



**Course Title: Alzheimer's Disease & Related Disorders (ADRD) for Homecare workers (1201)**

**Total Number of Contact Hours: 2**

**Intended Level of Learner: Introductory**

**Purpose/Goal: To prepare home healthcare workers for situations they will face when working with ADRD patients. This course reviews the progression of Alzheimer's disease and presents strategies for care and management of individuals with Alzheimer's disease or related Disorders.**

Objectives	Content	Resources
Compare the factors that contribute to dementia and dementia driven behaviors	Causes, Stages and Needs: --Causes of ADRD --Normal Brain Functioning --How Does Dementia Differ from Normal Aging? --Stages of ADRD --The Environment and Dementia Driven Behavior --Physical Condition/Well-being --Emotional Well-being --Nutrition/Fluid Intake --Psychosocial Needs	Course Material online Learning Scenario Post test Questions
Describe how ADRD affects communication skills	Communicating Effectively with Patients with ADRD: --ADRD: The Effect on Communication --Managing Communications in Three Stages of ADRD	Course Material Learning Activity Post test Questions
Identify challenging	Behavior Identification:	Course Material

<p>behaviors associated with ADRD</p>	<ul style="list-style-type: none"> <li>--The Sources of Problem Behavior</li> <li>--Medical / Physical Factors</li> <li>--Emotional Stress Factors</li> <li>--Environmental Stress Factors</li> <li>--Psychosocial Stress Factors</li> <li>--Solutions for Managing Problem Behavior</li> <li>--Behavior Profile</li> <li>--Documenting Behaviors</li> <li>--Tune-in to Your Patients</li> <li>--Steps to Resolving Problem Behaviors</li> <li>--Defuse &amp; De-escalate Potential Danger</li> <li>--Set the Stage for Success</li> <li>--Intervention Communication Skills Review</li> <li>--Coping with Resistant Behavior</li> <li>--Restraints and Alternatives</li> </ul>	<p>Learning Activity Post test Questions</p>
<p>Examine general strategies for promoting independence in the beginning, middle, and late stages of ADRD</p>	<p>Assisting with Activities of Daily Living (ADLs):</p> <ul style="list-style-type: none"> <li>--Philosophy of Care</li> <li>--Modifying Daily Activities</li> <li>--ADL Assistance in Stages of ADRD</li> <li>--Communication Skills Review for Modifying Daily Tasks</li> <li>--Dressed for Success: Personal Care Strategies</li> </ul>	<p>Course Material Learning Activity Post Test Questions</p>
<p>Identify issues and concerns of family members and patients during the early, middle, and late stages of ADRD</p>	<p>Working with Families and Caregivers:</p> <ul style="list-style-type: none"> <li>--Family Support Groups</li> <li>--Costs of Care: Time, Dollars, Feelings</li> <li>--Family Members: Part of the Care Process</li> <li>--Grief, Bereavement, and Mourning</li> <li>--Tips for Visiting Family Members</li> <li>--Helpful Strategies for Homecare Workers</li> <li>--Keep the Family Involved</li> <li>-- Share Support Resources</li> </ul>	<p>Course Material Learning Exercises Post test Questions</p>

	with Family Members	
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6/15/2011

# Alzheimer's Disease & Related Disorders (ADRD) for Homecare Workers (1201)

By  
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## Topic 1: Causes, Stages and Needs

**Topic Introduction:** Patients afflicted with ADRD can present some of the greatest challenges for homecare workers. Many patients who suffer from dementia may exhibit challenging behaviors as a result of the physical, social, and environmental factors that affect them. These factors can prevent patients from enjoying and participating in constructive activities and deter the attempts of all homecare workers. After reading through this topic section you will be able to compare the factors that contribute to dementia driven behaviors.

### Causes of ADRD

"Dementia [is] a progressive brain dysfunction [which] leads to a gradually increasing restriction of daily activities." Dementia is classified as a syndrome and is characterized by catastrophic, progressive global deterioration in intellectual function. Dementia can exist in both reversible and irreversible forms.

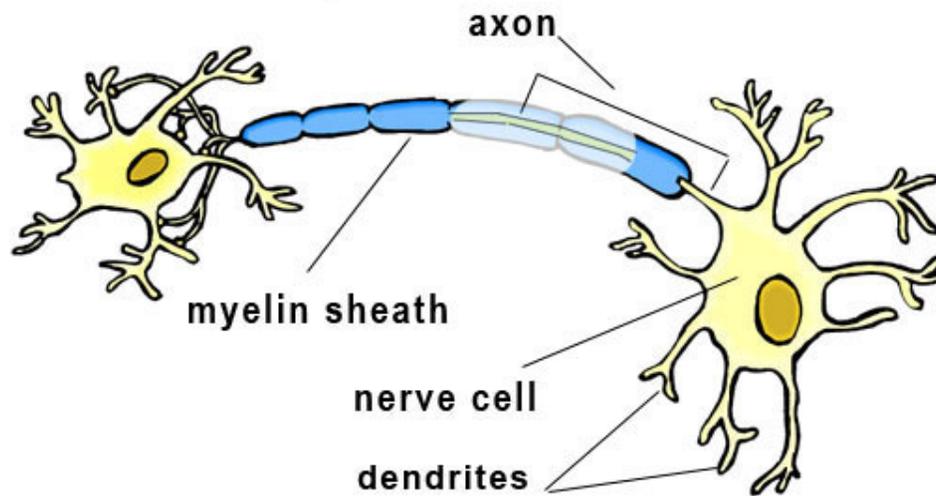
Alzheimer's Disease is one of the most common sources of dementia (Source: "psychiatry24x7.com-About Dementia"). The destruction of nerve cells in the brain is what triggers the symptoms of dementia (Source: "About Dementia"). ADRD is the acronym for Alzheimer's Disease & Related Disorders.

Scientists don't fully understand what causes Alzheimer's disease, but it is clear that it develops because of a series of events that take place in the brain over a period of time. It is speculated that the causes include genetic, environmental, and lifestyle factors. Because people differ in their genetic make-up and lifestyle, the importance of these factors for preventing or delaying Alzheimer's differs from person to person (Source: Alzheimer's Disease and Related Dementias Fact Sheet).



## Normal Brain Functioning

### Basic Neuron Design



In order for an impulse to be sent, a neuron (a nerve cell and basic unit of the brain) must be stimulated by something. This can range from a finger prick or a funny joke. Within the neuron, an electric impulse travels through the cell body to the tip of the axon, where there are tiny sacs containing neurotransmitters (chemicals that act as data messengers). The arrival of the impulse signals the release of neurotransmitters into a synapse, which is the space between the axon and an adjoining cell. In the synapse, the neurotransmitters bind to the receptors on the receiving cell. The membrane of the receiving cell is altered in a way that re-creates the impulse, and the process begins again. Neurons stay healthy by converting nutrients found in circulating blood, such as oxygen, into energy. Protein plays an important role in maintaining cells and tissues. Special proteins called enzymes help to speed up reactions and thus assist the metabolism.

### Brain Anatomy

The anatomy of the brain can be divided across the middle lengthwise into two halves called the cerebral hemispheres. Each hemisphere of the cerebral cortex is divided into four lobes. Please refer to the following table for a listing of each lobe and its function.

Lobe	Function
Frontal	Concerned with reasoning, planning, parts of speech and movement (motor cortex), emotions, and problem-solving.
Parietal	Concerned with perception of stimuli related to touch, pressure, temperature and pain.
Temporal Lobe	Concerned with perception and recognition of auditory stimuli (hearing) and memory.
Occipital Lobe	Concerned with aspects of vision. It also includes association areas that help in the visual recognition of shapes and colors.

### Plaques and Tangles

An understanding of brain cell changes that occur as part of ADRD requires a description of plaques and tangles. In people with ADRD, deposits known as plaques and tangles invade the brain tissue. Although some plaques and tangles develop as part of the normal aging process, people with ADRD have many more of them.

The protein that makes up plaques is normally found in the body. But plaques are sticky, abnormal clusters of this protein. Plaques are found in the spaces between the neurons and they can disrupt the pathways that carry impulses from one neuron to the other.

Tangles, too, are made up of a protein that is found in the body normally. But the protein loosens its structure and gets "tangled" up in the process, like threads wrapped around each other. Tangles are found inside the neurons and can clog them and prevent them from functioning properly. It is believed by some researchers that tangles damage the neurons, causing them to die. A protein named "tau" has been shown to be involved in forming tangles, but it is still unknown as to exactly how and why tangles form, and how exactly they affect the brain.

When neurons are clogged with tangles, and the spaces between neurons are clogged with plaques, nerve impulses cannot be sent from one neuron to the next the way they should. As a result, the brain has trouble performing some mental functions, such as remembering and thinking.

## Acetylcholine

Alzheimer's disease also causes changes in the brain's chemical messengers. The chemical messenger acetylcholine is particularly important. Acetylcholine is thought to be important in the working of neurons responsible for memory, thinking, and judgment. In Alzheimer's disease, acetylcholine is broken down more quickly than usual, so that overall levels of acetylcholine are decreased.

## How Does Dementia Differ from Normal Aging?

Although related to aging, ADRD it is not a normal part of aging. Not every elderly person develops dementia. It is important to ask about each individual's medical condition, rather than assume this diagnosis. When this disease is not present, the human brain often can function well into the tenth decade of life.

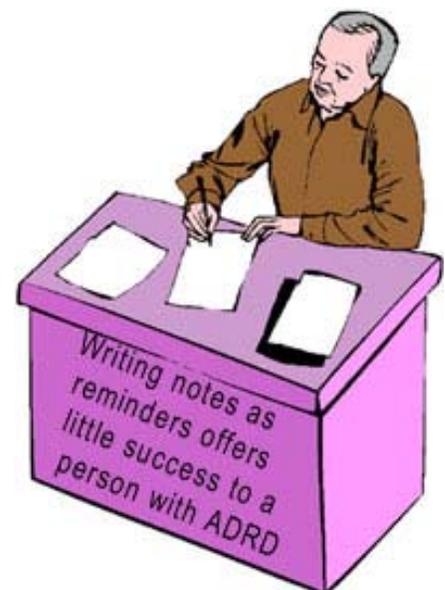
Everybody forgets things sometimes, particularly when feeling increased stress. As people age, they tend to forget things more often: appointments, names, or where they put the checkbook. ADRD differs from normal forgetfulness due to aging or increased stress. In persons who are aging normally, nerve cells in the brain are not lost in great numbers as they are in those who have ADRD.

Normal aging is associated with some mild memory changes. The ability to store and recall information decreases with age. Decision-making takes more time, thought processes seem to slow with metabolism. Some slower thinking and recalling information is normal. As young as 45 or 50, a person may notice the energy decreasing and the memory "slipping."

Devising memory-jogging methods can help those who are aging normally. Some "tricks" that help people remember tasks, events, names and the proper order of things are listed below.

- Making lists
- Writing notes on a calendar
- Placing keys and other items always in the same place
- Linking new information with something familiar

A person with ADRD has little or no success with these methods, particularly in the later stages of the disease. Lists get lost. Rather than being unsure whether to turn



left or right, the person with ADRD forgets where he is, why he is there and where he is going. This disorientation to time and place becomes more severe and frequent as the disease progresses.

The table below shows some differences between mild forgetfulness associated with normal aging and some common symptoms of ADRD.

Normal Aging	Signs of ADRD
Forgets the details of your wedding that he attended.	Forgets that you were ever married.
Asks you to repeat a phone number 3 times before being able to write it all down.	Cannot write down a phone number no matter how many times it is repeated.
It takes a minute for a grandmother to remember the names of all her grandchildren.	A grandmother forgets she has grandchildren.
Calm most of the time but gets frustrated now and then.	Becomes upset or angry at another person for no reason.
Personality and emotions are generally stable.	Personality changes and emotional instability develops.
Different eating and sleeping habits that do not interfere too much with daily living.	Sleeps very poorly with physical effects. Forgets to eat or forgets that she has eaten, with weight loss or gain.
Able to sit and calmly watch a television show or movie.	Unable to sit still, feels frustrated, restless, fearful. May pace or wander.
Sometimes forgets a turn when driving.	Forgets where he is, where he is going and why.
Provides self-care without assistance	Needs help bathing, dressing, and performing daily activities

## Stages of ADRD

The care team assesses and documents which stage of ADRD the individual is experiencing. Updates in the care plan are ongoing, addressed as the patient's needs shift. Below is a guide of symptoms associated with each stage.

### Mild/Early Stage (2 – 4 yrs)

Memory problems begin. Friends and family members may notice a decline in personal hygiene as daily activities like bathing, dressing, cooking, and grooming become difficult tasks. Conversations reveal the beginnings of language difficulties and other thinking challenges.

- Forgetfulness
- Language difficulties: searching for words
- Episodic disorientation of time and place
- Personality changes
- Frequent automobile and/or household accidents
- Poor judgment
- Hoarding food or keeping little or no food in the pantry
- Moodiness
- Unable to do routine tasks: meal preparation, housekeeping, paying bills
- Decline in personal hygiene
- Paranoid accusations
- Withdrawing socially



### Moderate/Middle Stage (2 – 10 yrs)

During this time, a person with ADRD needs more assistance bathing, dressing, and going to the bathroom. He may still be cared for at home, moved to a dementia unit in an assisted living community, or moved into a nursing home. Signs of Middle stage include:

- Wandering and repetitive behavior
- Increasing agitation and restlessness, especially at night
- Unable to complete tasks in order (cooking, balancing a checkbook)
- Frequently disoriented and forgetful
- Slower verbal communications, struggling to converse and understand
- More help needed with daily tasks, like showering and dressing
- Striking out verbally or physically (Shouting, slapping, kicking)
- Changed eating habits: eating less, eating odd foods at odd times, snacking on more sweets
- Saying or doing things that are inappropriate and embarrassing
- Hallucinating: seeing or hearing things that are not there (“I talked to Mom this morning,” when the mother passed away years ago.)
- Speaking less and less, not participating in activities, further withdrawing socially



### **Severe/Late Stage (1 – 3+ yrs)**

At this point in the disease, a person is bedridden and can do little or nothing without assistance. Swallowing problems may develop, reducing nutritional intake. This leads to an emaciated appearance and to other medical problems. Decisions about the use of feeding tubes and other end-of-life choices may have to be made. Signs of Late Stage include:

- Total dependence on caregivers
- Little or no speech or non-verbal communication
- Unable to walk or sit up; bedridden
- Almost always disoriented

- Often cannot recognize family, friends or own reflection in the mirror
- Unable to smile
- Problems with swallowing
- Emaciated appearance
- Complete loss of body functions and almost all intellectual abilities

## The Environment and Dementia Driven Behavior

The attributes of an ADRD patient's environment, such as the noise level from unfamiliar or unpleasant sounds, can affect his or her behavior. In addition to unsettling noises, a lack of sensory or environmental stimulation can also cause a patient to demonstrate upsetting or disruptive behaviors. For example, a lack of appropriate cues for navigating his or her surroundings may cause patients to become disoriented and exhibit inappropriate behavior.

When designing the surroundings for memory impaired patients, it is important to create an environment that is dementia friendly and has a "homey" feeling. The overall goal of the design should be centered on helping patients function at optimal levels. Some suggestions for improving the patient's environment include:

- Be aware of loud music or TV
- Provide a pleasant smell in the environment
- Adjust lighting to limit shadows
- Remove all tripping hazards
- Provide furniture with limited patterns
- Install solid colored or basic carpet



On the following page is a list of goals to improve the environment for patients with memory impairment:

Goal	Criteria	Options
Provide common areas for patient to live in.	Variability	Living room, dining room, sitting areas
Exit control	Safety	Security System, mat at doorway
Create a familiar atmosphere	Familiarity	Provide a warm atmosphere; include personal & familiar items
Outdoor Environment	Availability Supportiveness	Accessible outdoor space (e.g. secured yard). Safe interactions with nature (e.g. planter boxes with non-toxic plants and garden with non-toxic plants)
Stimulation: Limit the amount of distracting stimulus in the environment	Noise Management	Examples: warm colors, subdued patterns, limit loud music and TV, limited visual stimulation
Foster an environment that includes dementia training for family and caregivers	Education	Provide dementia training for all who interact with the patient.
Provide wandering paths and other devices to keep patients occupied	Continuing to find a way out	Circular walkway, no dead ends, visual aids (e.g. Bio-boards, pictures, signs)

## Physical Condition/Well-being

Older patients who display problem behaviors may be reacting to physical pain or a medical ailment. Some physical conditions that may trigger problem behaviors may include any of the following:

- Acute medical changes (such as a urinary tract infection)
- Illness
- Side effects of medication (such as increased fatigue)
- Hunger
- Visual impairment
- Auditory impairment



## Emotional Well-being

A patient may exhibit problem behaviors because he or she is experiencing feelings of anxiety, depression, or loneliness. Homecare workers need to determine what triggered the feelings in order to select the appropriate intervention.

Oftentimes, a change in a patient's emotional well-being is due to a change in the environment, such as:

- Changing caregivers
- No appropriate activities
- Too much idle time
- Over-stimulated environment

## Nutrition/Fluid Intake

Some patients may display problem behaviors because they are not drinking and eating enough. If you encounter patients with this problem, try any of the following to get patients to increase their food and drink intake:

- Offer finger foods
- Play classical music during meals to decrease agitation
- Limit choices on the patient's plates
- Serve small portions in bowls

## Psychosocial Needs

Memory-impaired patients have special psychosocial requirements that, if unattended, can result in unpleasant behavior. Specifically, memory-impaired patients desire the following psychosocial needs:

- Dignity
- Identity
- Sense of Control
- Self-Esteem
- Belonging/Inclusion
- Intimacy/Love
- Security
- Meaning/Purpose

Let's take a look at each of these psychological needs in more detail:

**Dignity:** Dignity relates to the way others see us. As a caregiver for patients with dementia, you can restore levels of dignity by preventing potentially embarrassing situations from occurring such as:

- Patient wearing clothing that is too tight or too loose
- Patient wandering without appropriate clothing
- Patient having poor hygiene
- Patient whose hair is uncombed and/or untidy

You can assist with patients' grooming and hygiene by participating in the daily routine. In addition, you can preserve patient's dignity by:

- Treating patients with respect at all times
- Acknowledging patients and looking into their eyes when talking to them. For example, if a patient is sitting down, you should bend down to talk to them.
- Giving clear verbal/physical cues and prompts as needed
- Redirecting attention away from the patient whenever an embarrassing situation occurs.

**Identity:** Patients often struggle with self-awareness and their relationship with others such as families, friends, employees, volunteers, etc. Homecare workers can reintroduce a patient to his or her own identity and past by presenting the patient with items that reinforce their continuation of life-roles based on their previous career. For example:

- If a patient was a maid, then you can provide her with items to fold, a table to wash, feather duster, etc.

- If a patient worked in an office, provide a desk and papers to shuffle, junk mail to open, etc.
- If a patient was a plumber, provide him with some PVC piping to manipulate.

Continuation of family relationships is also very important. Try to involve the patient's family as much as possible by performing any of the following:

- Host a monthly "family support" meeting
- Provide a resource library for the family
- Encourage families to have other family members and/or friends visit frequently
- Request that families hang favorite pictures in the patients' rooms, in a memory box and/or create a memory book
- Use reminiscing programs and "theme kits" to trigger the patient's memory of their past experiences, life roles and accomplishments. We will discuss more on "theme kits" later on in this course.

**Sense of Control:** Patients need to make an impact on the environment. Control is related to a sense of well-being and self-respect. You can improve a patient's feelings of control through the following actions:

- Identify tasks the patient can complete
- Provide support to enhance his or her success
- Create an illusion of control whenever real control is absent
- Environmental factors are extremely important. Patients need to have freedom from unnecessary rules whenever possible.

**Self-Esteem:** Self-esteem is the way patients view and value themselves, as well as how others value them. A memory-impaired patient is vulnerable to self-deprecation because he/she has a limited ability to care for their activities of daily living (hygiene, hair, makeup, and clothing).

When a patient with low self-esteem is identified, his or her self-value can be restored by:

- Planning activities that enhance the patient's strengths and minimize weaknesses

- Providing an accepting and non-judgmental environment

**Belonging/Inclusion:** Patients need to feel they belong to some sort of community, group and/or family. This also supports a sense of security, comfort and belonging.

You can foster a sense of belonging and inclusion for your patients by:

- Inviting patients to family and group programs in the community
- Including the patients in discussions
- Preventing isolation of the patient

**Intimacy/Love:** Feelings of intimacy and love are an important part of human nature. It often impacts relationships and the way a patient relates to change, i.e. communication, sharing and sex. Despite feelings of confusion, the patient still has the need for intimacy and closeness, such as holding hands, gentle hugs, and soft touch.

As healthcare professionals, we can fill the void for intimacy and love experienced by our patients through kind actions. Examples of these actions include:

- Listening to patients
- Focusing on the patient's strengths, what he/she can still do and use
- Reminiscing about old traditions
- Allowing patients the time to adjust to their new surroundings (if the patient has been moved to a new location.)
- Sharing old memories

**Security:** Patients who have any form of dementia are unable to view their world with a sense of "reality". Therefore, their world becomes unpredictable and frightening. They begin to express feelings of fear about the future, as well as complaints of disorientation and spatial distortions. Their decreased capabilities also lead to an increased need for assistance.

Homecare workers can comfort a patient's feelings of fear by providing the following:

- Provide a calm and predictable environment

- Design “homey” surroundings and decorations
- Provide an accepting atmosphere
- Create a failure-free environment
- Offer physical and verbal assistance
- Provide reassurance of love and caring

**Meaning/Purpose:** Just like the rest of us, memory-impaired patients need a reason and a purpose before participating in various activities. They need to feel a sense of accomplishment from completing an activity.

Homecare workers can provide memory-impaired patients with feelings of meaning and purpose by:

- Promoting continuation of past roles
- Providing structure and consistency to the patient’s daily schedule
- Providing meaningful activities and programs
- Providing reassurance about the importance of family
- Focusing on the patient’s strengths and abilities

**Learning Scenario:**

Angela, a new homecare worker, is assigned to assist a family in setting up a room in their house to use for a patient suffering from dementia. Angela comes to you for advice as to how to prepare the room. What suggestions might you give her? Write down your response then turn to the next page for the answer.

***Answer to Learning Scenario:***

There are a number of things which Angela can do such as:

- Reduce noise from other family member's TV or stereo (perhaps through the use of headphones)
- Provide a pleasant smell in the environment
- Adjust lighting to limit shadows
- Remove all tripping hazards
- Suggest furniture with limited patterns
- Suggest solid colored or basic carpet

**Topic Summary:** In regards to memory-impaired individuals, factors that can lead to problem behaviors include environmental conditions, such as disturbing sounds or improper lighting. Sometimes, the cause of a behavior problem can stem from a physical condition or ailment that the patient is experiencing. Other problem behaviors can be based on the patient's personality, emotional well-being, nutrition/fluid intake, or psychological needs.

## Topic 2: Communicating Effectively with Patients with ADRD

**Topic Introduction:** Developing communication skills for speaking to a person with ADRD is a vital aspect of providing quality care. In addition, it is important to learn how to “read” an individual’s non-verbal cues.



Just as clinical trials are ongoing to discover better medications to treat ADRD, researchers continue to seek ways to enhance the quality of life for both patients and caregivers dealing with ADRD. Presented in this part of the course are tips and techniques for better communication with ADRD patients, whether or not they are able to say in words what they need, want and feel. This topic will enable you to describe how ADRD affects communication skills and apply that knowledge when you work with ADRD patients.

### ADRD: The Effect on Communication

If a resident suffers from a form of ADRD that has damaged the Temporal Lobe, then the resident’s ability to use language will be affected. Along with memory and emotion, the Temporal Lobe is responsible for our ability to understand and use language. For example, an ADRD resident might struggle to find the right word to express himself.

### Effective Communication Techniques

In the Broadway musical, *Annie*, there is a song called “*You’re Never Fully Dressed Without A Smile.*” Thinking of that (or anything else that brings a smile to your face) when approaching a patient with ADRD may remind you to be friendly and compassionate, even if it is the end of a hectic shift. A positive greeting is a comforting prelude to whatever comes next. It can help soothe a patient who is fearful or not having one of his/her better days.

As ADRD stages progress, the patient experiences increasing difficulties with language. Both speaking and understanding what others are saying presents a greater challenge. A person may not be able to keep up with the conversation, especially if the setting is noisy or busy. Frustration, anger, confusion and sadness often result.



One technique that helps is called “Show and Tell.” It means showing with gestures, facial expressions and an open posture while telling in short, simple statements. Patients with ADRD will watch for clues in their efforts to understand what you are saying.

Practicing the tips listed below will help you communicate more effectively.

- Smile!
- Say the person’s name to gain his attention and remind him that he knows you.
- Pay attention to your posture, gestures and facial expressions. Keep them open, positive and kind.
- Maintain eye contact with the patient.
- Identify yourself by name to be friendly, respectful and serve as a reminder. Understand that patients may not remember you from day to day.
- Speak slowly, clearly, and simply: “Let’s go for a walk” may work better than saying, “Would you like to stroll over to the window and look out at the beautiful day and watch the birds build a nest?”
- Use a calm tone and keep a “smile” in your voice.
- If a person is unreceptive, leave him alone for a few minutes before trying again.
- Use names of things and words the patient knows. For example, say “fork” instead of “utensil.”
- Pay attention to nonverbal cues you are giving and receiving from patients.
- Give clear directions, “Mr. Jones, please sit in this chair.”
- Add gestures to match your words whenever possible. Use “show and tell” methods. Remember that ADRD patients watch *and* listen when they are trying to understand you.
- Be patient and wait for responses. Rushing will frustrate both you and the patient.

## Non-verbal Communication

Individuals with ADRD often lack the ability to process their experiences and communicate needs verbally. Many of these individuals are also likely to have one or more chronic health conditions that cause pain, which, in turn, contributes to unnecessary discomfort, dysfunctional behavior, and diverse behavioral symptoms. As a result, pain is an important factor to assess in older adults with ADRD. Some non-verbal behaviors that are common and typically considered pain related include:

- facial grimacing
- moaning
- groaning
- rubbing a body part

## Communication Cards May Help

- Print a clear message, using large print, positive words, simple language
- Personalize cards using “I”, “you”, “my”
- Read the card aloud with the patient and leave the card with the patient.
- You should plan for card making by having supplies ready. Include family in making cards.

## The BIG “Don’ts:” Things to Avoid When Communicating with AD Patients

- Don’t talk in front of patients as if they were not there
- Don’t speak to a patient using “baby talk”



**Treat resident  
with respect!**



**Don't talk to him  
in "Baby Talk".**

- Don’t argue or try to reason with a patient

- Don't yell, scold, threaten, or use an angry or condescending tone of voice
- Don't "quiz" the patient in efforts to sharpen her memory.

## Managing Communications in the Three Stages of ADRD

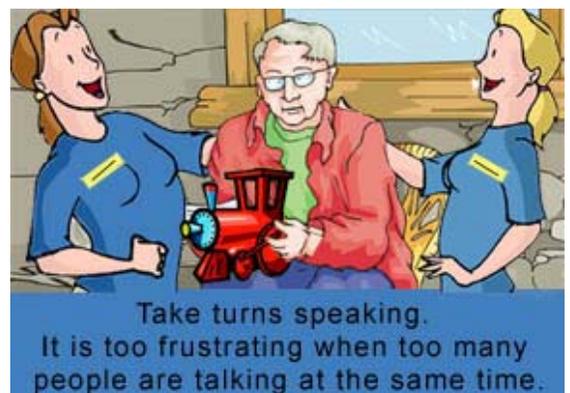
### Early Stage

#### ***Challenges for ADRD patients:***

- Cannot think of the right words to name things and complete sentences
- Scramble the sequence of events when telling stories
- Speak of past events as if they are happening now
- Cannot remember what was just said
- Have difficulty following directions.

#### ***How you can help:***

- Approach patient from the front.
- Introduce yourself. Know the patient may not remember who you are.
- Smile!
- Discuss important business at the best times for the person with AD.
- Talk about one topic at a time.
- When patient mentions past events, chat with him about those events.
- Give step-by-step directions, breaking down tasks into single elements.
- Use names of people and objects that are familiar – not fancy.
- Keep language specific, avoiding pronouns and general terms.
- Be patient and encouraging. Praise efforts.



## Middle Stage

### ***Challenges for ADRD Patients:***

- Confusion if you talk fast.
- Frustration if more than one person talks at the same time.
- Unable to pay attention.
- Less talking and responding.
- “Yes” or “No” answers mainly.
- Saying or shouting inappropriate, puzzling, or impolite things.
- Repeating the same questions and stories

### ***How you can help:***

- Maintain focus with gentle therapeutic touch.
- Offer easy choices (“Do you want to put on the red or blue shirt?”)
- Use sensory stimulation, like touch and smell, perhaps during meals and while bathing and grooming.
- Break down instructions into simple steps, one at a time. (“Put on your shirt” Then, “Put on your pants” rather than, “Get dressed.”)
- Smile and present a positive attitude, facial expression and stance when you need to redirect a patient: “Come take a walk with me,” instead of saying “Don’t go out that door!”
- Repeat instructions as needed, using the same language.
- Avoid gestures or postures that may appear angry or threatening (standing with arms crossed, frowning)
- Watch for non-verbal cues. For example, a patient who needs to go to the bathroom may start pulling at his clothes.
- Continue being patient and using praise
- Keep smiling!

## Late Stage

### **Challenges for ADRD Patients**

- Speech diminished to about 1 to 6 words a day.
- Words spoken may make no sense, or may just be sounds.
- Rather than responding to you, the patient may try to repeat what you say.
- Very little ability to communicate verbally or non-verbally.

### **How you can help**

- Keep talking to the patient, even if she seems unresponsive. It is not clear how much is heard and sensed by people in advanced stage ADRD.
- Say the patient's name often.
- Continue to comfort with therapeutic touch.
- Always use good manners. Say "Good morning." "Thank you." "Good-bye." Patients may hear and be comforted by your voice, even if they do not respond to you.
- Be kind.



### **Learning Scenario:**

You are training new homecare workers. You overhear Tim, a new homecare worker, talking to his colleague. Tim is explaining his approach to working with ADRD patients. "I always maintain eye contact with the patient and speak in a soft, clear tone of voice. Only if they don't respond, do I raise my tone and continue to speak until they respond."

How would you judge Tim's approach? Write down your answer and the reasoning behind it. Then turn to the next page for the answer.

***Answer to Learning Scenario:***

Give Tim two out of three points. He's right about the importance of making eye contact and speaking in a soft tone. However, raising the tone of voice is never a good idea even with a non-responsive patient. Also, if a person is unreceptive, Tim should leave the patient alone for a few minutes before trying again.

**Topic Summary:** Since people with ADRD have a diminished capacity to communicate and to understand the world around them, it is vital that caregivers adapt special practices to address the situation. Smiling and speaking in a calm tone is one way to establish a positive rapport. When speaking, give clear, straightforward instructions such as "please sit in this chair." If an ADRD patient is unresponsive, it may be advisable to leave the person alone for a few minutes. Also, use gestures to supplement your communication and use concrete terms such as "fork" rather than "utensil." Above all, be patient.

## Topic 3: Behavior Identification

**Topic Introduction:** Alzheimer's disease or related disorders (ADRD) is a progressive, irreversible disease that destroys a great number of brain cells. These damaging biochemical changes in the brain result in memory loss, thinking and language difficulties, uncontrollable behavior problems, loss of body functions and, eventually, death. Problem behaviors, like other symptoms of ADRD, are direct results of the disease process. Some behaviors can be puzzling, embarrassing, annoying or dangerous. Caregivers need to be aware of troublesome behaviors and how to prevent or manage them to maintain a safe, secure and calm environment. Reviewing this topic will enable you to identify challenging behavior associated with ADRD.



### The Sources of Problem Behaviors

To manage problem behaviors, you must understand their source. Problem behaviors can be triggered by the combined effects of damaged thinking processes resulting from the disease (which cannot be controlled) and certain stress factors (many *can* be controlled.) Types of stress factors include:

- Medical / Physical
- Emotional
- Environmental
- Psychosocial

### Medical / Physical Stress Factors

#### Malnutrition and Dehydration

Encouraging sufficient intake of nutrients and fluids can be a challenge for caregivers working with individuals who have ADRD. It is essential to address that challenge. Individuals with ADRD may not feel hungry or thirsty or may be unable to ask for food or drink. Patients may forget to eat and drink what is provided, especially when there are noises or distracting activities occurring in the area. Discomfort from ill-fitting dentures is another deterrent.

Monitoring the patient's fluid intake is vital and must be increased during hot weather. A patient who may be unaware of thirst will often drink liquids if offered. Inadequate intake of food and fluids can hinder elimination. Dehydration can contribute to confusion, disorientation, and other problem behaviors.

## ***Constipation***

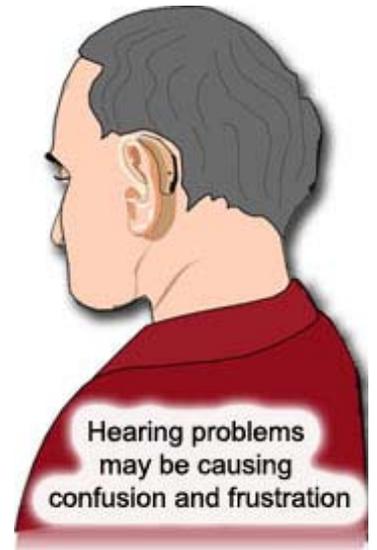
Improper elimination resulting in constipation and impacted bowels causes discomfort, irritability, increased confusion, even hallucinations and delusions. Setting up a toileting schedule for patients and monitoring elimination will allow you to identify the problem and take corrective measures.

## ***Poor Vision and Hearing***

Make sure that patients wear their eyeglasses and hearing aids. Routine vision and hearing tests are critical. Individuals with sensory deficits can misinterpret words or actions, which increases confusion and frustration.

## ***Pain***

Communication difficulties can result in pain being unreported. The patient may have joint pain, headaches, stomach cramps and other discomforts, but be incapable of putting the problem into words. Watch for non-verbal cues and signs of pain. Grimacing, wringing hands, moaning and increased agitation can be indicators of pain. Find the source of the pain and resolve it if possible, administering medication as prescribed. Relieving pain is a vital quality of life issue. It replaces frustration with calmness and fosters greater enjoyment of all activities, meals, visits and interactions.



## ***Medication Side Effects***

Polypharmacy, the concurrent use of several drugs, can result in a broad range of cognitive side effects. It is important to review all prescribed medications, including vitamins and herbal supplements. Keeping this information documented and updated enables the care team to evaluate the effectiveness of combined medications and identify possible drug interactions.

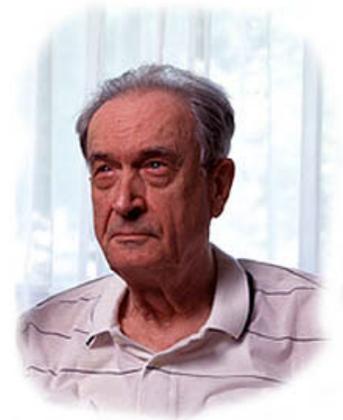
## ***Infections / Injuries***

The presence of undetected infection or unreported injury can cause illness, discomfort and strained interactions. In the advanced stages of ADRD, the patient is more prone to infections, such as urinary tract and bronchial infections. Simply bumping into a chair can leave a painful bruise or lesion that the patient forgets to report. A system must be in place to check patients for infection and injuries. This will help keep patients feeling well, improving receptivity and cooperation with caregivers and family members.

## ***Insomnia / Fatigue***

Disruptions in sleep patterns are common among individuals with ADRD. Too many daytime naps contribute to restless nights. A lack of sleep at night leads to fatigue and irritability during the day. To support the patient's normal sleep pattern, consider the following:

- Balance stimulants and physical activities with rest periods during the day.
- Reduce foods and drinks that contain sugar and caffeine.
- Develop a set evening routine, starting with quiet time prior to bedtime.
- Play soft music to aid relaxation.
- Encourage the use of sleep comforts, like a soft blanket or stuffed animal.
- Give medications as indicated.



## **Emotional Stress Factors**

### ***Fear about the Illness***

Patients with ADRD can become very fearful in all stages of this disease process. Fear is a strong emotion. It can cloud communication and initiate problematic behaviors.

Listed below are some reasons a person with ADRD feels fearful:

- Disoriented to time and place – feeling lost and nothing looks familiar.
- Inability to recognize loved ones.
- Unable to communicate needs or get help.
- Forgetting how to do everyday activities, loss of independence.
- Sensing that the end of life is near.

Caregivers need to offer patients with ADRD constant reassurance that they are safe and well cared for. Therapeutic touch, praise and hugs (if the patient is comfortable with that) can calm fears and help relax the person. A renewed sense of security often increases the patient's willingness and ability to communicate.

### ***Frustration***

At any time, an individual with ADRD may be struggling to understand what is going on or what you are asking him to do. This confusion is magnified by too many competing stimuli in the area. The person feels overwhelmed and

frustrated with himself for not being able to understand what is being said and done around him. When this happens, he may give abrupt responses, become uncooperative, anxious and angry. The patient may feel out of control but not know how to stop the anger and regain composure.

### ***Loss of Self***

A patient with dementia often feels lost, like a “stranger in a strange land.” Studies indicate that some dementia-related anxiety is caused by not knowing how to recover a sense of self; being the person he was before the illness. This loss of identity, sense of self-worth and purpose in life can bring on diminished self-esteem, despair and anger.

### **Environmental Stress Factors**

The physical environment influences how patients with ADRD feel, think and interact with each other. Maintaining a balance between stimulation and rest is key. A crowded or noisy living environment tends to increase anxiety and agitation among patients. Likewise, a room that is too quiet, dark, bright, hot or cold may elicit similar reactions. Introducing new equipment into an area also can be upsetting.

### ***Lost without Labels***



As the disease progresses, people with ADRD have increasing difficulties with directions. They can get lost in a hallway where all the doors look the same and nothing is labeled. They need a supportive environment that makes it easier for them to find their way. Labeling the doors to places like bathrooms and dining rooms with signs can be a tremendous help. Signage should display both words and illustrations that clearly depict the room’s purpose, like a picture of a toilet for the bathroom.

Placing a photograph of the patient over the door to her room helps her find her way with greater confidence. A photograph taken 30 years ago is often more easily recognized by the patient than a recent photograph. Labels posted inside

the patient's room ("Dresser" and "Closet") may help as well. Ask family members to keep familiar personal items in the patient's room, like a favorite blanket, pillow, or family photographs.

You can help pave the way to more positive interactions by adding little touches to the patient's environment that help her feel connected to her surroundings and more capable of navigating them.

### ***Privacy***

Patients have a right to privacy. Lack of privacy can be upsetting to them. Caregivers should respect patients' privacy and personal space conventions as much as possible. When assisting a patient with bathing and dressing, doors and curtains should be closed. Towels can be used as drapes while assisting with bathing and personal care needs. Similarly, a patient's condition, symptoms, medications or other care needs should not be discussed in the presence of strangers.

## **Psychosocial Stress Factors**

### ***Paranoia***

Patients with ADRD often feel threatened by an impending sense of doom. They fear some imagined or existing person or situation. They cannot reason their way out of that fear. They may feel rushed by caregivers or think that caregivers are angry with them. These feelings can be magnified by changes in the daily routine. Patients feel more secure when matched with the same caregivers as consistently as possible and when there is a set schedule for meals, activities, bath and bedtime.

### ***Denial***

A patient may be uncooperative because he does not want to admit the need for assistance. He may deny offers for help even when he needs it. You can support the patients' sense of dignity by monitoring a situation to ensure safety while allowing him to achieve daily activities (like shaving) with as much independence as possible.

### **Why is it a problem?**

To determine the scope of a behavior problem, ask yourself if the behavior is:

- Disturbing for the patient, or caregivers?
- Impinging on other patients' rights?
- A safety concern for the patient or yourself?
- Interfering with the patient's care, safety, or well being?
- Likely to cause the patient to become overtired?

## What is the problem?

Understanding different stress factors of ADRD and the impact they have on behaviors will help you cope with problems when they occur. This section defines common behavior problems and offers solutions for managing them safely and effectively.

**Agitation** is a *feeling* of non-specific restlessness, frustration or apprehension that can be disruptive. Medical, emotional and environmental stress factors contribute to agitation.

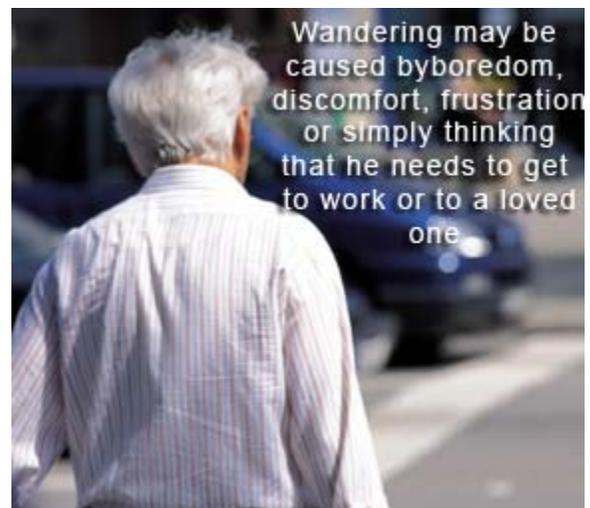
- **Physical signs:** pacing, disrobing, trying to go somewhere to find someone or something, repetitive actions and intrusive behaviors.
- **Verbal signs:** complaining, seeking attention, repeating questions, screaming and negativity.

**Aggression** is an *action*, and it is hostile toward others, objects or self.

- **Physical signs:** slapping, pushing, spitting, kicking, scratching, biting and throwing objects.
- **Verbal signs:** name-calling, shouting obscenities, threatening and accusing.

Aggressive behavior typically stems from anger, fear or extreme frustration. If you identify agitation before it escalates and intervene appropriately, aggressive behavior can often be prevented.

**Wandering** is an *action*. It is walking aimlessly, without purpose or destination, feeling unable to sit or stop walking. A patient may wander around the fringe of a group activity, refusing to participate or settle anywhere. He may wake up at night and wander, trying to leave the house. Wandering behavior is aggravated by medical, emotional, and environmental stress factors. Patients who wander must be monitored closely to ensure their safety and to prevent the person who wanders from getting lost or injured.



**Sundowner's Syndrome** is the name given to behavioral problems that increase in the late afternoon or evening. Possibly caused by fatigue, over-stimulation during the day and feeling confused by the

changing environment, symptoms of Sundowner's syndrome include pacing, wandering, increasing anxiety, sadness and asking to "go home."

**Altered perceptions** are mental distortions of reality. The person experiencing this state believes the distortion is real. She may be suspicious and fearful.

**Hallucinations** can be visual, auditory, tactile or gustatory (perception of a bad taste.) Refusal to cooperate with care, sudden mood changes, and physical reactions occur in response to hallucinations. For example, a patient who is experiencing a tactile hallucination may feel the sensation of things crawling on or under his skin. The physical reaction may be rubbing and scratching his arms trying to brush away what he feels crawling on him. He also may disrobe in efforts to rid himself of this disturbing feeling.

**Delusions** are fixed false beliefs that persist in the face of evidence to the contrary. For example, a patient may believe that people are stealing things or plotting against him. A wife may not recognize her spouse, identifying him as an intruder.

**Catastrophic Reactions** occur when a person with dementia becomes overwhelmed. Excessive stimulation (noise, activity, light) and demanding too much from the patient can be overwhelming for him. Talking too fast, giving multiple-step directions and asking for cognitive reasoning beyond the patient's capabilities can push the patient into sensory overload. Correcting a patient or pointing out his cognitive deficits will serve no constructive purpose and may lead to a catastrophic reaction. Watch for the following signs:



- Sudden change in mood
- Anger, crying, agitation
- Striking out, raising fists, any gestures of physical aggression
- Paranoia and accusations
- Flushed face
- Stubborn refusal to cooperate
- Pacing or wandering, trying to "go home" or "get out."

**NOTE:** Problem behaviors are part of the disease process and not done intentionally to annoy others. They indicate the patient's attempt to send a message, to communicate a physical or emotional need.

The person with ADRD is incapable of controlling his problem behaviors. However, the behaviors cannot be ignored or allowed to escalate because they

can become dangerous to other people. To ensure the safety and well being of other people who live in the home, you must address problem behaviors.

## **Solutions for Managing Problem Behavior**

Noise, such as TV, stereo, bickering children and calling out to someone down the hall, is distracting and disturbing. It adds to confusion among patients who have ADRD. Keeping the area as quiet and calm as possible should be a shared goal of all caregivers. Talking to a patient in a quiet area that is free from distractions is more likely to yield satisfactory results. Trying to be heard and understood in bustling surroundings often leads to agitation.

### **Tips for Soothing Agitated Behavior**

- Check for any reason the person may be in physical and/or emotional discomfort. If you can relieve the discomfort, do so.
- Redirect the patient with a constructive task, such as folding towels.
- Reduce the noise level in the area.
- Keep your voice low and calm.
- Approach the patient from the front and smile.
- Use the patient's name and identify yourself. Do not expect the person to remember you.
- Mention the patient's grandchildren or something she likes to talk about.
- Experiment with diversions, like holding an object or toy that can be manipulated.
- Turn off televisions and radios in the area.
- "Slow and easy" speech and movements help calm an agitated patient. Don't get as "ruffled" as he is. Modeling a calm demeanor shows the patient appropriate behavior. The "Show and Tell" technique used in everyday communications applies to resolving agitated behavior as well.
- Keep your voice low when speaking to co-workers, as well as when addressing patients. Calling out to each other from down the hall creates a sense of disruption in the environment.
- Ask the patient to go for a walk with you. Talk quietly and walk at the same pace as the patient wants to walk toward a peaceful area. Perhaps,

find a chair near a window or point out a beautiful painting or other soothing object to help redirect the person's focus.

- Make simple requests, one step at a time.
- Be patient for the patient to respond before moving on to the next step. For example, say "Mr. Jones, will you walk with me?" Then say, "Will you fold this towel?" Then say, "Thank you for helping, Mr. Jones."

### **Tips for Calming Aggressive Behavior**

- Approach the patient from the front, modeling a calm attitude.
- Respond to cues. Pulling at clothes may mean the person needs to use the bathroom.
- If a patient becomes aggressive while you are helping him, stop what you are doing and move others to a safe place. Make sure the aggressive individual is safe and not apt to harm himself. Then leave the person alone for a moment and try approaching him again when he begins to calm down.
- Redirect the person's attention with a change of scene or other distractions, like holding an object. This will keep his hands busy.
- Make a note of people who do not get along with the patient and keep them apart as much as possible.
- Plan a scheduled time each day for exercise programs. Take the time for an unscheduled stroll when needed to calm or redirect a patient.

### **Tips for Tracking Wanderers**

- Keep walkways and hallways clear of obstacles that could cause a fall.
- Alert all family members and let surrounding neighbors know that a patient wanders.
- Maintain a regular exercise program.
- Provide "busy boards" or stations where patients can go to sort scarves, handle fabric or fold towels.



- Place a rocking chair in the corner. Its motion can be soothing.
- Label rooms and objects to help patients who feel lost or disoriented.
- Post pictures and stop signs at exit and entrance doors.
- Use secure monitoring devices, like combination door alarms.
- Register patients with Safe Return, a national program assisting in the safe, timely return of individuals with ADRD who get lost when wandering away from home. Safe Return is sponsored by The Alzheimer's Association. For more information, go to the following website: [http://www.alz.org/we\\_can\\_help\\_safe\\_return.asp](http://www.alz.org/we_can_help_safe_return.asp)



### **Interventions for Sundowner's Syndrome or "Sundowning"**

- Provide daily exercise opportunities
- Reduce caffeine intake
- Plan more stimulating activities for morning hours
- Offer comfort – stuffed animal, favorite music or snack in late afternoons

### **Remember the 5 "R's" of Managing Catastrophic Reactions**

**Remain** calm. Never confront, argue or try to reason.

**Respond** to feelings. Say: "You seem upset" or "You seem worried."

**Reassure** the person. Say: "It's OK, Mr. Green. You are in a safe place."

**Remove** yourself for a moment and take a deep breath.

**Return** when the patient begins to calm down.

### **The Behavior Profile**

There is a strong link between impaired communication skills due to ADRD and the anxiety and agitation patients sometimes express. Understanding the importance of communication is the foundation for all interactions with people who have ADRD. Problem behaviors are attempts to send a message. If you respond appropriately, you will feel more in control of the situation. When working with an individual who displays anxiety or agitation, consider the verbal and nonverbal clues to his message. Behavior profiling is a tool for better

understanding the behavior's causes and devising the best approach to resolution.

<b>Triggered event</b>	What happened?
<b>Behavior exhibited</b>	How is the patient responding?
<b>Interventions</b>	What can you do?

When assessing the behavior of someone with ADRD, it is important to ask some basic questions:

- What is the behavior?
- Where is it occurring? (Bathroom, bedroom?)
- What is the time of day? (notice patterns: dinnertime, bath or bedtime)
- Did something create a disruption? (New arrival in the house? new activity?)

## Documenting Behaviors

Tracking behavior is essential to:

- Validate its significance, intensity and potential for recurring.
- Determine the effect of the resolution strategy on the behavior.
- Learn more about the behavior, patterns and potential prevention.

## Creating a Log to Document Problem Behaviors

The purpose of logging problem behaviors is to better understand and have written documentation of the specific circumstances within which the behavior occurs. Gathering all this information in a concise format like a log will aid the family's problem-solving efforts. The following are recommended components of a Behavior Log.

- Define the behavior
- Briefly describe surrounding circumstances
- Develop a plan for preventive measures.



Date	Time	Behavior	Circumstances	Prevention
2/14/03	4:30PM	Agitated/ Sundowning	Noisy area -TV too loud	Quiet music in late afternoons

**Tips for Making the Log Work**

- Communicate to all family members the benefits of logging behavioral information and ask that all agree to participate.
- Collect data over a period so patterns become evident.
- Designate a timeframe (24 to 48 hours) within which the family will evaluate the information logged.
- Recommended intervention plans should be determined following the evaluation.
- Advise all family members of the behavior logged and the intervention plan recommended.
- Include any helpful hints for dealing with a difficult behavior on the service plan.

**Tune-in to Your Patients to Prevent Problem Behaviors**

As a caregiver, you can learn to spot the potential for a problem and often stop it before the behavior fully manifests. This ability to tune-in to your patients will help keep challenges from escalating into unsafe situations. Be aware of subtle signs that patients are becoming bored, overtired, frustrated, angry or upset. Visually scan the area to see if other patients appear upset by something someone is doing or saying. The following five steps will help you evaluate patients' behavior.



**Restrict:** Stop the behavior. When a behavior looks potentially harmful, step in and stop it. Then, gently redirect the patient's attention to another area, focal point or activity.

**Reassess:** Double check to see if the patient is bored, experiencing some physical discomfort or reacting to a medication. Make sure that noise and

confusion are minimal. Focus your attention on the problem's cause, not the result.

**Reconsider:** A request that may seem simple to you might actually be much too difficult for a person with dementia. A task that was no problem for a person yesterday may be overwhelming for that same person today. Homecare workers must continually adjust expectations of a patient's remaining abilities, remembering that the stages of ADRD progress at different rates and in different ways for each patient. Also, a behavior that may seem peculiar to you may, in fact, serve a purpose to the person with dementia. (Holding a baby doll, for example.) The rule of thumb is this: if a behavior is comforting to a patient and not harming or disturbing anyone else, allow it.

**Redirect:** Presenting an alternative focal point is a key in stopping a behavior with a positive approach. Instead of saying, "Don't do that" you are saying, "Try this." Offering a favorite snack or enjoyable activity distracts the patient from the problem and guides her attention in a different direction.

**Reassure:** "It's okay, Mrs. Collins. You're fine. I'm taking good care of you." When a person is anxious or fearful, simple reassuring words go a long way to resolve their anxiety. Repeat reassurances. Tell her she's okay until she starts to feel okay.

## Steps to Resolving Problem Behaviors

Assessing and analyzing the possible sources and combinations of factors leading to disruptive behaviors is important. Documentation and analysis will help in developing successful strategies for coping with and modifying problem behaviors.

### **Step 1 – Analyze the behavior.**

Determine who, what, where, when, and why.

- Who was in the area when the behavior occurred?
- What was happening? Was it noisy or otherwise stressful in that area?
- Where does the disruptive behavior occur?
- When does the disruptive behavior occur?
- Why? Look at triggers such as illness or wet or soiled clothing?

### **Step 2 – Identify behavioral strategies.**

Create a treatment plan specifically designed to address that patient's particular pattern of behavior. For example:

“Mr. Green enjoys folding towels in the afternoon. He looks forward to this activity and sees it as his responsibility. Three days last week, Mr. Green became agitated and upset when there were no towels for him to fold. He began to pace. He became withdrawn, suspicious and accused others of stealing the towels. Presenting him with a handful of towels to fold in a quiet area resolved his symptoms. Having at least three towels on hand for Mr. Green to fold every afternoon before a 3:00 snack has been a successful strategy in modifying this problem behavior.”



### ***Step 3 – Implement a behavioral intervention.***

It may be necessary to make environmental and/or schedule changes to care for specific needs of individuals.

Advise all members of the family about the behavioral intervention plan. Anyone who has contact with the patient needs to know the plan and respond consistently as indicated by the plan. In the case of Mr. Green (above), any family member with whom Mr. Green might have contact needs to know about his pattern of problem behavior and the plan to provide towels for him to fold every afternoon between 2:00 and 3:00.

Monitor and document responses and observations regarding the behavior for the next step.

### ***Step 4 – Evaluate and modify the plan as required***

- Whether a strategy succeeds or fails, it can be used as a learning tool. The process helps caregivers get to know patients better and practice problem-solving skills.
- Adjust elements of the plan as needed to keep it working with the patient’s shifting needs.
- Some strategies seem to work initially, but do not succeed long-term. Revised strategies may need to be developed and implemented.

## **Defuse & De-escalate Potential Danger**

When a patient’s behavior becomes out of control or dangerous, the following techniques for de-escalation are recommended to defuse a tense situation:

- Present a calm, confident appearance. Do not match the patient’s anger and frustration with your own impatience.

- Protect patients and caregivers in the area by removing sharp objects and other items that could be harmful if thrown or used as weapons.
- Try to redirect the patient's attention. Distract him by offering a favorite activity or a food treat.
- Gently remove the person who is upset from the stressful environment. Sometimes a simple change of scene will change the mood.
- Keep your voice low and calm.
- Avoid trying to reason, asking questions or confronting any cognitive deficit. (Don't ask, for example, "What were you thinking?")
- Assess the level of danger for yourself, the patient and others in the area. Ask yourself these questions: "Am I in danger? How much danger? What can I do about it?" Oftentimes, you can avoid harm simply by taking five steps back and standing away from the patient for a few moments.
- If these practices are ineffective, leave the room and get help immediately.

### **Set the Stage for Success**

- "Accentuate the Positive"
- Help patients feel confident and capable by focusing on their abilities, not their deficits.
- Modify the environment as needed to prevent distractions and problems.
- Reassure patients to reduce their fear. Most patients need a lot of reassurance.
- Smile and use therapeutic touch when appropriate.
- "Flooding Praise" is a method of communicating recommended to improve relationships in a variety of settings. Everyone enjoys praise. Patients with ADRD need praise to feel safe, secure and valued. Try praising every effort, every bite, and every smile. "What a beautiful smile you have, Mrs. Smith!" and "I see you tried some of that delicious blueberry muffin. Excellent job!"



- Offer choices rather than commands. “Will you walk over here with me, Mr. Jones?” instead of “Don’t go out that door!” Avoid saying, “don’t”, “can’t” and “have to.” Presenting a direction as a choice shows respect and supports the person’s sense of dignity. It also invites a more cooperative response.

Respond to feelings, not facts. Here is an example:

**Fact:** Mr. Jones is pulling off his pajamas in the middle of the hallway.

**Responding to fact:** “Stop that! You can’t undress out here.”

**Responding to the underlying feeling:** “Mr. Jones, will you please come with me?” while quickly escorting him to the toilet, which he is in dire need of using.

## **Intervention Communication Skills Review**

- Approach patients slowly, from the front.
- Speak slowly and clearly in a calm voice.
- Stay calm.
- Use names – yours and the patient’s
- Use touch to reassure and comfort, not to restrain, patients.
- Make direct statements, using familiar – not fancy – language.
- Give the person a moment to hear you and respond.
- Break down tasks into step-by-step requests.
- Repeat request if needed, using the same words.
- Speak on an adult-to-adult level.
- Be patient.

## **Coping with Resistant Behavior**

If a patient is mildly resisting your suggestion to eat, drink, or get ready for bed, try gentle coaxing, then try a different approach to gain cooperation. Next, if a family member is present, get them to try. If resistance grows stronger, redirect the person to an activity she prefers and suggest the resisted activity again later.

It is not a job requirement to force a patient to do something she is not willing to do. It is required that you try options available to you.

If an unexpected catastrophic reaction occurs (an extreme outburst of emotion, anger, or agitation in response to a request or situation), know that the person is overwhelmed. Take immediate action to restore calm, redirect, and put the activity aside until a later time.

## Restraints and Alternatives

Restraints can be physical or chemical. The purpose of using any type of restraint is to keep patients safe. However, studies have shown that restraints sometimes create more problems than they correct. The use of restraints is associated with an increased risk of falls, injury, behavioral problems, agitation, and even death in patients. Homecare workers need to address the use of restraints on a case-by-case basis. Family members, and the patient whenever possible, should be part of that discussion with the care team.

Restraints can be very difficult to implement in a home setting, and can be dangerous. Generally, they are not advisable in a home setting.

### Restraint Alternatives for Patients who Wander

- Accompany the patient outside and walk with him at his chosen pace. Enhance the walk together with therapeutic conversation.
- Assign caregivers to be responsible for a patient who wanders. Each “watch” can last a short time period, depending upon available caregivers. Homecare workers are encouraged to learn the patient’s patterns of movement so they are prepared and able to remain calm and supportive and to train others in the household the best way to handle the patient.
- Provide a secure, enclosed outside walkway, with shaded benches for rest stops. Keep these walkways clear of obstacles, hoses, water or anything that could cause a fall.
- Wandering is often precipitated by a desire to find a loved one. Provide opportunities for patients to listen to tapes or watch videos of the people they are trying to find. When appropriate, allow them to telephone loved ones.



- Try increasing stimulating activities with patients who wander. Music, singing, conversation, reading aloud, and discussion sessions may help channel the energy used to wander. The better you know your patients, the better able you are to create programs they will enjoy. They don't need something different every day. People who have ADRD often enjoy repeating the same activities, and a set daily routine is comforting.
- Offer opportunities for exercise. Moving to music provides additional stimulation, which patients who wander may need.
- Develop activity programs that match the patient's interests and attention spans.
- Check "agenda behaviors" to be sure the person who is wandering is not seeking the toilet or trying to find his bed to have a rest.

### **Learning Activity:**

Please take 10 minutes now to learn more about Safe Return, a national program sponsored by The Alzheimer's Association. Find information that applies to your area and jot it down to share with anyone who needs it.



After clicking on the website below and completing your research, you will be able to hit the "Back" button to return to this course. The information can be found by clicking on the following website:

[http://www.alz.org/safetycenter/we\\_can\\_help\\_safety\\_medicalert\\_safereturn.asp](http://www.alz.org/safetycenter/we_can_help_safety_medicalert_safereturn.asp).

### **Restraint Alternatives for Patients who Pace**

Pacing differs slightly from wandering. Some patients pace in a path around a table or around a group of people. People who pace may not be trying to find someone or something. For some, the need to pace is related to changes in the brain. For others, confusion, agitation or boredom may be triggers for pacing. If the cause is modifiable, try to change the stimulus that is causing the pacing behavior. Factors that may motivate a person to pace include:

- Reactions to environmental changes
- Emotional response to a stimulus
- Boredom
- Need for exercise
- Constipation
- Pain or discomfort
- Too many daytime naps
- Need for toileting
- Hunger or thirst
- Biochemical changes in the brain

## Keeping Patients Who Pace Safe

- Check patients' shoes for appropriate support and non-slip soles. Patients who pace will need to have their shoes checked more frequently.
- Examine the patient's feet, toes and legs. Note any swelling, blisters or other problems. Notify the family of problems that may need treatment or examination by a doctor.
- Set up a secure area that is clear of obstacles, where a person can pace without danger of tripping, falling or getting lost, similar to an area designed to maintain safety for wanderers. A difference in a person who paces may be their choice to pace in a path repeatedly around a smaller area. (A table or chair, for example). Even so, offering to take a walk outside with a patient who paces can be helpful.
- Suggest frequent rest periods on benches or chairs along outside walkways.
- Provide treatment for blisters, muscle soreness and nail care.
- Offer frequent snacks and fluids. Like other forms of exercise, pacing burns calories.

## Restraint Alternatives for Agitated Patients

- Stay calm when approaching an agitated patient.
- Lead the agitated person to a "time out" area that is quiet and removed from other patients and stimuli.
- Increase communication with the person. Broach a subject you know the person enjoys talking about (grandchildren, hobbies, hometown)
- Acknowledge and validate their concerns. Avoid reasoning, correcting or explaining anything. For example, say, "Your mother sounds like she was a wonderful person. What was she like?" Do NOT say, "No, you cannot talk to your mother. You know she's dead."
- Reminisce with patients. Take an interest in their stories from the past. If you are aware that events are not told in proper sequence, refrain from correcting the person. This will increase, rather than reduce, their



agitation. Just go with the flow and enjoy the ride.

- Redirecting the person to an enjoyable activity is also an option that is preferred over using restraints.
- Offer opportunities for patients to listen to relaxation tapes with nature sounds, soothing music, prayers and guided meditations.

**Topic Summary:** Problem behavior in people with ADRD may stem from a variety of causes including medical / physical ailments, emotional distress, environmental triggers, and psychosocial anxiety. Problem behavior can include aggression, agitation, and hallucinations. Tips for soothing the nerves of people with ADRD include reducing noise, smiling, and speaking in a comforting tone. It is recommended that healthcare workers keep a problem behavior log to help track behavior patterns. A four step plan for dealing with problem behavior is described.

## Topic 4: Assisting with Activities of Daily Living (ADLs)

**Topic Introduction:** When working with ADRD patients it is deceptively easy to begin focusing on the problems their illness causes and forget that each person is more than a series of symptoms. Even people whose cognitive ability has been diminished need a sense of control over their own lives, as well as a feeling of being respected by others. Learn to honor the person's values and individuality while assisting with ADLs. At the conclusion of this topic you will be able to employ general strategies for promoting independence in the beginning, middle, and late stages of ADRD.

### Philosophy of Care

A philosophy of care statement is akin to a healthcare mission statement insofar as it states the ideas and principles that support and direct the practices of homecare workers and healthcare organizations.

Below is a list of principles that could be included in the philosophy of care statement for homecare workers:

1. Homecare workers will strive at all times to preserve and support the well-being and dignity of AD patients.
2. Homecare workers will strive to meet the special emotional, psychological, and physical needs of the AD patients.
3. Homecare workers will always keep in mind that those who suffer from dementia tend to feel isolated. Consequently, you will strive to make AD patients feel less alone.
4. Homecare workers will recognize and address the special needs of the families of AD patients.
5. Homecare workers will seek opportunities to enlarge their understanding of AD patients through continuing education and training.
6. Homecare workers will take whatever opportunities become available to educate the public about adult dementia and enlarge public understanding about the needs of the AD community.
7. In order to access the shared knowledge and experience of organizations which participate in the care of AD patients, homecare workers will participate in professional organizations dedicated to the dissemination of knowledge about adult dementia.

## Modifying Daily Activities

Each patient must receive a baseline assessment to determine which stage of ADRD he is currently experiencing and what type of assistance is needed to achieve activities of daily living (ADLs). Because every individual's progression through the stages of dementia is unique, it helps to refer to each patient's history. Knowing the person's habits, preferences, and behavioral issues can help you better connect with a patient or redirect one who is upset. This understanding of the person's history can be especially helpful when modifying activities of daily living. A familiarity with language and references to childhood friends, events and places can be the key to interpreting a patient's behaviors and speech.

Use this history to help you design a care plan that is based on the patient's remaining abilities and areas of need. Respect established patterns of waking, sleeping, bathing, and eating as much as possible within the framework of the family's schedules. If a patient prefers a morning bath, and it does not disrupt the schedule to accommodate that choice, honor that preference. Avoid situations, foods, and activities the patient dislikes. For example, if a patient says she likes apple juice but dislikes orange juice, honor that preference. Don't insist that she try the orange juice.

Modifying daily activities is based on the delicate balance between the patient's need for assistance and their need for independence. Again, knowing each patient helps you judge how much assistance to provide without "taking over" the task. It is important to allow as much independence as is safe. As the person's symptoms progress, she will need increasingly more assistance with bathing, toileting, grooming, dressing, and eating. There may be a great deal of variance among individuals, but there are some general guidelines regarding appropriate assistance with ADLs in early, middle and advanced stages of ADRD.

## ADL Assistance in Stages of ADRD

**The Early Stage** of ADRD is the beginning of the loss of functional brain cells. Patients in this stage exhibit memory loss and confusion that can impair their ability to recognize friends and loved ones, keep appointments and learn new things. Disoriented to time and place, they forget where they are, what they are doing, and what comes next. It is difficult for the person to perform tasks in a sequence. In the early stage, patients require prompting, reminding and monitoring.

For patients in early stage, caregivers need to:

- Talk about a single topic at a time.
- Name people and objects specifically, not with pronouns or general terms.
- Using language that is familiar to the patient.
- Broach important topics when the patient is rested and calm.

**The Middle Stage** marks advances in damaged brain cells and the resulting confusion and frustration. It is harder for the patient to carry out routine chores and activities, such as choosing apparel suitable for the weather and putting on clothes in the proper order. In the middle stages of ADRD patients require supervision and, at times, direct assistance.

For patients in middle stage, caregivers need to:

- Keep choices simple: “Juice or water?” not “What do you want to drink?”
- Give simple directions.
- Redirect problem behavior with a positive option.
- Repeat often.

**The Advanced Stage** is known for a significant loss in control of body functions, coordination and verbal communication. Swallowing problems often occur in this stage, and the person is typically bedridden. In the advanced stages of ADRD the patient requires full hands-on, direct assistance with all ADLs: eating, fluid intake, bathing, grooming, and voiding.



For patients in late stage, caregivers need to:

- Continue verbal (“Hello, Mr. Green”) and non-verbal communications (therapeutic touch) even though the patient’s ability to respond is limited.
- Use the patient’s name. Studies show that patients recognize the sound of their own names late into the disease process.
- Be courteous and observe social conventions. (“Good morning” , “Thank you” “Good-bye”)
- Watch for non-verbal cues for a need or emotion the patient may be trying to express.
- Honor the person’s values and individuality.

**The Final Stage** patients may lose the cough reflex, or the reflex controlling blood pressure and heart rate. Losing the cough reflex can lead to pneumonia, a common direct cause of death in patients suffering with ADRD. In the final stage patients require total care.

## Communication Skills Review for Modifying Daily Tasks

- Rather than saying “It’s time to get dressed,” break the task into small, concrete steps: “Sit here. Put on your socks. Put on these pants. Put on this shirt, etc.”
- Pause between each request to allow time for the information to be understood.
- Repeat instructions using the same language. Remember that it may take several repetitions before the patient can respond.
- Monitor and document declining abilities. Slower responses and increasing resistance or frustration may indicate that the task is too difficult. Documenting these behavioral changes will help all caregivers learn when to break the task into smaller steps or begin doing some of the steps for the person.
- Praise efforts and help the patient feel successful, not helpless.

## Dressed for Success: Personal Care Strategies

### *Dressing*

- Adjust room temperature and lighting to comfortable levels.
- Ensure the patient’s privacy by closing door and curtains.
- Lay out items of clothing on the bed, placing them in order of use.
- Encourage the patient to select clothing, but simplify the choices. (“Do you want to wear this red shirt or this blue shirt?”)
- Ask the family to provide simple clothing: pull-on pants with elastic waist, sweat suits and shoes with Velcro fasteners.
- Group outfits together on hangers.
- Label dresser drawers.
- Avoid arguing over a change of clothes or about what “goes together.”
- If a patient chooses to wear the same clothes every day, ask the family to buy duplicate sets of the outfit. This way the person can wear what she wants and be dressed in clean clothes.

- Stash rarely worn or out-of-season clothing so it is easier to reach the clothes the person wants to wear on a daily basis.

## **Bathing**

- Determine the best time of day and type of bathing, based on the patient's preference. Be consistent with that schedule and regimen.
- Make sure the bathroom is warm enough and has appropriate lighting.
- Close doors and curtains for privacy.
- Be prepared with bath supplies ahead of time.
- Approach the patient with a calm, quiet, positive tone of voice.
- Do not discuss the need for a bath.
- Support your verbal directions with visual cues.
- Let the patient feel the water before getting wet.
- Keep reassuring the patient with soothing vocal tones.
- Drape a towel over the person's shoulders to offer privacy. Some patients may be embarrassed about being undressed or needing help with bathing.
- Give the patient a toy or something to hold to redirect his attention during the bath.
- Allow the patient to do as much of the bathing as possible.
- Check the person's skin for any sign of sores or a rash.
- Towel-dry the patient thoroughly.
- Check the person's fingernails and toenails. Report any problems that may need medical attention.
- If a person resists a bath, do not argue. Try again a few minutes later.



## **Eating**

- Keep it simple at mealtime. Eliminate unnecessary items from the table.
- Plates with colors that contrast the placemats or tablecloth are easier for the patient to see and use.
- Reduce noise and distractions at meal times.
- Serve meals at a set time and stay on schedule whenever possible.
- A quiet, relaxed atmosphere is best at mealtimes.
- Ask if the person is comfortable and try to resolve any discomfort.
- Remind the patient to eat if she gets distracted, with verbal and nonverbal cues.
- Focus on the person who is eating, but do not rush her or intimidate her.
- Consider the patient's historical eating habits.
- Make sure the food is not too hot or cold before serving.
- Eliminate unpleasant odors, like cleaning products, from the area when serving a meal.
- Praise the person for eating.
- Extend multiple opportunities to eat. Patients with ADRD tend to prefer small snacks to full meals. By presenting a variety of nutritious snacks every few hours, the patient's desire to eat less is satisfied without sacrificing the nutrition her body still needs.



### **Learning Activity:**

Think about a patient in your care who is rarely interested in eating more than one or two bites of food at a time. Jot down three new options from the course material that you can try to encourage the patient to improve his or her eating habits.

## Grooming

- Encourage easy care hairstyles.
- It can be extremely upsetting to some patients to have water poured over their heads and faces. Hair shampooing may need to be separated from the bath for these patients.
- Use beauty/barber shop for patients when possible, especially if this has been a part of their regular routine. Sometimes having a shampoo in a stylist's chair at a beauty salon is much more comfortable for the patient.
- If the patient enjoys wearing makeup and wants to apply it, allow it, with supervision.
- Let patients continue to shave as long as possible, with supervision.
- Provide electric razors for safe, simple shaving.
- Encourage patients who can to maintain healthy nail care by trimming their fingernails and toenails. If they need assistance, provide it. Advise the family if you notice any problems that may need medical attention.
- Patients who need to have their nails cleaned and trimmed for them may be more relaxed and cooperative if it is done while they are watching TV or listening to music.
- Document the need for a podiatrist to address and foot problems, including thickened toenails that are very difficult to trim.
- Help patients brush their teeth twice a day and check for ill-fitting dentures, thrush, broken teeth or sores. Mouth and denture problems can cause pain and affect eating habits.
- Use adaptive devices as needed to assist with oral hygiene.
- When tooth brushing is very difficult, consider Peridex® mouthwash if the patient is able rinse and spit.



## **Toileting**

- Causes of incontinence include: inability to remove clothing in time, inability to feel or recognize the need to toilet, dehydration, constipation, medications, stress or urge incontinence, disoriented and unable to find the bathroom, and the perception of a lack of privacy.
- Know the patient's non-verbal toileting cues, like pulling at clothes.
- Quickly respond by taking the individual to the bathroom.
- Maintain adequate lighting in the bathroom. Make it easy for the patient to distinguish the toilet from other bathroom fixtures.
- Learn techniques to help patients who have trouble urinating. (For some, it helps to let warm water from the sink's faucet run gently over their hand while they are seated on the toilet.)
- Try to help an anxious patient relax and calm down before toileting.
- Implement a schedule for toileting before and after meals.
- Reassure patients who have had an accident. Help her get her clothes changed quickly and quietly, maintaining respect, privacy and dignity.
- Use protective garments on patients who have incontinence problems. Dress the patient in loose clothing that conceals the protective garments.
- Clean skin thoroughly after toileting or an accident. Use protective ointments when needed to soothe irritated skin.
- Remind or assist the patient with maintaining healthy skin care.
- Strategies for handling nighttime incontinence:
  - Use protective pads as needed.
  - If the patient's intake of fluid is adequate, try decreasing fluids near bedtime.
  - Just before bedtime, encourage patients to use the toilet, and check to be sure that they actually urinate before leaving the toilet.

**Topic Summary:** Homecare workers who assist people with ADRD must be mindful of the stage of the disease their patient is in so as to offer the correct type and level of assistance. Since every person is unique, it is important to review the patient's personal history. Balance the patient's need for assistance with their need for independence.

## **Topic 5: Working with Families and Caregivers**

**Topic Introduction:** “No man is an island,” observed the poet John Donne. In other words, each individual exists in a web of relationships with others. The successful homecare worker understands that, to work successfully with a patient, one must also work successfully with the patient’s family. This dynamic becomes more complicated when working with ADRD patients who may no longer be able to recognize and respond to their friends and family. This inability to connect creates a sense of isolation for both the patient and the family. Thus, it is crucial for homecare workers caring for ADRD patients to identify issues and concerns of family members and patients during the early, middle, and late stages of ADRD. This topic will help you accomplish that task.

### **Family Support Groups**

Family members need an opportunity to express their feelings and connect with others who share those feelings. It is important to find a support group that is specific to families of patients with ADRD. If support group meetings are not yet offered in your community, consider coordinating monthly meetings, led by a care team social worker, counselor or the agency’s director of social services.

Designate a lead person as a contact for questions regarding the family support group. Invite a member of the clergy to attend family council meetings, as well. This connection can help families with the grieving process, which begins prior to the actual death of the person with ADRD.

Additional support for family members includes:

- Educational programs focused on the stages of ADRD.
- Handouts showing what to expect as the disease progresses.
- Telephone support among other families.
- Grief sessions facilitated by a licensed psychotherapist and clergy member.
- Emphasizing the importance of participating in care planning for their family member.

### **Costs of Care: Time, Dollars, Feelings**

The national Alzheimer’s Association conducted a survey documenting that the average caregiver living with a relative who has ADRD spends about 100 hours per week providing care. Among caregivers employed outside the home, an average of 40 hours weekly is dedicated to providing care. Half of the caregivers

surveyed reported feeling they did not have enough self-care time. Other costs to spouses include the psychological loss of an intimate relationship and companion and the burden of taking on duties the spouse once handled.

Adult children trying to care for a parent with ADRD note their discomfort with role reversals as their mother or father gradually became more like their child. Research findings show that caregivers are at great risk of becoming ill and suffering emotional distress. Depression and fatigue also were cited as byproducts of long-term caregiving. The financial burden is enormous due to the duration of the illness.

## **Family Members: Part of the Care Process**

A sense of unity among patients, homecare workers and family caregivers will contribute to meaningful and individualized care. Families bring vital historical information about the patient to homecare workers' attention. These factors will help you build a better care plan, including stimulating activities and food preferences. When interacting with family members, you are on the same team with the same goal of providing optimal care to their loved one. Include the family in decisions and seek their advice, ideas and assistance.



Let family members know how important visits are to the patient. Have them encourage other family and friends to visit. Remind them that some days the person with ADRD will recognize them and some days they will not. Either way, the visit is important and meaningful. Connecting with another person always has great value.

## **Grief, Bereavement, and Mourning**

The effects of dementia extend outward from the afflicted to their friends and family. Alzheimer's can seem like a "death in life" because it's victims lose the sense of self built over a lifetime. The memory loss which often accompanies dementia can create a chasm between the disease's victims and their loved ones. Consequently, family and friends can experience emotions that are normally felt after a loved one has died.

Grief, mourning, bereavement are terms that are often incorrectly used interchangeably. Yet, each describes a vital component of preparing and coping with serious illness as well as death on an emotional, physical and spiritual level. To confuse them is to cheat ourselves and deny the importance of what we feel and do.

**Grief** is the physical, emotional, intellectual and spiritual reaction to loss. The nature of the loss is not the determining factor in the extent of grief. Instead it is the intensity or depth touched in our being by the loss. It will manifest itself in many ways such as tightness in the chest, numbness, anxiety, insomnia, loss of appetite, isolation from others, or a search for the meaning of life and death. It will appear and stay for days, months, or even years.

**Bereavement** refers to the state of suffering loss. Three elements comprise bereavement as defined by Charles A. Corr, Clyde M Nabe and Donna M. Corr. These are:

1. A relationship with some person or thing that is valued
2. The loss – ending, termination, separation – of that relationship
3. A survivor deprived of the valued person or thing by the loss

Everyone who suffers loss may be considered to be bereaved but the intensity of the former relationship shapes the intensity of the bereavement. To clarify the difference between grief and bereavement consider the following examples.

**Mourning** refers to the ways and means by which we cope with the death or loss. It includes the use of counseling and support groups for emotional stability, as well as the use of rituals and rites such as burial traditions, the use of sacraments or other ways in which public support is sought by the bereaved. Mourning rites may be as basic as sorting through the deceased individual's clothing or possessions, or as complicated as prayers and ceremonies lasting 100 days.

## Tips for Visiting Family Members

Here are some tips you can give other family members about what to do when they come to visit their loved one who is in your care.

- Try to plan the visit at the patient's best time of day, if possible considering their work schedules and other family obligations.
- Encourage family members to share some kind of activity, such as something uplifting to read or photo albums to look at together, but be prepared to drop the idea if it doesn't work out that day. Try again during another visit.
- Share with family members your communication skills, especially establishing eye contact, speaking in a calm, soothing tone of voice and using names to help the person remember and recognize visitors.

- Mention the need to respect the person's personal space. Their desire to be hugged may vary from day to day.
- Emphasize the wisdom of responding to feelings and not behaviors, accepting the person's confusion without arguing or "setting him straight."

Remind the family not to take personally anything unkind, untrue or puzzling the person may say, as that is part of the disease process.

## Helpful Strategies for Homecare Workers Collaborating with Family

- Know that, initially, it may seem like you actually have to care for both the patient and the family members who have been his caregivers up to now.
- Keep lines of communication open with family members so there are no surprises.
- Listen and absorb feelings expressed by family members. Help them feel safe sharing their concerns with you.
- Educate family members about the process of ADRD and the aspects of the patient's behavior that are part of that disease process.
- Encourage family caregivers; let them know that both you and the patient greatly value their assistance.
- Point out the strengths of people with ADRD, even in the end stages of the disease. Help family members see positive traits.
- Converse with family members who visit about their other interests, besides the illness and the patient.
- Advise family members about the importance of non-verbal communications, like comforting touch, handholding, eye contact, and non-threatening posture and soothing vocal sounds to express acceptance and love to people with ADRD.
- Remind family members to take time for their own needs, interests and health.



## Keep the Family Involved

Family members begin to feel at a loss when visiting with a relative who has advanced memory impairment. The following suggestions may help.

- Reminisce with the patient, sharing stories and photo albums.
- Go outside for a walk, or sit on a bench, enjoying the wind and trees.
- Listen to music together.
- Bring in a favorite food or order a meal to share from the facility.
- Help the person decorate by posting seasonal décor around the room.
- Rub lotion over the person's back, legs, feet or hands.
- Therapeutic touch shows love – holding hands, hugs, pats on the back.
- Frequent brief visits may be better than fewer extended visits.
- Respond to the underlying emotional message in the patient's pleas to go to their original home. Offer reassurance and do not argue about going home.



## Share Support Resources with Family Members

In addition to family support groups, family members should contact The Alzheimer's Association and Area Agency on Aging for more information and support. On-line support groups exist for family members who cannot attend meetings. (See references.)

### **Learning Activity:**

Consider a patient in your care with family members who are visiting less frequently because they are at a loss for how to interact with the loved one. Think of tips you could give that family member. Jot it down and plan to use it on your next home visit to that patient.

**Topic Summary:** It is important to remember that the families of patients with ADHD are a part of the care process. Assist them by connecting them with support groups for people with family members suffering from ADHD. Also remember the special strain that family members labor under. Make certain that they feel welcome as active members of the care team.

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## Online Resources

### **General Information about ADRD**

[www.alzheimers.org/](http://www.alzheimers.org/)  
[www.alzheimer-europe.org/](http://www.alzheimer-europe.org/)  
[www.coa.uky.edu/ADReview/contents.htm](http://www.coa.uky.edu/ADReview/contents.htm)  
[www.mayohealth.org/](http://www.mayohealth.org/) - search "caregivers"  
[www.alz.org](http://www.alz.org)  
[www.alzheimer.ca/](http://www.alzheimer.ca/)  
<http://www.clinicaltrials.gov>

### **For ADRD Caregivers**

Administration on Aging: <http://www.aoa.dhhs.gov>

Alzheimer's Disease Education and Referral Center: <http://www.alzheimers.org>

Florida Agency for Health Care Administration – Florida Nursing Home Guide Update: <http://www.fdhc.state.fl.us>

[www.zarcrom.com/users/alzheimers/index1.html](http://www.zarcrom.com/users/alzheimers/index1.html)

<http://my.smartbotpro.net/sea/>

[www.adcr.wustl.edu/ALZHEIMER/submit/caregive.html](http://www.adcr.wustl.edu/ALZHEIMER/submit/caregive.html)

<http://health.tbo.com/health/caregiveers/index.htm>

[www.caregiving.com/support/html/resource.htm](http://www.caregiving.com/support/html/resource.htm)

[www.carethere.com/](http://www.carethere.com/)

[www.totallivingchoices.com/](http://www.totallivingchoices.com/)

[www.caregiving.com/years/index.htm](http://www.caregiving.com/years/index.htm)

[www.alzbrain.org/resource/links.html](http://www.alzbrain.org/resource/links.html)

### **Respite Information**

[www. chtop.com/locator.htm](http://www. chtop.com/locator.htm)

## Author Biography

### Jeanne Christian MA, SLP-CCC

Jeanne Christian has her BS and MA from St. Louis University, St. Louis, Missouri. She has over 25 years of healthcare experience in hospital and skilled nursing settings. Regional and national positions include operations, clinical management and training. Her special expertise and focus is in the areas of program development, cross-discipline training, and regulatory and accreditation management. She is a former CARF surveyor, and is a Co-founder of *online HealthNow, Inc.*



Jeanne Christian's credentials include being a Certified Trainer of Alzheimer's and Related Disorders, accredited by the Florida Department of Elder Affairs-Nursing Home Alzheimer's Disease or Related Disorders Training Provider Certification number NH504. This special certification is only awarded to those individuals who demonstrate extensive clinical/practical experience in working with and developing programs for those individuals experiencing Alzheimer's Disease or other related disorders.

### **Contacting a Florida Approved DOEA Alzheimer's Disease and Related Disorders training provider.**

The approved Florida DOEA Alzheimer's Disease and Related Disorders training provider for this course is Kim Tartaglia, BSN, MBA, RN, CPHQ. You can contact Kim with your questions regarding this course at 1-866-703-9497 from 9:00 am to 4:00 pm Monday through Friday.

## Alzheimer's Disease & Related Disorders (ADRD) for Homecare workers (1201)

### Post Test

1. A neuron is:
  - a. A nerve cell
  - b. A basic unit of the brain
  - c. Both a and b
  - d. None of the above
  
2. Which of the following is NOT a good practice with patients?
  - a. Encouraging family to visit
  - b. Reminding the patient that everything is under your control so the patient isn't burdened by any sense of responsibility
  - c. Providing support to enhance his or her success
  - d. None of the above
  
3. Which of the following is an aspect of the "Show and Tell" technique of working with persons with ADRD?
  - a. Showing with gestures,
  - b. Showing with facial expressions
  - c. Using an open posture while telling in short, simple statements
  - d. All of the above
  
4. Which of the following is an inappropriate technique for communicating with persons with ADRD?
  - a. If a person is unreceptive, speak again in a clear, firm voice, raising your tone slightly
  - b. Use names of things and words the patient knows. For example, say "fork" instead of "utensil."
  - c. Pay attention to nonverbal cues you are giving and receiving from patients.
  - d. None of the above

5. Which of the following are examples of good techniques to use with patients with ADRD?

- a. Maintain focus with gentle therapeutic touch.
- b. Offer multiple (more than three) choices to stimulate cognitive activity
- c. Use sensory stimulation, like touch and smell, perhaps during meals and while bathing and grooming.
- d. Both a and c

6 Which of the following conditions can cause stress that leads to problem behaviors?

- a. Medical / Physical problems
- b. Emotional problems
- c. Both a and b
- d. None of the above

7. Which of the following are signs of agitation in a person with ADRD?

- a. Slapping
- b. Name-calling
- c. Disrobing
- d. All of the above

8. Which of the following could be responsible for aggressive behavior in a person with ADRD?

- a. Anger
- b. Depression
- c. Extreme frustration
- d. Both a and c

9. \_\_\_\_\_ is the name given to behavioral problems that increase in the late afternoon or evening.

- a. Late day melancholy
- b. Sundowner's Syndrome
- c. Sundowner's Depression
- d. Evening Blues

10. \_\_\_\_\_ can be visual, auditory, tactile or gustatory (perception of a bad taste)

- a. Delusions
- b. Hallucinations
- c. Both a and b
- d. None of the above

11. \_\_\_\_\_ are fixed false beliefs that persist in the face of evidence to the contrary.

- a. Delusions
- b. Hallucinations
- c. Both a and b
- d. None of the above

12. The proper way to view problem behaviors is to see them as:

- a. Disobedience that must be actively fought to slow the disease's progression
- b. The patient's attempt to send a message, to communicate a physical or emotional need
- c. Always a sign of ineffective caregiving
- d. None of the above

13. Which of the following is NOT a good technique when working with problem behaviors?

- a. Approach the patient from the front and smile.
- b. Keep your voice stern, using an assertive tone
- c. Use the patient's name and identify yourself. Do not expect the person to remember you.
- d. None of the above

14. Which of the following is NOT one of the five "R"s of managing catastrophic behavior?

- a. Remain
- b. Reason
- c. Remove
- d. Return

15. The proper purpose of restraints is to \_\_\_\_\_

- a. Keep patients safe
- b. Any situation where a problem behavior becomes apparent
- c. Both a and b
- d. None of the above

16. Which of the following areas should a healthcare worker be familiar with in order to work with a patient with ADRD?

- a. The person's habits
- b. The person's preferences
- c. The person's behavioral issues
- d. All of the above

17. For patients in middle stage ADRD, which of the following should caregivers NOT do?

- a. Offer multiple choices to stimulate brain activity
- b. Give simple directions.
- c. Redirect problem behavior with a positive option.
- d. None of the above

18. Which of the following is NOT a good approach to helping ADRD patients with dressing habits?

- a. Lay out items of clothing on the bed, placing them in order of use.
- b. Encourage the patient to select clothing, but simplify the choices.
- c. Ask the family to bring familiar clothing with belts and zippers so patients can practice motor skills
- d. Group outfits together on hangers.

19. Which of the following is NOT a good approach to helping ADRD patients with bathing?

- a. Give the patient a toy or something to hold to redirect his attention during the bath.
- b. Allow the patient to do as much of the bathing as possible.
- c. Check the person's skin for any sign of sores or a rash.
- d. Allow the patient to dry themselves

20. According to the national Alzheimer's Association, how many hours weekly do caregivers employed outside the home dedicated to providing care?

- a. 20
- b. 35
- c. 40
- d. 45

21. Which of the following is NOT a good strategy for a healthcare worker collaborating with family?

- a. Educate family members about the process of ADRD and the aspects of the patient's behavior that are part of that disease process.
- b. Encourage family caregivers; let them know that both you and the patient greatly value their presence.
- c. Point out the strengths in people with ADRD, even in the end stages of the disease. Help family members see positive traits.
- d. Avoid conversing with family members who visit about their other interests. Keep focused on the illness and the patient.