Hi Buddy: The developmentally delayed individual with Alzheimer's disease.*
(19 minutes). $150 purchase $75 rental. It is available from Video Press at [www.videopress.org](http://www.videopress.org) or 800-328-7450.

*Hi Buddy* introduces Roger, a 53-year old man with Down's syndrome and a diagnosis of Alzheimer's disease. Despite Roger's decline, he still retains the ability to win over the world with his smile and cheerful nature. Observe Roger at home, at work, and at a doctor's appointment where you will see areas of independence and where he now requires assistance.

*Let's go to church.* (60 minutes). $64. Available from Health Professions Press at [www.healthpropress.com](http://www.healthpropress.com) or 888-337-8808.

Residents and clients experiencing moderate to advanced dementia will be reassured and calmed by the strains of old, familiar hymns performed on guitar by a friendly pastor in this 60 minute video. Viewers are encouraged to sing along and move with the music, to share an uplifting prayer, and to reminisce about their church going days. This engaging video will provide repeated entertainment and solace for frail or confused elders who are unable to participate in religious services.

*Living with Alzheimer's disease—the family care givers guide.* A six-tape series, (20-25 minutes each). $150 purchase, or $75 rental for each, or $800 series price. Available from Video Press at [www.videopress.org](http://www.videopress.org) or 800-328-7450.

- **The Beginning.** Topics include: symptoms indicating the need for an evaluation; how to make determinations about a person's ability to live alone; and appropriate care giver responses to loss of memory, confusion, and disorientation.
- **The Middle Years.** Topics include: how to manage potentially distressing behaviors such as aggression, wandering, and memory loss; how to develop a therapeutic routine for the resident; and how to minimize catastrophic reactions.

(September 2007)

Kansas Association of Homes and Services for the Aging
• Endings. Family members share their experiences during the final years of Alzheimer’s disease. Issues discussed include: what to anticipate; how to manage increased care needs; learning about respite care; dealing with the ever-increasing loss; and understanding the important decisions that need to be made near the end of life.

• The new relationship. Dr. Peter Rabins talks with family caregivers about the changes they experience in their relationships and how they manage to create new positive roles.

• The caregiver’s options. Families discuss care options and how to make timely and responsive decisions. When can a family member no longer be left alone? What options for help are available? When do assisted-living or nursing homes become the most therapeutic environment? And, how can families work together to make these decisions?

• Ethical issues. Topics include: the need for medical assessments; limiting independent living, dealing with the driving dilemma; what to do when the truth is upsetting; and making advanced directives and other medical decisions.


Other Resources:
KAHSA Lending Library (members only)

Best Friends. By Virginia Bell and David Troxel. (20 minute video with book)

This best friends approach to Alzheimer's care shows how easily you can make a difference in the life of a family member or client in your care. Bell and Troxel are recognized nationally for their groundbreaking and innovative work helping people with Alzheimer's disease and their families. Amidst the many challenges and faces of disease, it takes all the same ingredients of any good friendship to provide support; mutual respect, affection and understanding.

A day in the life of Nancy Moore: Caring for the Alzheimer’s resident. (Accompanying booklet entitled “Optimum care of the nursing home resident with Alzheimer's disease: Giving a little extra”. Terra Nova Films, Inc. (28 minutes)

A video tape with accompanying booklet specifically designed for nurses' aids. It walks with Nancy as she cares for several residents with dementia, and highlights the importance of customizing care for each resident and developing a good
relationship with the family. The video clearly recognizes and validates the critical role of the CNA in determining quality of care for residents with Alzheimer's.

**Everyone wins: Quality care without restraints.** Set of 6 videos with in-service training manual. A comprehensive training program that offers practical strategies to provide quality care without physical restraints. Topics include: The new resident, minimizing the risk of fall injuries, working with residents who wander, aggressive behaviors, staying restraint-free, and a family guide to restraint-free care.

**Special programs for people with dementia.** Some of the topics covered in this book include: staff training to work in special care; programming and activities; clinical issues in advanced dementia; family concerns; interior design/renovation; maximizing reimbursement, and innovation in special care.

**A decision-tree method for reviewing, evaluating, and planning the status of a special care unit for persons with dementia illness.** (cost $5.)

**Best practices for special care programs for persons with Alzheimer’s disease or a related disorder.** AAHSA publication.

This best practices booklet can assist organizations to distinguish what is unique about special care programs, identify exemplary methods for care providers, to serve as a starting point for new programs or to evaluate established programs, and develop consumer education regarding special care.

**Preventing resident to staff aggression.** KAHSA long-term care safety series.
OTHER CAUSES OF DEMENTIA

• Vascular Dementia (Strokes, Mini-Strokes).

• Brain Tumors.

• Metabolic Problems.

• Viral Infections.

• Drug Interactions.

• Substance Abuse.

• Psychological Problems.

• Parkinson’s Disease.

(September 2007)

Kansas Association of Homes and Services for the Aging
AGE-ASSOCIATED MEMORY CHANGES

- Increased Forgetfulness.

- More Time for Learning New Information.

- Decreased Ability to Retrieve Information.

- Decreased Speed in Processing Information.
STAGES OF ALZHEIMER’S DISEASE

Early stage: 0-4 years.

• Loss of short-term (recent) memory.

• Ability to perform known tasks but hesitation to perform new tasks.

• Declining interest in life.

• Difficulty identifying people.

• Indifference to courtesies and rituals.

• Vague, uncertain, indecisive behavior.

• Nouns are often forgotten.

• Somatic complaints.

• Mood changes and short aggressive outbursts.
Stages of Alzheimer’s Disease

Middle stage: 4-10 years.

• Significant decline in memory, recall, retention.

• Slowed response to questions.

• Disorientation to time.

• Complaints of being neglected.

• Misplacing of important papers, forgetting of responsibilities.

• Inability to follow simple directions.

• Neglect of physical health and hygiene.
STAGES OF ALZHEIMER’S DISEASE

Later stage: 3-5 years.

- Disorientation to place and time.

- Misidentification of people; no self-recognition in mirrors or photographs (“mirror” sign).

- Deterioration of motor abilities.

- Major communication problems.

- Catastrophic reactions.
STAGES OF ALZHEIMER’S DISEASE

Final or terminal stage: 1-2 years.

• Incontinence.

• Lack of verbal communication.

• Physical deterioration.

• Total dependence on care givers for all needs.
Dispelling Myths

Myth 1: Memory loss is a natural part of aging.

Myth 2: Alzheimer’s disease is not fatal.

Myth 3: Aluminum can cause Alzheimer’s disease.

Myth 4: Aspartame causes memory loss.

Myth 5: Therapies are available to stop the progression of Alzheimer’s disease.
GENERAL SUGGESTIONS FOR CARE

General guidelines:

• Be flexible.

• Observe resident’s facial and body movements.

• Treat resident as an adult.

• Encourage a sense of humor.
CHOOSING ACTIVITIES:

- Build on past learned skills.

- Avoid complicated, new activities.

- Keep activities simple.

- Break activities into small separate steps.

- Play quiet music from resident’s era.

- Limit activities to 20 minutes.

- Choose meaningful activities.

- Allow resident simple choices.
**TIPS FOR DAILY CARE**

General guidelines:

- Maintain a consistent daily routine.
- Provide appropriate sensory stimulation.
- Provide regular periods of rest and activity.
- Minimize disorientation.
- Assist resident to stay as involved as possible.
- Identify tasks the resident needs help with.
- Validate the resident’s feelings.
Environmental guidelines:

- Provide a safe environment.
- Remove items that could be dangerous.
- Have a minimum of furniture.
- Place non-skid strips where resident may walk.

Physical Guidelines:

- Fall precaution measures.
- Attend to physical problems promptly.
- Administer medications prescribed for anxiety, depression, and agitation.
INTERVENTIONS FOR PACING, HYPERACTIVITY, WANDERING

Environmental:
• Use an alarm system.
• Install childproof safety locks.
• “Stop” signs may be helpful.
• Have a safe outdoor area for residents.
• Prepare “rummaging boxes”.
• Put up screens or curtains over doorways.

General:
• Schedule daily exercise.
• Identify wanderers.
• Anticipate the person’s needs.
• Provide consistent staffing.
• Decrease triggering events.
INTERVENTIONS FOR COMMON RISK BEHAVIORS

Eating issues:
• Follow a mealtime schedule.

• Avoid foods that are too hot.

• Avoid foods that are difficult to chew.

• Offer only one or two choices at a time.

• Thicken liquids or choose semisolid foods.

• Encourage the resident to feed self.

• Use adaptive equipment.

• Remind resident how to use utensils.

• Prompt resident to drink often.

• Keep resident sitting to decrease swallowing problems.
INTERVENTIONS FOR COMMON RISK BEHAVIORS

Incontinence:

• Orient residents to bathroom.

• Have a toileting routine.

• Use appropriate size of products.
**Communication:**

- Treat the person with dignity and respect.

- Speak clearly.

- Use short sentences, simple language.

- Do not expect person to remember what was said a few minutes earlier.

- Face the person while speaking.

- Use sense of humor.

- Remember that people with dementia are sensitive to emotions of others.
DEPRESSION

This is common in the early stage of Alzheimer’s disease.

• Assessment for depression.

• Appropriate support.

• Counseling.

• Medications.
AGGRESSIVE BEHAVIOR

• There is a cause and a purpose for all behavior of the person with Alzheimer’s disease.

• Aggressive behaviors are usually demonstrated by hitting, slapping, screaming, pacing, verbal abuse of nearby persons.

Strategies to use are:
• Allow the person to feel a sense of control.

• Enhance situations that bring comfort.

• Use a calm voice.

• Avoid arguments, reasoning and confrontation.
DELUSIONS AND HALLUCINATIONS

Both are common with dementia.

Interventions that may be helpful:

• Communicate with the care team about these problems.

• Be sure that the person is wearing his or her glasses and hearing aids.

• Be sure there is adequate lighting.

• Offer calm reassurance.

• Validate the resident’s feelings.