Florida: Alzheimer's Disease and Related Dementias, 1 unit

1 contact hour: $19

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Florida DOEA Approval: This 1-hour training program has been approved by the Department of Elder Affairs and is in compliance with 400.1755 FS and rules 58A-4.001 for Nursing Homes, Hospice, and Adult Day Care. Approval number NHAD 447.

Certified Trainers: The authors are certified as ADRD trainers by the Florida Department of Elder Affairs and are available via e-mail at ADRD@ATrainCeu.com or by phone Monday-Friday (Pacific Time) from 9 am to 5 pm at 707 459-1315.

Course Summary: This course is designed to educate and train nursing home staff who have direct contact with residents.

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Criteria for Successful Completion: 80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

This course will be reviewed every two years. It will be updated or discontinued on June 1, 2013.

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Target Audience: Occupational Therapists, OTAs
Instructional Level: Introductory
Content Focus:

- Category 1 - Domain of OT, Client Factors

Other Professions and Accreditations

See the ATrainCEU Accreditation page at http://www.ATrainCeu.com/accreditation.php.

Instructions

1. Read the course material and then complete the following forms:
   A. Answer Sheet
   B. Evaluation Learning Activity
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When we receive your forms and payment, we will mail (or email, at your request) your completion certificate. If you have any questions, please call or email Info@ATrainCEU.com.

Learning Objectives

When you finish this course, you will be able to:

- Define dementia and differentiate between Alzheimer's disease and other related dementias.
- Identify the characteristics and stages of Alzheimer's disease and related dementias.
- Describe the challenges facing caregivers at each stage of ADRD.
- Outline effective strategies for communicating with residents who have ADRD.

Understanding Dementias

The goal of this training is to promote awareness and understanding of Alzheimer's disease and other types of dementia. This section will define dementia, describe how dementia affects the brain, and discuss how the symptoms of dementia differ from the normal cognitive changes of aging.

Defining Dementia

Dementia is the loss of mental ability due to disease or injury to the brain. It is not a normal part of growing old. There are many things that cause dementia but all types of dementia have certain things in common, including forgetfulness, confusion, poor safety awareness, and fatigue. Although most adults who have dementia are older, dementia is not considered a part of normal aging. Dementia has probably been around since the first humans appeared on the earth but it is only as we live longer that we have begun to see so many cases in older adults.

Alzheimer's disease (AD) is the most common cause of dementia in aging adults. The most obvious symptom of AD is a gradual loss of short-term memory. This means that a person can remember events from earlier in their lives but cannot make new memories. AD affects a little less than 10% of people over the age of 65 and about 40% of those over the age of 80. It is responsible for about 50% to 75% of all cases of dementia.

There is no blood test or x-ray that can diagnose Alzheimer's disease, or most other types of dementia. We decide that someone has dementia because of their symptoms, such as mental changes, changes in behavior, and growing inability to care for themselves. The only sure way to know if someone had AD is to examine their brain after they die.

Even though Alzheimer's disease is fairly common it isn't the only thing that causes dementia. The symptoms are a bit different in each type of dementia, depending upon the part of the brain that is affected. **Frontal-temporal dementia (FTD)**, which affects the front part of the brain, is the most common dementia in those under the age of 60; FTD is responsible for about 5% to 10% of all cases of dementia.

V**ascular dementia**, which is caused by small strokes, occurs in people with longstanding, inadequately controlled, high blood pressure. It is responsible for about 20% to 30% of all cases of dementia. **Lewy Body dementia**, which often accompanies Parkinson's disease, can cause hallucinations and mental changes. It is responsible for a little less than 5% of all cases of dementia. Acquired immune deficiency syndrome (AIDS) can also cause a form of dementia called **AIDS-related dementia**.

Type of dementia	Part of brain affected	Symptoms
Alzheimer's disease (AD)	Starts in the **hippocampus**—the area of the brain just above your ears that makes and stores memories. It spreads from there to the front part of the brain.	• Loss of short-term memory • Behavioral and personality changes • Apathy • Rapid mood swings • Slow onset
Vascular dementia (VaD)	**Frontal lobe** (the front part of your brain)	• Memory affected but less than in AD • Poor judgment • Mood changes—more prominent than AD
Frontal-temporal dementia (FTD)	Frontal and temporal lobes	• Emotional changes • Poor judgment • Behavioral changes • Loss of moral reasoning • Loss of inhibition
Dementia with Lewy-bodies (DLB)	**Substantia nigra** (an area deep inside your brain)	• Visual hallucinations • Sleep disturbance • Motor control problems • Mental changes • Shuffling gait
AIDS-related dementia	Frontal lobe	• Loss of judgment • Poor impulse control • Language problems • Motor control problems

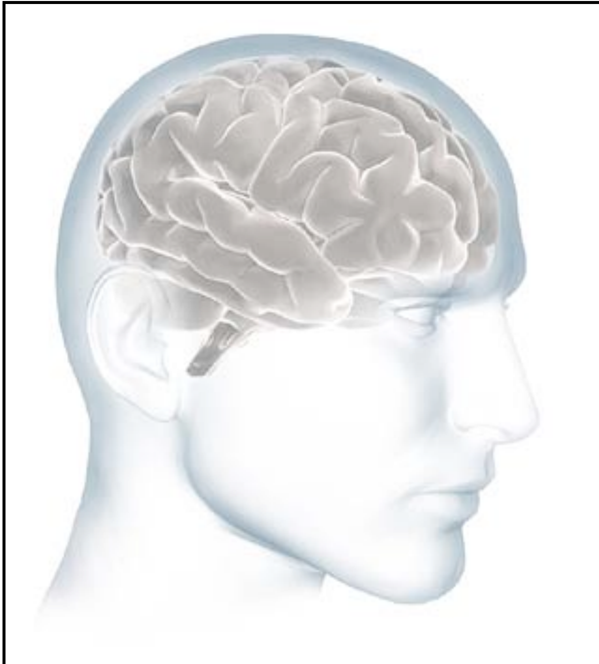
How Dementia Affects the Brain

Our brains are very powerful, yet they weigh only about three pounds. The brain has three main parts: the cerebrum, the cerebellum, and the brainstem. The **cerebrum** fills up most of the skull. It is involved in thinking, remembering, problem solving, talking, and emotions. It also controls movement, vision, and hearing.

The **cerebellum** is at the back of the head. It controls coordination and balance. The **brain stem** is also at the back of the head, above the back of your neck. It connects the brain to the spinal cord and controls automatic functions such as breathing, digestion, heart rate, and blood pressure.

The brain's wrinkled surface is a specialized outer layer of the cerebrum called the **cortex**. Areas of the cortex are linked to specific functions such as talking, understanding speech, movement, vision, hearing, and memory. Many of these areas of the cortex are damaged by dementia.

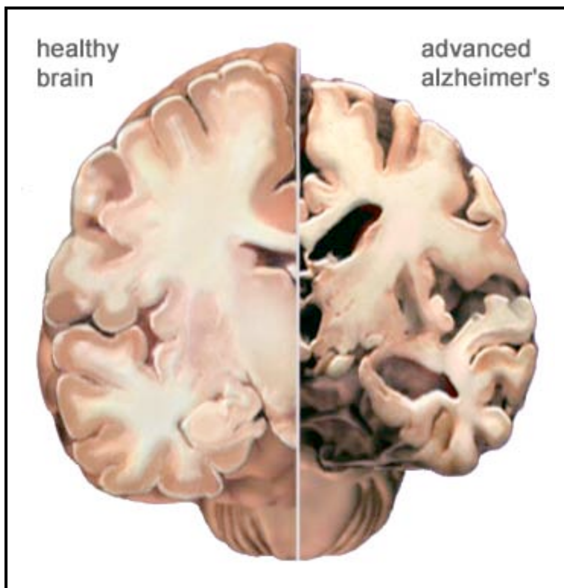
The Human Brain



Source: Courtesy of The Alzheimer's Association. Used with permission.

Dementia changes the entire brain. For example, in Alzheimer's disease, nerve cells in the brain die and are replaced by "plaques and tangles." As the nerve cells die the brain gets smaller. Over time, the brain shrinks dramatically, affecting nearly all its functions.

Normal Brain Contrasted with AD Brain



A view of how nerve cell loss changes the whole brain in advanced Alzheimer's disease. Left side: normal brain; right side, a brain damaged by advanced AD. Source: Courtesy of The Alzheimer's Association. Used with permission.

Normal Age-Related Changes

Memory does change with age, but **age-related changes** are not the same as dementia. Older people can be forgetful—for example, forgetting where they left the car keys. They may take longer to do certain mental tasks or be unable to memorize a string of words as well as a younger person. Older people may also have difficulty doing more than one thing at a time (multi-tasking). Normally, older adults can prepare their own meals—they do not forget what a coffee pot is or how to operate a microwave. They understand when they are in danger and know that they should call for help or get out of a house if there is a fire.

Mild cognitive impairment (MCI) is a condition in which people have memory problems that are noticeably worse than age-related changes. However, people with MCI do not have the problems, associated with dementia, of personality changes and difficulty with thinking. Some people with MCI do go on to develop AD, but not everyone does.

As opposed to age-related changes or MCI, people who have dementia don't know what to do if they are in danger. They forget how to operate a shower and how to get dressed. They may be unable to prepare meals for themselves and may forget the purpose of a coffee pot or a toaster. They slowly lose the ability to care for themselves. Some of the differences between someone who is aging normally and someone who has AD or dementia are described in the table below.

Normal Aging vs. Dementia	
Normal aging	AD or dementia
Occasionally loses keys	Cannot use a key; cannot remember what a key does
May not remember names of people they meet	Cannot remember names of spouse and children—don't remember meeting new people
May get lost driving in a new city	Get lost in own home, forget where they live
Is able to use logic (for example, if it is dark outside it is night time)	Is not logical (if it is dark outside it could be morning or evening)
Bathes, feeds, and dresses self	Cannot remember how to fasten a button, operate appliances, or cook meals
Participates in community activities such as driving, shopping, exercising, and traveling	Cannot independently participate in community activities

Characteristics of ADRD

In the early stages of dementia it is often hard to tell the difference between age-related changes and mild dementia. By studying the characteristics of dementia we can begin to understand the differences between dementia, health problems, the effects of medications, and psychological issues such as depression.

Stages

We often describe dementia as mild, moderate, or severe. The earliest stage of Alzheimer's disease begins with mild forgetfulness. As people with dementia enter the moderate stage, they lose connection with recent events. Language and reasoning get worse, and the person might become withdrawn and less talkative. People with severe dementia can no longer survive without assistance. They may forget how to do simple tasks such as getting dressed or eating with proper utensils. In the final stage, palliative care or hospice services may be needed.

Symptoms and Behavior Changes

Certain symptoms and behaviors are associated with the stages of dementia. Caregiver responsibilities change and increase as the dementia gets worse. The progression from mild to moderate to severe dementia may mean moving from home to a board-and-care, assisted living, or skilled nursing facility.

Mild Dementia

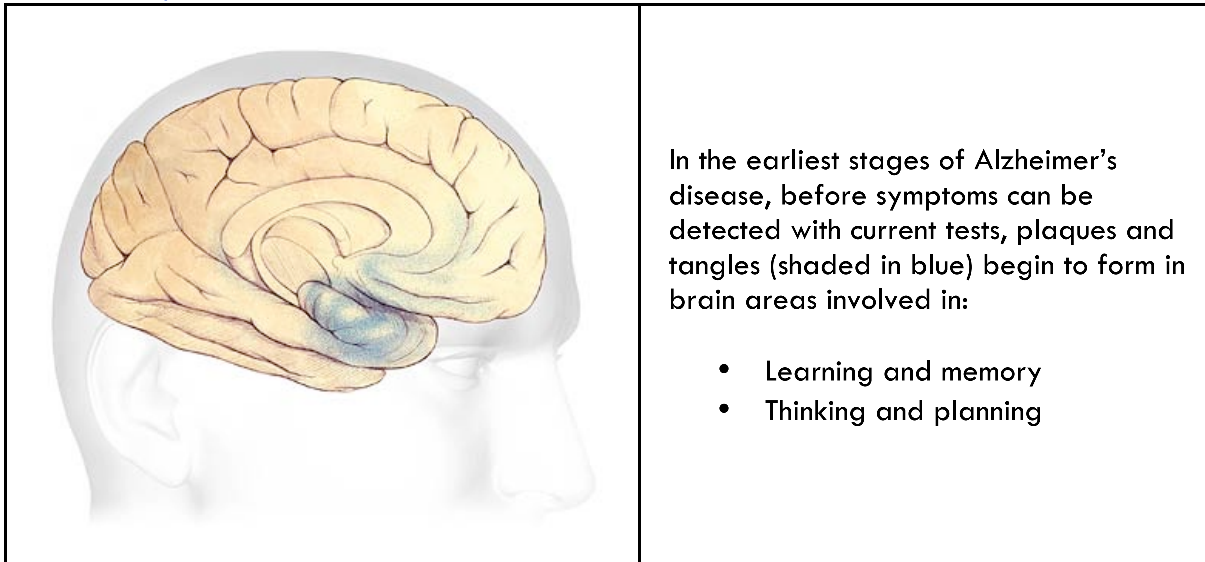
The early stage of dementia usually lasts about a year or two. During this stage people think less clearly and can be easily confused, especially with new tasks, people, and places. Memory loss can be significant, especially for recent events. Someone might forget names or misplace possessions or get lost in familiar places. Although many older people occasionally forget words, memory problems gradually worsen in those with Alzheimer's disease.

People in the early stage of dementia may cover up their increasing confusion by turning to others for help with simple tasks. They may occasionally become angry or aggressive and have difficulty making decisions. They may lose motivation and interest in hobbies and activities. Mood changes such as depression and anxiety are common. It may be difficult to learn new tasks, follow new rules, or successfully complete complex tasks. Faulty judgment and mild changes in personality are common.

Someone with mild dementia may still be working, driving, and living independently. Although safety skills and judgment are mildly affected they may be able to hide these changes. Mild dementia can be dangerous when it goes unrecognized. Someone with mild dementia may make mistakes on the job or may forget to turn off the stove after cooking. Many people who have mild dementia shrug off the concerns of family or friends and go on with their lives.

Although AD typically starts with loss of short-term memory, the early symptoms of other types of dementia can be different. For example, **frontal-temporal dementia (FTD)** usually starts with changes in behavior rather than memory loss. These changes may start at a younger age than AD—in the early to mid-fifties—often when someone is still working. In FTD, a formerly honest person might begin to shoplift or steal money from co-workers or business partners. These changes in personality are not as obvious as changes associated with AD and can be confusing to friends and family.

Brain Changes in Mild Dementia



Source: Courtesy of The Alzheimer's Association. Used with permission.

Moderate Dementia

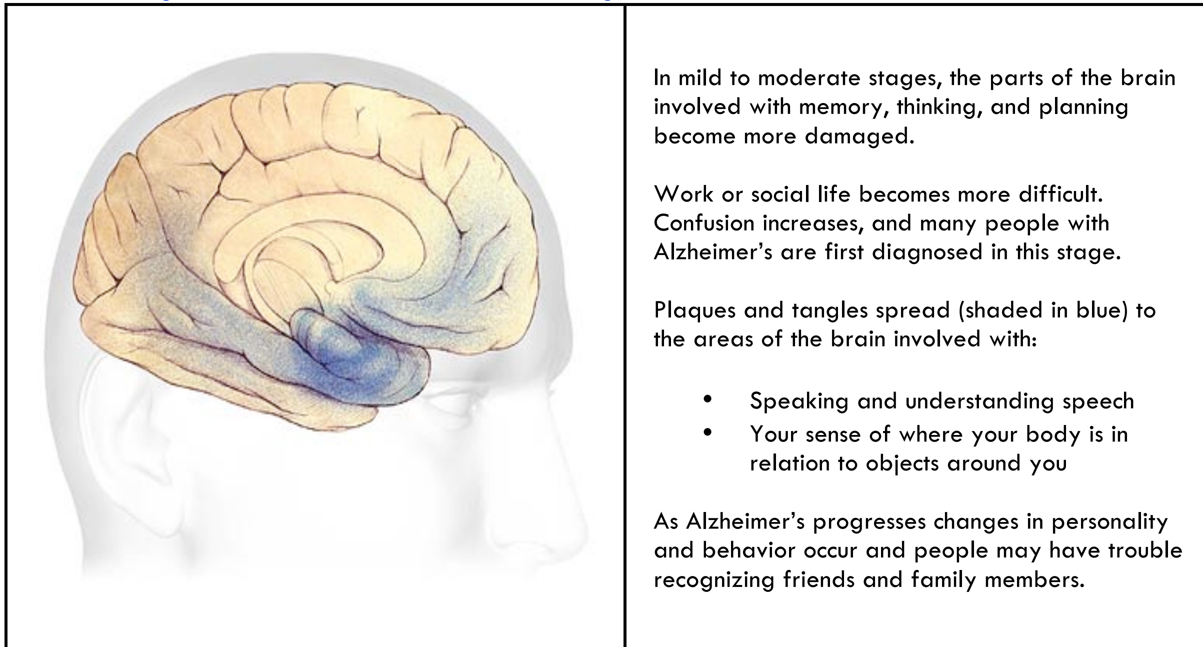
Dementia gets worse as abnormal plaques and tangles spread throughout the brain—especially to the front of the brain (frontal lobe). The frontal lobe is the part of the brain that controls judgment, safety awareness, logical thinking, and planning. Damage to the frontal lobe due to AD is responsible for many behavioral changes such as aggression, impulsive behavior, and safety problems.

As dementia progresses to the moderate stage, travel, work, and keeping track of personal finances become difficult or impossible. Insomnia, anxiety, agitation, and suspicion can develop during this stage. Inappropriate behaviors such as cursing, kicking, hitting, and biting are not uncommon.

In the moderate stage, people begin to rely on others more and more for daily activities. Safety becomes a real concern for caregivers in this stage. People may start to wander and are no longer safe on their own. Because of this, family caregiver responsibilities increase, causing stress, anxiety, and worry among family members and caregivers. In the moderate stage, a person:

- May become very forgetful—especially of recent events and people's names
- Can no longer manage to live alone without problems
- Is unable to cook, clean, or shop
- May become extremely dependent on their family and caregivers
- Needs help with personal hygiene, toileting, washing, and dressing
- Has increased difficulty with speech
- Shows problems with wandering and other behavior problems such as repeated questioning and calling out, clinging, and disturbed sleeping
- Becomes lost at home as well as outside
- May have hallucinations—seeing or hearing things that aren't really there (ADI, 2009)

Brain Changes in the Mild to Moderate Stage of AD



Source: Courtesy of The Alzheimer's Association. Used with permission.

Severe Dementia

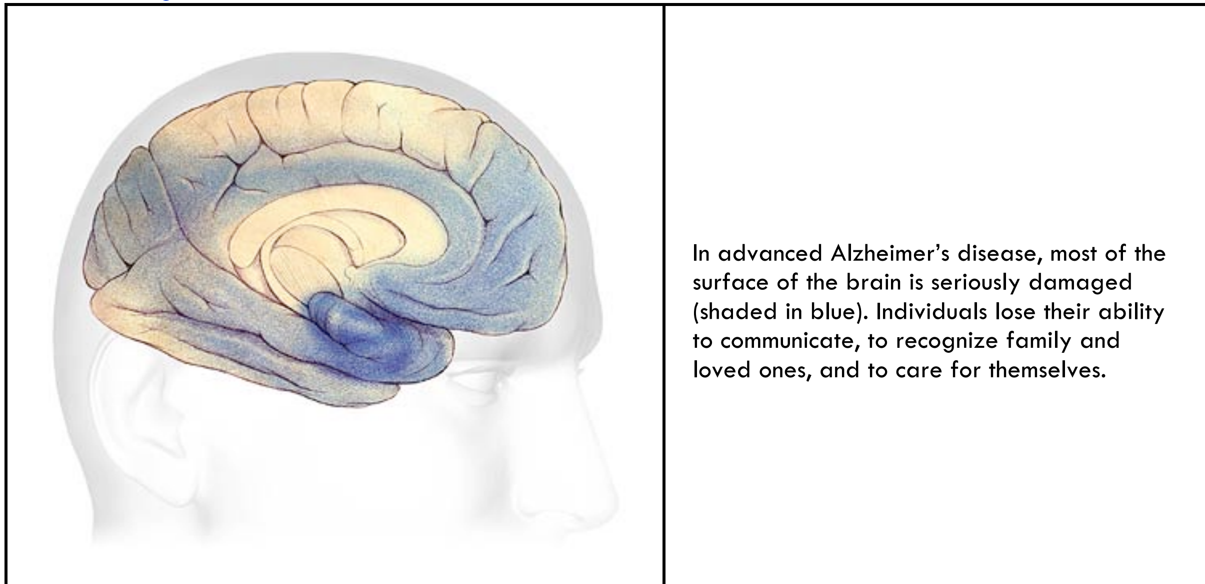
As dementia becomes more severe, independence is gradually lost and caregivers must provide around-the-clock care. People at this stage must be assisted with eating, bathing, walking, and other daily living skills. They gradually lose control of bodily functions. Family members may find it impossible to continue to provide care and may have to move their loved one to an assisted living or skilled nursing facility.

Disruptive vocal outbursts are very common among people with severe dementia. These include screaming, swearing, crying, shouting, loud demands for attention, negative remarks to other residents, and self-talk. Boredom, loneliness, depression, excessive cold or heat, loud noises, and pain can trigger outbursts. Because those with severe dementia are often not able to communicate their needs, regular assessments are necessary.

Poor (or non-existent) safety awareness and wandering require constant monitoring. Even with severe dementia, people are usually still able to walk. This is because the part of the brain that controls movement is not affected until the very late stages of dementia. If the person with dementia is still in the home, tired and overworked caregivers must provide even more support to maintain a safe environment. If in a facility, healthcare workers must receive proper training and the facility must provide enough staffing and equipment to create a safe environment.

Balance and safety awareness get worse over time, and eventually walking independently is no longer safe. To prevent injuries from falls, it may be necessary to use bed and chair alarms or provide a one-on-one caregiver during the day. Caregivers and healthcare providers must make difficult decisions to prevent injury and to provide a safe environment. In general, restraints are not recommended and may actually increase the danger of injury.

Brain Changes in Severe Dementia



In advanced Alzheimer's disease, most of the surface of the brain is seriously damaged (shaded in blue). Individuals lose their ability to communicate, to recognize family and loved ones, and to care for themselves.

Source: Courtesy of The Alzheimer's Association. Used with permission.

End of Life

Eventually dementia becomes so debilitating that patients are bedridden and likely to develop other illnesses and infections. Most commonly, people with AD die of pneumonia. As they approach the end of life they may no longer be able to communicate their needs and desires. They may be unable to eat, swallow fluids, or move without help. They may become unresponsive or comatose, eventually experiencing total systems failure. The most common behavioral symptoms cited for residents with severe dementia in assisted living and nursing homes at the end of life are agitation, psychosis, delirium, restlessness, and depression (Tilly & Fok, 2007).

End-of-life care is usually carried out by a group of people who work together to care for and comfort someone prior to death. **Hospice care** is available under Medicare, most state Medicaid programs, and some private insurance plans. Hospice provides care for those with less than 6 months to live.

Advance directives such as a living will and a durable power of attorney should be on file. These legal documents allow a person to communicate their wishes about end-of-life care while they are still able to make these decisions.

Challenges for Caregivers

> "My mom cusses at me every day, usually in public, and usually loudly. I suppose I am beyond the point of being mortified. There's nothing to do but accept it with good humor. That did not come easily or quickly. People in the support group tell me that this period probably will not last."
>
> ADEAR, 2011

Family caregivers—most of whom are women—must juggle child care, jobs, personal health issues, and other responsibilities while caring for family members who can no longer function on their own. The presence of other complex health problems such as heart disease and diabetes complicates care.

Professional caregivers and healthcare providers also face daunting challenges when working with dementia patients. One of the biggest struggles for any caregiver is dealing with difficult behaviors. Dressing, bathing, eating—basic activities of daily living—often become difficult to manage. Many caregivers find it helpful to use strategies for dealing with difficult behaviors and stressful situations, although each person with dementia is unique and will respond differently, and each person changes over the course of the disease.

Care provided for people with dementia includes:

- Personal activities of daily living (ADLs)—washing, dressing, grooming, toileting, eating
- Instrumental activities of daily living (IADLs)—cooking, shopping, laundry, household finances
- General supervision (ADI, 2009)

In a study of family caregivers in high-income countries, a daily average of 1.6 hours was spent assisting with personal activities, 3.7 hours was spent assisting with instrumental activities, and 7.4 hours was needed if general supervision was added to these other tasks (ADI, 2009).

The severity of the dementia determines how much care is needed, particularly for personal activities of daily living. In one study, the amount of care increased from an average of 2.3 hours per day for someone with mild dementia to 7.1 hours per day for someone with severe dementia (ADI, 2009).

> "I'm exhausted. I can't sleep because I have to watch out for my wife. She wanders around the house, takes out all kinds of stuff from the kitchen. I don't know what she's going to do."
>
> ADEAR, 2011

Early Dementia

In the early stage of dementia, family caregivers may not know much about the disease. Even experienced medical professionals can stumble and need help with a family member who has dementia. Caregivers may not recognize the signs of dementia and may not seek help. They may be confused and frustrated when their family member "acts funny." The behavior may also cause them to be concerned about their own future as they age.

Moderate Dementia

In the moderate stage, family caregivers can no longer ignore the changes brought on by dementia. The stress of caring for a previously independent loved one can lead to anxiety, sleep disruption, anger, and depression. A great deal of time and money may be required for caregiver duties. Loss of free time, work conflicts, and family issues may seem impossible to resolve. Often the responsibility of caregiving falls most on one person, leading to anger and frustration with other family members. The daily tasks formerly handled by the person with dementia now fall to daughters, sons, spouses, or friends.

Severe Dementia

In the later stages of dementia, when fulltime caregiving is required, family members will undoubtedly face difficult decisions about hiring a fulltime caregiver or moving their loved one to a long-term care facility. Frequently, they have no choice but to seek placement in a board-and-care or nursing home.

One difficult issue in the moderate to severe stage is that people with dementia usually have no trouble getting around, and they tend to wander. Loss of balance and falls are a problem. This creates a real safety challenge for caregivers—whether at home, in a board-and-care home, or in a nursing facility. Caregivers must worry constantly about safety. They must somehow create a safe place for wandering without turning the home or facility into a prison.

Unpredictable behaviors—inappropriate sexual behavior, agitation, irritability, obscene language, tantrums, and yelling—tend to get worse in the later stages. These behaviors are embarrassing, tiring, and frustrating for caregivers. People may throw things, strike out, or even bite. They may threaten or even injure their caregivers. Caregivers may react out of fear and strike back or yell to stop these behaviors, creating guilt and more frustration. In extreme cases, caregivers may have to think about how to protect themselves from assault and injury.

Triggers for Behavioral Problems

People with dementia do not misbehave on purpose. Whether at home, in adult daycare, or in a nursing facility, you can reduce the stress of caregiving by knowing how that person acts, what kinds of activities they like, and what triggers misbehavior (see box). If a person's behavior changes suddenly, it might be because they have become ill.

Triggers for Behavioral Problems

Medical issues

- Pain
- Health problems such as a urinary tract infection
- Depression
- Recent change in medications
- Sleep disorders
- Lack of exercise/stimulation
- Caregivers not respecting personal preferences

Personal issues

- Needing to use the bathroom
- Invasion of personal space
- Frustration at declining abilities
- Loss of personal control or choice
- Feeling unsafe or afraid of the unknown
- Being too hot or too cold
- Boredom
- Being tired

If you notice *sudden* changes in behavior, report these changes to the doctor or to your supervisor. These changes may be due to a medical problem or other unfulfilled need—not due to the dementia. Sudden changes in behavior may include:

- Hallucinations or delusions
- Moaning or crying
- Paranoia

- Increased wandering
- Anger, threats, agitation, and aggression
- Shouting, throwing things, hitting
- Rummaging and hiding things
- Hypersexuality

Caregiver Training

> There is a general consensus that providers who care for residents with dementia need to be specifically "dementia-trained." Training content should include knowledge of disease trajectory, symptoms, approaches to care, goals of care (cure or comfort), palliative care measures, end of life issues, signs of impending death for persons with dementia, and how to interact with residents and families.
>
> Tilly and Fok, 2007

If the caregiver is a spouse, adult child, or friend, the responsibilities of caregiving can be overwhelming. The caregiver may be in poor health and be unable to take on the burdens of fulltime caregiving. Even healthcare providers can find it difficult to deal with demented patients day in and day out.

For both professional and family caregivers, training and education can be a big help. It is possible to get better at caring for someone with dementia. Training and education can help caregivers recognize signs and symptoms of injury and illness and reduce stress. It introduces caregivers to resources and equipment that improve health and safety.

Communicating with Those Who Have ADRD

Because of damage to the brain, people who have dementia gradually lose the ability to think logically. Something that makes perfect sense to you may not make sense to a person with dementia. They do not necessarily understand, for example, that if it is dark outside it is nighttime.

Dementia also affects a person's ability to carry on a normal conversation. It damages the parts of the brain needed for remembering, understanding, and forming new thoughts. For someone who has dementia, talking to and understanding another person takes a lot of effort.

Nevertheless, communicating with others is still an important part of daily life—it creates positive relationships. It gives us an outlet for our feelings and the sense that someone cares. It gives the caregiver an opportunity to assess the behavior and well-being of the person they are caring for.

A person with dementia can experience these types of communication problems:

- Trouble finding the right words and understanding their meaning
- Difficulty thinking logically or following logical discussions
- Loss of common sense
- Problems paying attention
- Loss of their train of thought
- Trouble remembering the steps in common activities, such as cooking a meal, paying bills, getting dressed, or doing laundry
- Problems blocking out background noises

- Frustration when communication isn't working
- Being very sensitive to touch, tone, and loudness of voices (ADEAR, 2011)

Strategies for Verbal Communication

In the early stages of dementia, communication problems are mild, and with a little help from caregivers and family members conversations can be successful and satisfying. A caregiver should be relaxed, friendly, and cheerful. Smile—this provides reassurance as you begin your conversation. Keep in mind that some conversations involve specific tasks and some are for the purpose of general communication. In general, you can follow these steps:

- Make eye contact, approach from the front in a relaxed manner
- Greet the person using their name
- Be aware of your body language
- Ask a question and wait for a reply
- Be attentive and sympathetic
- Continue the conversation by asking a follow-up question
- Ask if there is anything you can do to make them more comfortable

Case

George has moderate dementia and is living in a board-and-care home. He is dressed and bathed and is sitting in his room. Ann, a nursing aide, enters his room without introducing herself and says, loudly and rapidly, "Come on George. Are you hungry? Did you sleep well? Time for breakfast! Stand up. Let's go into the kitchen." George just sits in the chair and looks at her, so Anna continues, "Come on, George, get up. You don't want your breakfast to get cold do you? I don't think so." She takes his arms and pulls him to his feet. George pulls away and sits back down.

Discussion

George is sitting in the chair and is comfortable. He's not sure what time of day it is. He's not thinking about food and isn't particularly hungry. Someone has entered his room and is saying something to him. He is still trying to figure out what she said when she says something else. Her voice is too loud, which is a little painful. He is confused and is not sure what she wants from him. When she takes his arms he supposes he should go with her but she pulls too hard and he sits back down.

Ann would have more success if she introduced herself and entered George's room quietly and respectfully. She should speak more slowly and pause at then end of each sentence to give George time to understand the conversation. She should use shorter sentences and wait for George's response: "Hi, George." Pause. "Time to go to breakfast." Pause. If George doesn't respond, Ann can repeat: "George, time to go to breakfast." Now George only has one simple statement to think about and he is more likely to answer or respond appropriately.

For general conversations, you may have to rely on memories of early life. Because early memories are still intact, you can have a pleasant conversation by asking about the person's early life and where they lived as children. Ask about childhood friends, family members, and pets. If there are photos in the person's room, ask about the photos. Memory can be stimulated by touching, by fragrance such as perfume, or by using auditory cues. One-on-one singing is a great activity—it stimulates memories, improves breathing, and is a relaxing activity for everyone involved.

It is always good practice to talk slowly and avoid arguments. Use gentle persuasion and be positive when giving directions. Instead of saying "You can't go outside now," try saying, "Let's sit down here, I would love to talk to you." Use hands gestures and unhurried movement to reinforce your words. You can even try silence, which is calming and reassuring. If the person does not answer right away, be patient and wait for a bit.

When starting a conversation, use short sentences without using a condescending tone of voice. If necessary, repeat what you've said in a relaxed manner. Use an adult tone of voice and choice of words—remember that you are not talking to a child. Sit on the same level as the person; do not stand over him, which is intimidating.

It is okay to talk about yourself, about your workday, your commute, or your family, and to say good things about other workers at the facility. If another worker is in the same room, be sure to involve your coworker in the conversation, which shows friendliness. It is also okay to talk about today and what is happening now. Remember, that, for people who have dementia, especially severe dementia, you will need to start all over again tomorrow. They may not remember what you talked about yesterday but they still want to hear what you have to say, even if you are repeating something said earlier.

Nonverbal Communication

Nonverbal communication is communication without words. We all use nonverbal cues for emphasis. Humans are very good at understanding the true meaning of a discussion by reading nonverbal cues. We've all had the experience of saying one thing and meaning another.

Examples of **nonverbal communication** are facial expressions, eye movements, hand gestures, and movements of the arms and legs. How you dress, your posture, and how close you stand to another person are also examples of nonverbal communication. For example, standing above a seated person can imply dominance. Even silence is a form of nonverbal communication.

Nonverbal communication includes vocal sounds such as loudness, tone, inflection, pitch, and rhythm. How you speak is important, not just what you say. Your tone can reveal calmness or impatience, affection or disapproval, confidence or fear.

Touch is also a powerful form of nonverbal communication. Touch can be friendly, frightening, soothing, dominant, or supportive. Touch has different meanings depending upon your culture, gender, age, and situation.

We also communicate nonverbally through the environment. A clean, nicely decorated room with good lighting provides a supportive environment. It encourages people to communicate with one another. A drab room with harsh lighting and little decoration has the opposite effect—it discourages interaction. Some studies have shown that people say they don't like people when they see them in unattractive rooms and don't want to return.

How you approach a person with dementia can influence the outcome. If you act hurried, frustrated, or angry, your patient will pick up on your mood or nonverbal body language more quickly than your verbal communication. If you are rushed or abrupt your patient will likely become anxious.

Case

A nursing assistant and a physical therapy aide are walking Mr. Trudell back to his room. His walking is unstable and they are holding onto his arms and waist. They are talking loudly to one another and laughing. Mr. Trudell feels embarrassed and confused. He is getting agitated and begins to yell. Asked what's wrong, Mr. Trudell says "They're attacking me!" A dressing on his forearm has come loose and the NA is trying to replace the dressing without explaining what she is doing. Mr. Trudell starts hitting her. The physical therapy aide grabs his arm and tells him to stop. Mr. Trudell starts yelling even more and hits the PT aide.

Discussion

Mr. Trudell doesn't know these people and doesn't know where they're taking him. They miss his signs of frustration and agitation because they aren't paying attention to him. They would have more success if they introduced themselves in a quiet tone of voice and explained in short sentences what they are trying to do. They should wait for Mr. Trudell to respond and look for cues to see if he understands what they are asking. If he looks or acts frightened, they should step back and observe. Finally, they should give their attention to Mr. Trudell rather than laughing and talking to each other.

It takes practice to sound relaxed when other things are on your mind. Use humor; smiling at and laughing with a person can set a relaxed tone. Avoid sarcasm, which likely will not be understood and may cause anxiety.

Communicating When a Person Is Nonresponsive

In the late stage of dementia a person may be unresponsive or only be able to utter a few incomprehensible sounds. Communicating with a person at this stage is a challenge for family and caregivers. If they are unable to speak or even use nonverbal communication, we have no way to know what they are thinking or feeling. Fortunately, many of the techniques that work in the earlier stages of dementia are useful in this stage as well. Common sense and creativity are even more important than before. Always assume that the person can hear and possibly understand even when they don't respond.

When approaching someone who is unable to communicate, move slowly and calmly, use few words, give one choice, and wait for an answer. Try to use gestures instead of words. Give the person time to understand why you are there. Keep in mind that, although they need a lot of help, they have been getting out of bed in the morning for possibly 80 or 90 years, and on some level they still understand these repetitive daily tasks. They need your patience and help. Use a calm, slow, and respectful attitude.

Providing comfort using pillows for neck, arm, and leg support, a warm blanket, or gentle repositioning will comfort a noncommunicative patient. Mild range-of-motion (ROM) exercise, gentle touching, and massage are reassuring. If the person enjoyed music earlier in life, it may still be enjoyable. Keep the environment peaceful and avoid loud or sudden noises; the person has no way to tell you when a sound is annoying. Reduce discomfort and confusion by keeping the area around the bed or chair free of clutter. Keep the walls and room clean and open.

Communication Skills for Noncommunicative Patients

- Approach slowly and calmly, making eye contact.
- Be aware of your own movements.
- Re-introduce yourself at each encounter.
- Address the person by a preferred name or title.
- Use short, simple sentences.
- Break down tasks into simple steps.
- Repeat the same sentence, if necessary, rather than rephrasing.
- Avoid open-ended questions.
- Offer simple choices.
- Do not argue.
- Avoid a condescending tone.
- Avoid giving strict orders.

Communicating with Family Members

By the time someone with dementia arrives at a care facility, family and friends have been involved for a long time. They have watched the steady decline of their loved one. In some cases, they have not accepted the degenerative nature of dementia. They may not understand that dementia cannot be cured and will continue to get worse.

Family and friends feel stress and anxiety about their loved one's dementia. They are losing a person who has been an important part of their family. Naturally they have concerns. The cost of care and the time spent caring for and visiting their loved one is a constant worry. They may even lack confidence in the healthcare facility.

Reassure family and friends that their loved one will be treated with respect and will receive good care, proper medications, food, and cleanliness. Assure them that comfort and pain levels are continually assessed and that conversational opportunities and activities are readily available.

Conclusion

Dementia is a disease of the brain that interferes with a person's ability to perceive and think in a normal manner. Many people with dementia are not able to think logically, but in other ways they are like any other person. They have many of the same likes and dislikes they had earlier in life.

Working with people who have dementia can be satisfying and rewarding. It takes patience, practice, and training to learn to understand the world from that person's point of view. People with dementia can still enjoy life. They can enjoy memories, interactions with the people around them, and activities that are matched to their preferences and abilities. Your efforts to make the person comfortable and happy can make a big difference in their final years of life.

(Resources begin on next page)

Resources

2-1-1 Information and Referral Search
For help with food, housing, employment, health care, counseling, and crisis intervention in many counties in Florida.
www.211.org

Alzheimer's Association
Provides Alzheimer care, support, education, and research with local chapters in Altamonte Springs, Clearwater, and West Palm Beach, Florida. Excellent online resources and educational material.
www.alz.org
800 272 3900

Alzheimer's Disease Education and Referral (ADEAR) Center
Excellent educational material on Alzheimer's disease.
www.nia.nih.gov/Alzheimers
800 438 4380

Eldercare Locator
www.eldercare.gov
800 677 1116

Family Caregiver Alliance
Addresses the need of family and friends providing long-term care at home.
www.caregiver.org
800 445 8106

Florida Council on Aging
Provides education, information sharing, and advocacy for Florida's older adults.
www.fcoa.org

Florida Department of Elder Affairs
Coordinates and develops policy for the Alzheimer's Disease Initiative, which was created in 1985 to provide services for individuals with Alzheimer's disease, and similar memory disorders, and their families. The program includes four components:

- Supportive services including counseling, consumable medical supplies and respite for caregiver relief
- Memory disorder clinics to provide diagnosis, research, treatment, and referral
- Model day care programs to test new care alternatives;
- A research database and brain bank to support research.

Website: http://elderaffairs.state.fl.us/english/alz.php
Phone: 850 414 2000

Florida Elder Helpline
800 963 5337

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Alzheimer's Disease Education and Referral Center (ADEAR). 2011. *Caring for a Person with AD*. Retrieved January 17, 2011 from http://www.nia.nih.gov/Alzheimers/Publications/CaringAD/.

Alzheimer's Disease International (ADI). (2009). *World Alzheimer Report*. Retrieved January 17, 2011 from http://www.alz.co.uk/research/files/WorldAlzheimerReport.pdf.

Tilly J, Fok A. (2007). Quality end of life care for individuals with dementia in assisted living and nursing homes and public policy barriers to delivering this care. Retrieved January 17, 2011 from http://www.alz.org/national/documents/End_interviewpaper_III.pdf.

(Post Test begins on next page)

Post Test

Use the answer sheet following the test to record your answers.

1. Dementia is:
   a. Loss of mental ability due to disease or injury to the brain.
   b. A normal part of aging in many people.
   c. A reaction to a life of stress.
   d. Extreme forgetfulness.

2. Alzheimer's disease is:
   a. The formal name for all dementia.
   b. Diagnosed by a special blood test.
   c. The most common type of dementia.
   d. The gradual loss of long-term memory.

3. Dementia is different from normal aging in that:
   a. Sometimes the person gets lost when driving in a new city.
   b. There is less interest in community activities.
   c. The person has lost the ability to think logically.
   d. Ability to keep track of possessions is diminished.

4. A common reaction of people in the mild stage of dementia is:
   a. Shrug off others' concerns and go on with their life.
   b. Immediately give up driving because it could be dangerous.
   c. Enlist the help of family and friends.
   d. Begin to plan for a life with diminished abilities.

5. Moderate dementia is evident when:
   a. Phone calls are brief and uncommunicative.
   b. The person can no longer manage to live alone without problems.
   c. Unusually chatty behavior is seen.
   d. Personal hygiene becomes obsessive.

6. With severe dementia:
   a. Restraints are often recommended to prevent wandering.
   b. Patients are unable to walk in most cases.
   c. Outbursts are rare because of generalized depression.
   d. Safety becomes a serious concern.

7. Typically, caregiving responsibility rests on:
   a. Professionals.
   b. Daily visits by a healthcare worker.
   c. One person, often a woman.
   d. All members of a family.

8. Verbal communication can be stimulated by: A
   a. Singing together.
   b. Watching a football game on TV.
   c. Looking at magazines.
   d. Asking questions about their weekend.

(Answer Sheet on next page)

Answer Sheet

Florida: Alzheimer's Disease and Related Dementias, 1 unit

Name (Please print your name): ____
Date: __________________

Passing score is 80%

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______

Course Evaluation

Please use this scale for your course evaluation. Items with asterisks (*) are required.

5 = Strongly agree

4 = Agree

3 = Neutral

2 = Disagree

1 = Strongly disagree

*1. Upon completion of the course, I was able to:

a. Define dementia and difference between Alzheimer's disease and other related dementias.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

b. Identify the characteristics and stages of Alzheimer's disease.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

c. Describe the challenges facing caregivers at each stage of ADRD.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

d. Outline effective strategies for communicating with residents who have ADRD.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*2. The course was written in a way that facilitated my learning.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*3. This course was free from commercial bias.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*4. The course met my continuing education needs.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*5. The material presented was supported by evidence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*6. The author avoided the use of anecdotal information as the main source of material.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*7. The course was free of product promotion.

❑ Yes ❑ No**

** If you answered no, please answer #8.

8. Was product promotion the sole purpose of the presentation?

   ❑ Yes ❑ No

* 9. It took me 60 minutes per contact hour to complete the course, test, and evaluation.

   ❑ Yes ❑ No**

   ** If your answer was no, how long did it take?

   ____

10. My professional educational level is (check one):

   Nursing

   ❑ Nurse Aide ❑ LVN/LPN ❑ RN (diploma) ❑ RN (AD)

   ❑ BSN ❑ MSN ❑ Nurse Practitioner/Advanced Practice Nurse

   ❑ PhD/DNSc

   Therapy

   ❑ OT Aide ❑ COTA ❑ OT ❑ MOT ❑ OTD

   ❑ PT Aide ❑ PTA ❑ PT ❑ MPT ❑ MSPT ❑ DPT ❑ PhD

   Other (please specify): ____

11. I heard about ATrain Education from:

   ❑ Search engine ❑ Advertisement

   ❑ Government or Board website ❑ Returning customer

   ❑ Friend ❑ Publication (Magazine, etc.)

   ❑ Other __________________________

12. I found the ATrainCEU.com website easy to use:

   ❑ Yes ❑ No

13. Comments or suggestions (optional): ____

   ____

   ____

(Registration on next page)

Registration Information

Please answer all of the following questions (*required).

* Name: ____

* Address: ____

* City: ______________________________ State: _______ Zip: ________

* Phone: ____

* Professional Designation: ______________________________________

* License Number and State: ______________________________________

Please email my certificate: ❑ Yes ❑ No
Email (required if you want your certificate sent by email): ______________________
(If you request an email certificate we will **not** send a copy of the certificate by US Mail.)

Payment Options
You may pay by credit card or by check.
Fill out this section only if you are **paying by credit card.**
1 contact hour: $19

Credit card information:
Name ____

Address (if different from above): ______________________________

City: ______________________________State: _______ Zip: ________

Card type: ❑ Visa ❑ MC ❑ American Express ❑ Discover

Card number ______________________________ CVS # ____________

Expiration date ____

Test Completion and Mailing Instructions

1. Complete all forms:
   - ❑ Answer Sheet
   - ❑ Evaluation Learning Activity
   - ❑ Registration Form (this page)
2. If you are **paying by check**, prepare a check for $19 made out to ATrain Education, Inc.
3. Mail the completed forms and your payment to:

   ATrain Education, Inc
   5171 Ridgewood Rd
   Willits, CA 95490

When we receive your forms and payment, we will mail (or email, if you request it) your certificate of completion. If you have any questions or concerns, please call or contact us at Sharon@ATrainCEU.com. And thanks for taking the ATrain!