Dementia Care: Common Sense Guidelines

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Contact hours: 3.5

Course price: $29

Instructions

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The course is based on the book entitled *Kisses for Elizabeth: A Common Sense Approach to Alzheimer's and Dementia* (2012), by Stephanie Zeman, RN, MSN. All the case studies are real, although patient names have been changed to protect their privacy. The book contains 35 additional cases based on Zeman's experience in working with Alzheimer's and other dementia patients for more than twenty years. It is available through kissesforelizabeth.com and amazon.com, where it has five-star reviews.

Course Summary

This pragmatic course is based on twenty years' experience with patients who have Alzheimer's or other dementias. Zeman's common sense guidelines for working with dementia patients reflect the foundational belief that we must keep in mind the person who existed before the onset of dementia and put ourselves in their place in order to understand what they need from us today.

COI Support

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Criteria for Successful Completions

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

Course Objectives

When you finish this course you will be able to:

- Explain the Omnibus Reconciliation Act of 1987 and how it has led to better care for patients in residential care settings.
- Discuss the importance of putting yourself in the place of the person with dementia to figure out what she needs.
- Name 3 new dementia communication skills you have learned. Give four reasons for
- avoiding arguments with your dementia patient. Explain the importance of validation
- and how to use it.
- Say what it means to “consider the whole person.”
- Define “feel-goods” and explain how to use them to change the mood of the person with dementia.
- Explain why reality orientation is not appropriate for residents in mid- and late-stage dementia.
- List 4 ways to encourage independence in your patient.
- Suggest 3 ways to determine appropriate activities during care.
- Explain the importance of love and other positive emotions for the person who has dementia.
- Discuss how important it is for people with dementia to feel they have something important to do and suggest five activities designed to satisfy their need.
- State four examples of judgmental behavior and how to move past them. Explain the wise
- use of humor in your work.
- Discuss the benefits of religion for dementia patients who practiced it when they were well.
- State what it means to expect the unexpected.

Alzheimer’s and Other Dementias

People who have Alzheimer’s or other dementias are themselves our best teachers about their needs and level of care. This course presents fifteen common sense guidelines based on what these individuals taught me over the twenty years I worked as a dementia care nurse.

Looking for Guidance

In the 1980s, when little was known about dementia and memory care units did not exist, we were hungry for knowledge about this fragile population. Standards of care for nurses and physicians had existed for a good many years. They combined usual practices with the minimal level of care needed for patients to have an optimal outcome (good quality of life and the ability to reach their highest level of functioning).

Then, in 1987, the Omnibus Reconciliation Budget Act (OBRA) published federal standards for nursing homes that are commonly referred to as OBRA-87 (Turnham, 2009). Those that did not comply by October 1990 were at risk for losing Medicaid reimbursements (Hawes et al., 1997). In order to judge the quality of the care given in nursing homes, surveyors looked to see if the facility met all of these standards.

For those residents with dementia who were in long-term care settings, however, the OBRA regulations fell far short of ensuring an optimal outcome. When this became obvious somewhere around 1990, interest grew in the creation of *dementia care units*, which evolved eventually to become **memory care settings**. Since that time, long-term care professionals have been struggling to understand the needs and behaviors of residents with dementia.

The provision of care for this population is more complex than for residents needing just physical care; cognitive decline requires an additional level of support. This includes care plans designed to preserve the skills for activities of daily living (ADLs) and additional provisions for the socialization, stimulation, and safety of residents who wander or cannot call for help when needed. Additional training for staff members was developed that includes the causes of dementia and what to expect in the various stages of the disease.

Good dementia care also includes the recognition that there can be major differences in each person residing on a dementia unit. The type of dementia, the stage of dementia— and even the fact that several different dementias may exist in an individual at the same time—can be an issue. Additionally, most people with dementia are elders who may be suffering from multiple chronic diseases.

Simply put, good dementia care must be flexible. Dementia is not a “one size fits all” disease. For this reason, I created guidelines—not rules—based on common sense. These guidelines go further to meet the needs of dementia patients than the OBRA regulations, which are inflexible and not directed at long-term care residents with cognitive disabilities.

Understanding Human Needs

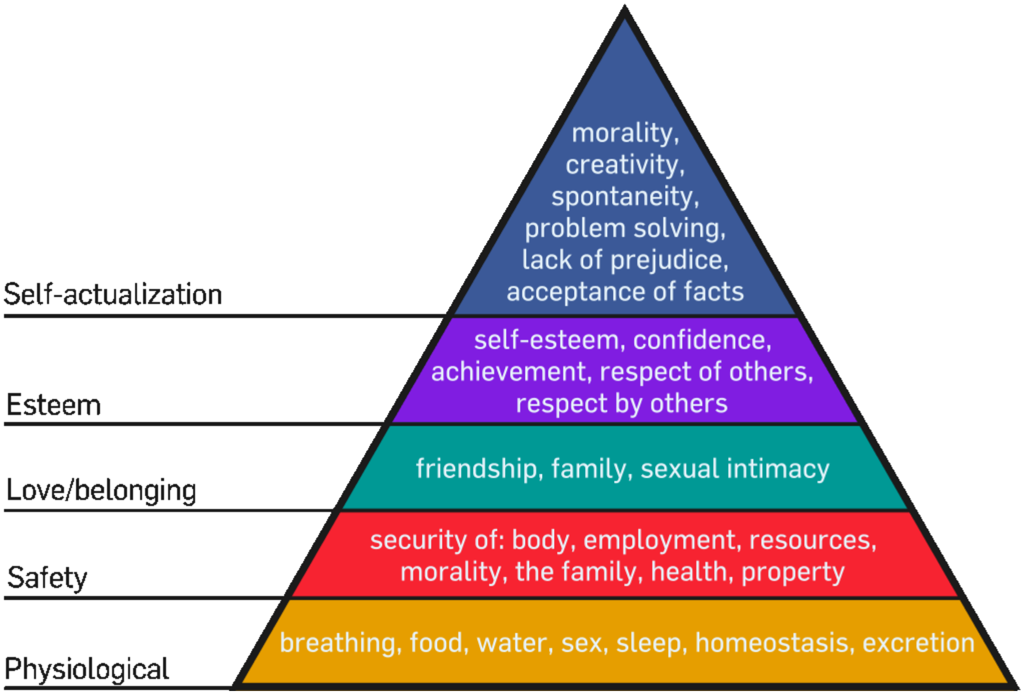
> People do not consist of memory alone. They have feeling, will, sensibility, moral being. It is here that you may touch them, and see a profound change.
>
> Alexander Rossinovich Luria
>
> Founder of Russian Neuropsychology

In 1943 Abraham Maslow introduced his *hierarchy of needs* as a framework to help us understand the stages of human development. Maslow laid out the stages in the shape of a pyramid (see below) to illustrate that we move successively from the base toward the top as our needs are met. We cannot progress if our basic needs (the base) are not met.

Similarly, each level must be achieved before we can move higher in the pyramid.

The base of the pyramid shows that humans all have the same needs at birth; these include food, water, clothing, and shelter. Once bodily needs are met, we become concerned with safety. When we feel safe, we tend to seek love and a sense of belonging. Later, as we mature, we develop a need for respect and self-esteem. The top of Maslow’s pyramid represents self-actualization, the need to meet one’s potential. As human needs are successively met, self-actualization becomes the ultimate goal.

Maslow’s Hierarchy of Needs



Source: Maslow, 1943; image from Wikipedia Commons.

It is often said that individuals suffering from dementia become more and more childlike as their disease progresses. *This is wrong.* While children are moving up the developmental pyramid, they gain experience where none existed before. People who have dementia are moving down the developmental pyramid as they lose memory of their life experiences.
Even though they are declining, they are still adults with memories, experiences, and skills. What remains still affects who they are and how they relate to their families and caregivers.

Never Treat Adults As If They Are Children

Individuals who have dementia are not becoming childlike. Although they are losing memories, they remain adults and must be considered to be, and treated as, adults.

With each stage of dementia, major losses occur, and the caregiver must work to support and preserve the person's skills as long as possible. Before dementia, a person filled many roles in life, and may have achieved—or come close to—their full potential. Dementia takes this away.

Despite these losses, families and dementia care staff have the ability to help trigger memories and bits of information. Even late-stage dementia patients have been known to experience moments of clarity, recognizing loved ones and remembering bits of information believed to have been erased by their disease.

As caregivers it would be helpful for us to imagine what it is like for the person with dementia to suffer so many losses and what it does to a person's quality of life. Our ability to do this is the basis for common sense dementia care.

The Guidelines

Here are the guidelines that I have developed over my years of working with people who have Alzheimer's or other dementias. Each one of them is explained further in its own module.

Guideline 1. Imagine yourself in the place of the person with dementia.

Guideline 2. Learn good dementia care communication skills.

Guideline 3. Do not argue with or say no to the person with dementia.

Guideline 4. Validate the feelings of the person with dementia.

Guideline 5. Consider the whole person, not just the dementia.

Guideline 6. Learn to use "feel goods."

Guideline 7. Don't use reality orientation except for early-stage dementia.

Guideline 8. Encourage independence.

Guideline 9. Arrange for appropriate activities.

Guideline 10. Everyone needs to love and be loved.

Guideline 11. We all need something important to do each day.

Guideline 12. Don't be judgmental.

Guideline 13. Keep your sense of humor. Use it wisely.

Guideline 14. Religion is a comfort even for people with dementia.

Guideline 15. Expect the unexpected.

Try answering the boldfaced blue questions found in each of the modules. They are designed to help you engage more fully with the person who has dementia.

Imagine Yourself in Her Place

GUIDELINE 1 Imagine yourself in the place of the person with dementia.

> We are who we are because of what we learn and what we remember. Who am I, then, if my memory is impaired?
>
> Eric Kandel
> Nobel Prize-winning Neuroscientist

When you are working with a person who has dementia, think about what it would be like to be in the situation in which she finds herself.

What would it be like to have needs you are no longer able to fulfill? What would you need from a person who might be able to help you? How would you like to be approached? How would you like to be treated? How will you know you can trust the person providing your care?

Answering the questions will help you to imagine yourself in her place.

➤ What would you have done in the following situation?

Alice

As I came up the driveway to the facility I saw a police car at the door, with about thirty people standing around watching what was going on. A gray-haired elderly woman sat in the back seat and the facility's administrator, Phyllis, was talking to the policewoman behind the wheel. All the doors of the car were open. When she saw me, Phyllis asked me to help.

Alice, a resident with dementia, had gotten out of the facility, and a policewoman found her crying in the middle of the road a few blocks away. Although Alice was relieved when the police found her, she was now refusing to get out of the car.

Phyllis described Alice as easily frightened and perhaps a little paranoid. She had been refusing to leave the safety of the police car for almost an hour. It was summertime and the temperature was in the high nineties. Alice was at risk of dehydration and needed to be brought inside immediately. She was obviously frightened and was refusing water from Phyllis. Everyone, including the policewoman and the facility staff, had tried to get Alice out of the car but to no avail. Forcefully moving her was not an option unless there was life-threatening emergency.

I tried to imagine what it must be like for Alice. She probably left the facility because she wanted to go home or was looking for someone. However, once away from the familiar building, she most likely became confused and frightened. Standing in the middle of the road, she started to cry. The policewoman who found Alice offered her the safety of the police car and, once inside, Alice did not want to leave. It didn't help that a crowd of people were standing around watching and calling to Alice. I assumed they were one of the reasons Alice didn't want to leave the police car.

➤ How would you help Alice?

Putting myself in her place, I decided that Alice would like someone to save her from this situation. Raising my voice, I scolded the crowd: "What are you doing here? Leave that woman alone! Go away! There is nothing to see here!" The crowd of people slowly disappeared. Now that I had taken care of part of her problem, I had Alice's attention.

➤ How would you approach Alice? What would you say to her?

I knelt down beside her and introduced myself. "Are you all right?" I asked gently. "What can I do to help you?"

Alice started to cry again, asking for her daughter Peggy. Without pressing her to get out of the car, I asked her to tell me a little about Peggy and her family. Within a few minutes, and with the crowd of onlookers gone, I felt Alice had some trust in me. I suggested we go inside to get an iced tea while Phyllis called Peggy.

I was delighted when she took my hand and let me walk her back to the building. (The police were also delighted to have their patrol car back on duty!)

➤ Think about what you learned from this interaction.

As caregivers, our behavior has a lot to do with the response we get. Rather than bullying Alice by insisting she leave the car and walk past the crowd that had gathered to watch her, it was better to relieve some of Alice’s stress by giving her privacy and encouraging her to tell me what she needed.

Caregivers can be “heroes” in the sense that they rescue their patients from distressful situations. While the people you care for may not remember your name or even recognize your face, they will remember that they can trust you.

It’s better to figure out the needs of the person in distress by putting yourself in their place. This is good common sense dementia care. Being an advocate by reducing the stressors in the environment, or moving the person to a quieter area, can be the best way to reduce fear and develop trust. It takes a little time, but it can prevent a situation from escalating to an emergency.

A good description of how it feels to have dementia can be found in *Understanding the Dementia Experience* (Ghent-Fuller, 2002).

Learn Dementia Communication Skills

GUIDELINE 2 Learn good dementia care communication skills.

> To effectively communicate, we must realize that we are all different in the way we perceive the world and use this understanding as a guide to our communication with others.
>
> Tony Robbins
> Motivational Author and Speaker

Communication is a two-way street. In order for communication to be successful, the message sent must be received, understood, and processed before a response is formulated. This must also be done in a way that makes sense to the receiver. A clear understanding of the message sent is hard to achieve when the other person has dementia.

➤ **Think about a time when you may have misinterpreted what someone said. Did it result in your having negative feelings such as anger or even fear?**

The person with dementia suffers from increasing cognitive decline and memory loss. The message they receive during communication with a caregiver is often blocked by distractions, or seems fragmented and incomplete.

Body language (tone of voice, facial expression, the way we carry ourselves) can send a different message from what we are saying. For instance, a caregiver may be reacting to the thought of having to toilet a patient, and on some level may be angry she has to do it. If the caregiver does not monitor her facial expression or tone of voice, the emotion she feels will show. Upon seeing this, the patient may respond with mistrust, fear, anger, and other negative emotions. The result can be a defensive response to what may have been an offer of assistance. The patient’s attempt to protect the self when frightened or upset is often reported as combative behavior, when in fact it is not.

The caregiver should also recognize that as dementia progresses there are changes in the person’s ability to communicate and express needs. This affects their ability to respond appropriately.

As dementia progresses, these changes include:

- The loss of the ability to find the right word, often describing objects rather than naming them
- The inability to finish sentences or express cohesive thoughts The loss of
- train of thought
- Reverting to language of origin (memory loss beyond the time of learning English) The need for
- longer periods of time to respond

➤ **Think about your own style of communication when you work with people who have dementia. What steps do you take to make sure your patient understands you?**

The guidelines for good communication skills include:

- Approach the person with dementia from the front or side, Do not startle him.
- Monitor the body language of the person with dementia. Body language can broadcast anger, fear, hostility, approachability, friendliness, and a host of other emotions. If her body language is negative, re-approach at a later time.
- Monitor your own body language, facial expression, and tone of voice to avoid giving mixed messages. Don't let your personal feelings show.
- Do use positive facial expressions to reinforce your message.
- Introduce yourself each time you approach. Don't forget that people with dementia have short-term memory and may not recognize you.
- Make sure the light is on your face so the person with dementia can clearly see you and use visual cues to help him understand what you need from him.
- Monitor the environment for distractions that might take away attention, frighten or upset the person with dementia. Turn off the TV or music or move the person to a quiet area.
- If possible, sit next to the person at eye level. Standing above them is intimidating.
- Speak slowly and distinctly in short sentences. Make one point at a time. A sharp voice or rapid speech can also intimidating.
- Take time to explain what you are doing and why. Negative behaviors are usually a reaction to not understanding why something is being done, such as taking medication when the person does not realize they are sick.
- Avoid using pronouns such as *him* or *her*. Say the name of the person and their relationship to your patient: "Catherine, your daughter". . .
- Allow extra time for a response.

It's important to note that communication is not limited to a verbal exchange and evaluation of body language. All of the senses are used to interpret information about the environment and the people around us. Taste (especially sweet and salty), touch (eg, massage) or smell (eg, aromatherapy) can also be used to convey positive comforting messages, especially in the later stages of dementia.

Don't Argue or Say No to Him

GUIDELINE 3 Don’t argue with or say no to the person with dementia. Use diversion and distractioninstead.

> I would never lie; I willfully participate in a campaign of misinformation.
> Fox Mulder
> *The X Files*

It is never a good idea to say no to a person who has dementia. First of all, you can’t win, and second, it will probably upset her or even make her angry. When a person with cognitive loss wants something, he is only concerned with his own needs and desires.
Dementia takes away the ability to reason why the request is denied. She doesn’t have the ability to see both sides of an argument.

- **Think about the last time you said no to or argued with a person who had dementia. Did you stop the behavior or win the argument?**

Obie

Every morning Obie took possession of a large recliner near the nursing station, and it immediately became “his.” This is where he read his paper, all day long. If the chair was not available, he would yell loudly and belittle anyone who dared to sit in his favorite spot. Eventually, it was rare that anyone but Obie could be found in it.

A 76-year-old man who had multi-infarct dementia, Obie had also suffered a mild stroke. Because of this he used a wheelchair and a cane to get around. Obie was able to push himself from one place to another, scooting along with his feet. The cane came in handy to help with balance when he transferred from the wheelchair to the recliner and back again. Once Obie was comfortably seated in his recliner, the nursing assistants would move the wheelchair next to him, so it was waiting when he was ready to return to his room.

- **Imagine yourself in the place of Obie. How important is your wheelchair? What if it disappeared?**

Sometimes, in an emergency, we do whatever it takes to keep people safe. A nurse had caught a resident who became dizzy and was about to fall. This happened just a few feet down the hall from where Obie was sitting. Ordinarily the staff would never think of taking Obie’s wheelchair away, but upon hearing the nurse call for help, a nursing assistant grabbed the wheelchair and slipped it under the resident. The two women then took her to her room.

A few minutes later, the nursing assistant brought the wheelchair back to an angry looking Obie, who took one look at it and said “That’s not my wheelchair. I want my own wheelchair back!”

One of the nurses tried to assure Obie it was his, but he raised his voice again, and his anger was obvious.

“That is not my wheelchair you ninny! I want my wheelchair back!”

- **What was the appropriate response? What should the staff have said to Obie at that point?**

The staff had been taught not to argue with residents who suffer from dementia because people who have cognitive deficits can’t reason or understand a situation. Nonetheless, the staff tried to reason with Obie. They explained to him that the wheelchair was only borrowed for a few minutes and was brought right back. They showed him his name painted on the back of the chair.

“That is not my wheelchair. Give it back to me!” Obie yelled, calling them some not-so-nice names.

Once again they tried to convince him but they only succeeded in irritating him more. He picked up his cane and threatened the aides with it.

➤ Why was Obie so upset?

The staff finally realized they were not following the advice they had been given in training. There was no way they could change Obie’s mind and had no business arguing with him. They had to think of something different. Finally, common sense kicked in. Give him what he wants.

The staff made a quick phone call and asked the maintenance department for a favor. They were happy to help and few minutes later a young man came through the doors at the front entrance to the unit. He smiled at Obie and said, “I was fixing your wheelchair, and I have it in the back. Someone brought you the wrong one.”

Taking Obie’s wheelchair from beside the recliner, he wheeled it down the unit and out the back exit. A few minutes later, the front entrance doors opened and once again the young man appeared with the same wheelchair in tow.

“Here’s your wheelchair, Obie. Sorry about the mix-up,” he said.

Obie took one look and said “Now that’s my wheelchair! Thank you!” and went back to his paper.

➤ What did the staff learn from this situation?

When Obie denied the wheelchair was his the staff learned once again that it’s fruitless to argue with people who have dementia. Arguing or disagreeing infuriates them and makes the situation worse. Obie and other people with dementia simply do not have the cognitive ability to see both sides of an issue. It is extremely difficult to change their minds and its far better to try to understand how they feel and find a better solution.

Nurses and nursing assistants are often faced with situations such as having to quickly remove an object a resident is trying to eat, or stop a resident from pushing or hitting someone else. Saying no could escalate the situation. The idea is to figure out how to best work around the problem.

➤ What would you do in this situation?

Whenever you have to take an item away from someone with dementia, offer something in its place. A resident trying to put something inedible in their mouth has to let go of it when offered an item that is edible. However, if there is no acceptable alternative to offer, try distraction. This can include such things as telling the resident they have a phone call, telling them to look at something, or asking a question.

The same applies to residents who are arguing or threatening each other. First, distract the least aggressive person and remove them to a safe area. Then diffuse the situation by offering something the aggressive person likes, such as a treat or a walk.

It’s important to figure out why the aggression occurred in the first place so you can prevent it from happening again. For instance, Obie would threaten people who tried to sit in “his” chair by the nurse’s station. Since the staff was aware of his habits, they would encourage the other residents to sit in nearby chairs before an argument could start.

Good communication skills were covered in Module 3. Following them will have a positive effect. Here are some things you should avoid because they will cause a negative response:

- Don’t try to explain the situation.
- Don’t argue.
- Don’t say no.
- Don’t question recent memory.
- Don’t take it personally.

Validate His Feelings

GUIDELINE 4 Validate the feelings of the person with dementia.

To validate: to recognize or affirm the validity of a person, their feelings or opinions.
Oxford English Dictionary

It is important for the caregiver to acknowledge and accept the feelings and beliefs of the person with dementia. Whether they are caused by delusions or misinterpretation of the situation or environment, acknowledging them and putting yourself in that person’s place often helps to prevent or resolve problems.

Henry

Henry, who had stage 5 Alzheimer’s disease, was admitted to a memory care unit because Grace, his wife of 55 years, and the person who had been his caregiver, died suddenly of a heart attack. After the funeral, his daughter Catherine brought Henry home with her to live, but she found she could not provide the supervision he needed. Catherine was also upset because Henry could not remember that Grace had died. He kept asking where she was.

Over and over again, Catherine explained that Grace had died, but each time Henry heard this was like the first time. Each time he would cry and grieve most of the day. However, when Henry went to his room at night Catherine knew he would forget that his wife had died, and in the morning would once again ask for Grace. This was so upsetting to her that she finally took the obituary notice that had run in the local paper and hung it on the refrigerator door. Each of them was suffering the loss of Grace. . . over and over again.

Before he was admitted, Catherine had told Henry he would be going to a large facility in the country. Henry was under the impression he was at a hotel for an extended vacation. Surprisingly, he was anxious to meet the other “guests” and easily fit in with the others on the unit. Since this delusion made it easier for Henry to accept his new home, the staff did not challenge his beliefs.

Once he was admitted, however, the staff had to decide how to handle Henry’s question “Where is Grace?” Everyone knew they all had to have the same answer, but they were not going to tell Henry his wife had died. They felt this was cruel and unnecessary. He obviously missed her, however, and the staff could not ignore his feelings. They decided instead to acknowledge his concern and love for Grace. They would simply say “She isn’t here right now, Henry, but I don’t know her, why don’t you tell me a little about her and the things you like to do together?”

After a few minutes spent talking about Grace, the staff would spin the conversation off to something else or follow it with some type of distraction like an offer to take him for a short walk or get him a cup of tea. This plan would certainly not work for someone who did not have dementia, but Henry, whose cognition and memory were failing, loved to talk about Grace and it was the kindest thing to do. It also helped him to relive some of the wonderful times he and his wife had together.

Henry never stopped believing he was in a hotel, and his caregivers did their best to treat him like a guest. Catherine was happy to do the same. They never challenged his belief or caused him grief with the news that he had lost his wife. Henry asked frequently about Grace in the beginning, but as his dementia progressed, Henry stopped asking about her.

Henry's belief that he was living in a hotel was a delusion. Delusions are not uncommon in people with dementia and it is important to recognize the person's feelings or beliefs are real to them. If delusions fill a need and are not upsetting or harmful, there is no reason to treat them.

Henry's care plan encouraged his caregivers to imagine themselves in Henry's place and work within his reality. The goal was to get Henry to openly express his feelings about Grace by allowing him time to talk about her and remember their life together. This helped Henry to cope with her absence and encouraged a feeling of warmth and understanding between Henry and the staff.

If Henry's delusion about living in a hotel had been troublesome and caused agitation, the staff would have intervened and assessed whether Henry needed psychiatric help. Because of their insights and ability to validate Henry's feelings, his quality of life was good despite his dementia.

* * *

Naomi Feil developed *validation therapy* as a method of working with patients she described as severely disoriented (Feil, 2002, 1963). Her work over the years has led to the increasing use of validation in dementia care as a way of demonstrating to the patient that their feelings, thoughts, and opinions are acknowledged and respected by the caregiver. A combination of validation and reminiscence is often useful in helping confused patients experience the joy of earlier life experiences and contributes to their quality of life. A demonstration of Fiel's work can be viewed in the following video.

Gladys Wilson and Naomi Feil

http://www.youtube.com/watch?v=CrZXz10FcVM

Consider the Whole Person

GUIDELINE 5 Consider the whole person, not just the dementia.

> Those with dementia are still people and they still have stories and they still have character and they're all individuals and they're all unique. And they just need to be interacted with on a human level.
>
> Carey Mulligan
> Oscar-nominated Actor

Throughout the course of dementia, each person's level of functioning depends on the support system built into their care.

- **Put yourself, once again, in the place of the person with dementia. Are you still a multi-faceted individual?**

A person's physical and mental status are only two aspects of what makes them tick. The roles they fill in life (child, sibling, friend, lover, parent, employee) help to make them who they are. The same is true for a person's culture, ethics, spiritual beliefs, education, and the choices they made in life. They are all combined in one unique individual.

Common sense dementia care addresses needs of the *person* with dementia, not just the *dementia* in the person we care for.

- **Think about the type of care you give to people with dementia right now. Do you see the person with dementia as an individual with the skills they currently possess, or do you focus on their illness and the abilities they may have lost? Is the woman in the room next to the nursing station Mrs. Martin, or the patient with vascular dementia?**

Taking the time to find out about more about your patients helps you provide a higher level of care and a better quality of life for them.

Polly

A daycare center in Ohio did its part to help Mel when he called and asked about admitting his wife to their program. The center was designed to care for people with dementia in various stages of the disease and Mel believed his wife Polly would do well there.

Visiting the next day, he was impressed. Polly could stay at the center for the whole time he was at work, and professionals would make sure she was safe, had a good lunch, a nap if she needed one, and activities she would enjoy. It seemed like the ideal solution, and Mel thought it would allow him to remain employed for another year or two.

Polly, however, had other plans. She did not like the idea of a daycare center, and especially the people she imagined were staying there. She told Mel she was "not one of them." She refused to consider it and decided she wanted to go back to work instead. She told Mel she needed to be around people, enjoy her job, and have things "like they used to be."

Polly had worked as a secretary in a law office for almost twenty years. When she retired, still wanting to keep busy, she took a part-time job at a nursery school and volunteered at the local animal shelter. Polly described herself as a "people person."

Not knowing what else to do, Mel called the daycare center for suggestions and they gave him an idea. That evening, Mel explained to Polly that her previous employer had hired another person. Her old job was gone, but if she was interested, he found another job for her. He told her he thought she would like it because she could be around a lot of other people.

The following day he took Polly to the daycare center. Mel explained that it was a place for people who had problems with their memory and they were looking for help. The director greeted them and told Polly they wanted to hire her because they needed someone to help the staff keep the people there happy and engaged in activities. Her job would include talking to them, helping to set the table for lunch, handing out snacks, accompanying others to activities, and helping with pet therapy.

Polly was given a tour of the center and was treated as if she were a prospective employee. On the tour she saw the attendees in various activities including group exercise, a reminiscence circle, and flower arranging. She also met the pet therapist, who was bringing in two beautiful dogs that Peggy admired.

Mel was pleased that the center had recognized Polly's need to "work" and their willingness to use that to encourage her interest in attending the daycare program. Of course they knew that no real demands or expectations would be placed on Polly and that she would be encouraged to make friends and enjoy the activities. They waited to see what Polly's decision would be.

Polly did decide to take the "job" at the center. For a few weeks, she managed to hang on to the idea that she was there to work with the other people who had dementia. But gradually Polly just enjoyed going to the center to see her "friends."

People with dementia are just like you and me. The roles we fill help to define us. The staff at the dementia care center didn't see Polly as another potential client, but saw her as an individual person whose job was important to her quality of life. By "hiring" Peggy, they helped her to enjoy something she valued while receiving the care she needed.

There are still other reasons to know about a person's life and understand the joys and traumas they have experienced. Here is part of Rivka's story to illustrate why this is important.

Rivka

Rivka's moods went up and down a bit at first, but it didn't seem unusual for someone newly admitted to a dementia unit. She also exhibited slight confusion and words frequently escaped her. Short-term memory loss was also a problem but overall Rivka was functional and seemed happy. We knew she had been born in Germany and had come to the United States as a child, but she would not talk about her childhood. She preferred, instead, to sing and dance to old Jewish songs. I can remember her dancing with a tablecloth wrapped around her like a skirt, so she could swirl it as she danced.

In a few weeks, however, things began to change. Rivka would become hysterical at times, hiding and crying in her room. We were concerned and made a record of it each time it happened to see if we could find a pattern. Eventually, we discovered it was happening most often right before the evening meal. Soon Rivka started saying that the Nazis were coming.

Piecing things together, we were able to figure out that Rivka was reacting to the noise the food carts made when they came over the threshold to enter the units. Apparently, it reminded her of the approaching tanks when the Nazis came to her town in Germany when she was a child. Almost every synagogue in Germany was damaged or destroyed during Kristallnacht ("Night of Broken Glass"). Rivka's father was killed that night. These flashbacks terrified Rivka, and she stopped eating.

Here is an example of a terrifying incident occurring in childhood that Rivka seemed able to cope with to some extent until her dementia reached the point where her ability to do so was gone.

The pre-dementia life of an individual is a strong predictor of the problems that crop up during the person's decline. Caregivers will be limited in their ability to provide the type of care that enhances quality of life and keeps their patients as functional as possible unless they make an effort to treat the whole *person*, not just the *dementia*.

Learn to Use "Feel-Goods"

GUIDELINE 6 Learn to use "feel-goods."

> Today I'd like to sit and sip, Forget the world a little bit, Ignore the things I have to do And just enjoy a cup or two.
>
> Anonymous

Working with people who have dementia often means approaching a person who is experiencing fear, anger, agitation, or any number of other emotions. A resident who is cooperative one day can easily be moody and unapproachable the next. Gaining her cooperation often means having to come back at a later time or risk causing an incident of combative behavior.

Dementia patients lack the ability to control their negative feelings or to realize that they are causing problems. They feel the same emotions we do, but don't understand them or why they are happening. The resident who gets up in a bad mood because of poor sleep, or flashes back to a bad memory that makes him angry, won't be able to do anything about it.

However, the caregiver can.

Elizabeth

In 1990 I took a job in a small assisted-living facility in Virginia. My assignment was to coordinate care, assess the patients' needs, work with the physicians, and supervise the nursing assistants. After settling in, I held a meeting with the staff. Elizabeth was the first patient they wanted to discuss. Living in the facility for less than three months, she had managed to intimidate the staff to the point that some of them refused to have her on their assignments. The main problem they were having was how to wake Elizabeth and provide morning care without getting injured by her.

Elizabeth had mid-stage dementia. Her communication skills were poor, but she let the staff know she did not want to get up in the morning by striking out at the person who had the responsibility of waking her. Unfortunately for the staff, Elizabeth still had fairly good reflexes and a surprisingly good aim. Showing me their bruises, several nursing assistants complained, saying they could not care for her any longer.

Obviously frustrated, the staff related many of the things they had tried to gain Elizabeth's cooperation. These included letting her sleep as long as she liked (Elizabeth slept most of the day), altering the light in the room (this did not help), changing caregivers, waking her to music, and simply moving out of the way when she started swinging. Usually, no matter what method was used, Elizabeth awoke out of sorts and her disposition rarely improved during the day.

I congratulated the staff on the measures they had already taken to solve the problem, and tried to put myself in Elizabeth's place. Why was she so upset in the morning? I knew we had to resolve this quickly. If we could not, Elizabeth might have had to be medicated to change her behaviors or transferred to the state facility. This was something I wanted to avoid since the side effects of psychotropics often bring about a decrease in functioning and quality of life. Unfortunately, although I spent quite some time trying to figure out what was bothering her, I never did.

Elizabeth was lucky to have an understanding and loving son. Robert visited twice a week to take her out for a car ride and a late lunch despite her sometimes bizarre behaviors.
After returning from one of these outings, he came to me with a little paper bag full of chocolate kisses.

"Please give my mother one or two a day. They are her favorite. She used to tell me how much she loved them as a child," he said. "If I leave them in her room, she'll eat them all as soon as she finds them. Mother loves chocolate, and I'd like her to have a few at a time each day."

Since Elizabeth was not a diabetic, I agreed. After he left, I thought about a way we could help Elizabeth change her morning attitude.

The next day, I gave the nursing assistant some instructions and peered around the door to watch. As she approached Elizabeth, the aide gently touched her shoulder, hoping she could carry out our plan before Elizabeth attacked. The room was quiet except for the ticking of the small clock on her bedside.

"Elizabeth, look what I have for you," the aide said, getting ready to duck.

As Elizabeth opened her eyes, the first thing she saw was the chocolate kiss. Watching intently as the aide unwrapped the treat, I saw the beginnings of a grin at the corners of her mouth. As soon as the cover was off, Elizabeth snatched it up and popped it in her mouth.

Unbelievably while I watched, our efforts were rewarded with a big smile. Elizabeth sat up without fuss. Since she had no teeth and the staff could not get her to wear her dentures, she had the chocolate in her mouth for quite a while, happily gumming it until it was gone. During this time, the nursing assistant was able to get her up, toilet her, wash her hands and face, and bring her to the breakfast table. I was more than pleased when Elizabeth allowed all of this without striking out even once, and as an added bonus for us, was in a fairly good mood for the rest of the day.

Since people with Alzheimer's disease have short-term memory loss, we decided to surprise Elizabeth the next day as well. And again, she was all smiles, and we were able to repeat this scenario every day.

Most caregivers do not realize they have the ability to alter the mood of the person with dementia by using "feel-goods." Simply defined, feel-goods are the same things we do for ourselves when we are down, tired, angry, and sad, or simply need a mood change.

Common feel-goods include such things as a hot bath, a cup of coffee, going to a movie, or even having a piece of chocolate. We do something nice for ourselves and it distracts us from our problems. It puts us in a better mood. The same would hold true for the person with dementia if they were able to use these distractions themselves.

To help nursing assistants work more efficiently with residents on the memory care unit, one facility tried giving them fanny packs filled with items to distract the residents and make them feel good. They included things like mini chocolate chip cookies and manipulatives like small wind-up toys or balls that squeaked. The staff was also taught the words and music to a number of "oldies," which the residents often enjoyed singing or listening to. These things were used to help the residents relax and distract them while personal care was done. After a 1-month trial with the "feel goods," the facility decided to make them part of their dementia training inservices.

The emotions of the person with dementia should not be ignored. Caregivers may not always be able to find the cause for anger or aggression, but they do need to recognize feel-goods as one of the tools that are available to change it.

Be Selective with Reality Orientation

GUIDELINE 7 Do not use reality orientation except for early- stage dementia.

> Reality leaves a lot to the imagination.
> John Lennon
> Beatles Singer-Songwriter

Reality orientation is a program designed to improve cognitive and psychomotor function in persons who are confused or disoriented. It is often employed in long-term facilities to help residents focus on their immediate surroundings. With this technique, caregivers actively and repetitively present information needed to orient patients to the time and day, as well as their environment and the people around them. This process is most helpful for the person in early stages of dementia. While sensory stimulation is helpful in the later stages, attempts to orient the person to date and place only serve to confuse and agitate them.

➤ **Have you ever awakened in a strange bedroom and momentarily forgot that you are in a hotel or another person's house? Were you frightened by this? Imagine going through the day with the same kind of fear. This is similar to what happens when a person develops dementia.**

For most of us, knowing this information is essential to get through the day. But reality orientation won't help if the person has mid-stage dementia. Short-term memory loss and cognitive deficits make it impossible to remember or even understand much of this information. Trying to get the individual to focus on reality when significant confusion and cognitive loss are issues can serve to increase the confusion and cause agitation.

Try this common sense approach instead: When a person with dementia has a delusion or hallucination, "get into their reality" to allay fears, solve the problem, or figure out the cause of it.

Delusions (false beliefs) that do not distress the person with dementia can probably be left alone. They will pass as the dementia progresses. Delusions that do cause distress should be treated. This is usually done by medication.

Hallucinations are caused by the misinterpretation of sensory input. Taking time to experience what the person hears, sees, and feels (putting yourself in their place) may well lead to discovery of the reason the hallucination is happening.

A good example is something that occurs frequently in the later stages of dementia. Because of memory loss, people in the mid- to-late stages of dementia will not recognize themselves in the mirror. This occurs because they have aged and memory loss has progressed to the point that, in their minds, they are much younger than their reflection appears to be. This is also why at some point they cease to recognize spouses, children, and friends as they are today.

- **Put yourself in the place of someone in late-stage dementia. Your ability to understand your reflection is gone. You go into the bathroom and see another person looking at you. How would you feel?**

If you do the exercise above it will help you to understand why reality orientation does not work in the later stages of dementia.

- **What can be done to help this person?**

Two things can happen when a dementia patient does not recognize herself in the mirror. She can either perceive her reflection as friendly (and may even talk to it) or see it as someone to fear. If the reflection does not cause distress, simply monitor the situation, but if the reflection is frightening to the person or causes anxiety of any kind, it's better to remove or cover the mirror.

Since sounds, reflections, smells and other sensory input can be misinterpreted and bring on delusions and/or hallucinations, most memory care units today use full-spectrum lighting. This helps to avoid shadows easily misinterpreted as other people or animals.
Rugs and satin gloss flooring are chosen to reduce glare for the same reason. Overhead paging is also eliminated or reduced to avoid misinterpretation of the voices and announcements, which can be a trigger for delusions.

When hallucinations or delusions do occur, and reality orientation does not work, it's common sense to use therapeutic "little white lies" to help the person with dementia.

Rose

Rose was upset at noises she heard during the night. She was convinced that animals were living in the ceiling of her room and would hurt her. Because she was so frightened by this, Rose started sleeping in a recliner by the nurses' station.

When I heard about this, I asked a staff member "put herself in Rose's place and listen for the noise" by staying in her room for a while. Surprisingly, around midnight the staff member heard scratching noises from above.

An investigation of the noise discovered a tree branch was scraping the roof of the one- story facility when it was windy. It was removed the next morning, but Rose was still frightened and would not go into her room. No amount of explanation or "reasoning" with her would help. In her mind, she was in danger from the animal in her room.

Once again we thought about what we needed to do for Rose. We even considered changing her room, but eventually the staff decided to "get rid of the animal." They brought in a ladder and a paper bag. Removing a ceiling tile, one of the housekeeping staff climbed up and made some banging noises. Inflating the bag, and twisting the top, he came down the ladder with the "animal" in tow. Rose, who had been watching from the door, was relieved, and since the noise from the branch was gone, the "animal" never came back.

These examples show why reality orientation won't work with mid- to late-stage dementia patients who lack the ability to understand what they cannot see or hear for themselves, and who can easily misinterpret the sensory information they do perceive.

Encourage Independence

GUIDELINE 8 Encourage independence.

> Every accomplishment starts with the decision to try.
>
> Anonymous

Quality of life can be measured by many different criteria. High on the list is one’s sense of independence. The losses that accompany a diagnosis of dementia are many, and they grow in number over the course of the disease. Even in the earlier stages, people with dementia may have to relinquish much of their independence when they can no longer drive. Other losses follow as they become more dependent on others.

➤ **Think about all the things you are now free to do. Include such things as choosing what to watch on TV, going to bed and waking when you want to, choosing what to eat and what to wear. How about the ability to make choices in general?**

As dementia progresses, losses occur rapidly. How the person perceives and adjusts to these losses affects his or her quality of life. Loss of independence can bring on feelings of frustration, uselessness, and a loss of control. Often depression follows, and the rate of decline increases even more. As caregivers, we have the ability to change this by helping our residents to preserve their life skills and by fostering independence.

➤ **Think about how the care you give changes when you are rushed.**

Helping people with dementia to preserve their skills requires a little additional time. Unfortunately, caregivers feel the pressure of having a set amount of time for each person on their assignment. Often they wind up doing a task (such as dressing someone) themselves rather than guiding the person through it. Interestingly, there is not much more time needed to provide the type of care that foster’s independence, because doing so means people with dementia can do more for themselves for a longer period of time.

When a person stops doing things independently, it probably means that they have forgotten the steps needed to accomplish the task and don’t know where to start. Helping the person by breaking the task into smaller steps that they can manage on their own, preserves their ability to do it. For instance, if George is asked to brush his teeth, and has a hard time getting started, some simple directions might put him back on track. However, the caregiver must start at the beginning and guide him through each step.

One day I had my staff count the number of steps required to brush one’s teeth. Starting with unscrewing the cap on the toothpaste and ending with putting the toothbrush back into the holder, there are as many as 20 steps. It’s easy to understand how George may know what he needs to do, but not know the order in which to do it.

Aside from breaking tasks down, we should also help preserve independence by giving choices to people who are still able to make them. In the earlier stages of dementia, most people are still able to select their own clothes and decide what they would like to eat. But as the dementia progresses, the person gets confused by too many choices.

Using common sense dementia care means understanding this change and helping the person with dementia to continue to have a choice when possible. The woman who has a closet full of clothes will eventually become confused and frustrated at the task of finding something to wear. This can result in poor choices such as a dressy blouse with pajama bottoms. At this point, the caregiver should use what we call “guided choices” and help by laying out two complete outfits and letting the person choose between them.

As dementia progresses, however, this woman will eventually not be able to manage even this simple choice. Rather than taking over the choice of clothing completely, caregivers can still offer a choice of one item. People with dementia should be able to answer yes or no well into the later stages. By breaking tasks down and using guided choices, we are helping not only to preserve skills but also helping to maintain the resident's dignity and quality of life.

Helping our patients maintain their independence means making sure that the person with dementia who uses hearing aids and glasses has access to them every day. We also need to be sure that treating physical health issues does not take a back seat to dementia care. Dental health, physical therapy for prevention or treatment of disabilities, and monitoring for and treating pain are also of major importance and can greatly enhance quality of life.

Arrange for Appropriate Activities

GUIDELINE 9 Arrange for Appropriate Activities.

> The quality of a life is determined by its activities.
> Aristotle
> Greek Philosopher

Helping residents to maintain their independence and preserve their life care skills depends in great part on providing them with enough exercise, appropriate activities and interesting and stimulating things to do.

➤ **Think about the way you spend the day. How many tasks and activities do you accomplish? How often are you multi-tasking so you can fit it all in? Now imagine you have dementia and are living on a memory care unit with 2 or 3 hours of activities available each day. What will you do with the rest of your time?**

What are the interests of the person with dementia? Since we are all so different and have different backgrounds and cultures, the things that would interest us are varied. No one activity will suit everyone. Using person-centered care and some common sense, the staff will be able to modify the interests a person had before dementia and create activities that are enjoyable.

Ideally, activities should:

- Provide mental stimulation.
- Reflect the past interests of the person with dementia.
- Seek to maintain or slow the loss of skills without requiring the person to learn new ones.
- Provide socialization, stimulation, and physical activity within the functional limits of the person with dementia.
- Be sensitive to the cultural differences of those attending the activity. Be failure
- free.

Staff should be aware that activities may be too loud or too stimulating for some people with dementia.

The benefits of activities and regular exercise have included better physical health, higher self-esteem, maintenance of socialization skills, improved sleep habits, and decreases in depression and anxiety.

A recent study showed that mental and physical activities delay cognitive decline in older persons with dementia (Sheung-Tak Cheng et al., 2014). In addition to scheduled activities, dementia care staff should be taught to consider any contact with the person who has dementia as an opportunity for positive activity. Reminiscing, singing old songs, talking about interests they share, getting the resident to help with minor chores like watering plants, and breaking tasks down to allow the person to complete them, can all be enjoyable and stimulating activities and should be a regular part of the day. The more enjoyable it is, the more beneficial it will be.

I was Director of Nursing in a nursing home with a 40-bed dementia unit. Although we had a small activity budget, we used it wisely. We almost always had music available, but also had quiet areas for residents who wanted to do other activities. Everything from colorful magazines to puzzles and games appropriate for our residents' levels of functioning were on the unit. We used free talking books from the library, had a small indoor garden donated by the garden club, and set up an aquarium. There was also an old upright piano in the recreation room for residents who could still play or wanted to tinker.

The unit was not fancy and needed updating, but the staff had decorated it with meaningful items that would often be the source of wonderful old stories from the residents. Hand crocheted lap robes, Norman Rockwell prints, and collections of things the residents could rummage through were found throughout the unit. We found that our residents seemed happier in this environment and so did the staff. The unit was more relaxed and the staff felt free to do such things as bring in flowers from their gardens and bring their children to visit. I've always remembered that unit as being the one that offered the highest quality of care to its residents.

Everyone Needs Love

GUIDELINE 10 Everyone needs to love and be loved**.**

> We can cure physical diseases with medicine, but the only cure for loneliness, despair, and hopelessness is love. There are many in the world who are dying for a piece of bread, but there are many more dying for a little love.
>
> Mother Theresa
>
> Nobel Prize-winner for Peace

All people, especially those with dementia, do best in a safe and loving environment, and this should be one of the goals in long-term care. It's just common sense. Yet, although we strive to provide this type of care, many new residents feel abandoned and unloved. It's always a surprise to me when facilities advise families not to visit for a week or two. The belief is that doing so will help the person with dementia become accustomed to their caregivers and adjust more quickly to their new home. Under these circumstances, how could a new admission to a dementia unit *not* feel abandoned by their family? Remember that people with dementia are just like you and me in many respects, and the need to give and receive love and affection is universal.

➤ **Think about what it must be like for the person on a dementia unit. Think about someone who experienced the love of family and friends and now may not even be able to remember them. What if that someone felt the joy of giving love in return. How would you feel in their place?**

Hannah

All of us need affection. We need to know that that our existence matters to someone, that we are important enough to have the support and love of those around us every day.

The first long-term care facility I worked in was very small. While there was an office for the administrator, there was no space for a nursing station of any kind. As a result, my desk was housed in a small hall that led to two rooms that had been added to the facility. Unlike the other rooms, these were private, and the residents who stayed in them were physically functional but had mid-stage dementia.

I usually arrived at my desk around 7:30 in the morning, in time to write up the nursing assistant schedules for the day, which required about twenty minutes to complete. I had been away for a few days and did not know the resident who had been admitted to one of the new rooms while I was gone. Settling in, I looked up to see a very sleepy woman who appeared to be in her seventies, wearing pajamas. Before I could say anything, she gave me a hug and sat down in my lap, putting her head on my shoulder. We sat there for a while.

After a few minutes, I coaxed her up and led her back to her room where she let me tuck her back in bed before falling asleep. I learned that her name was Hannah, and she had just been admitted the previous evening.

Later that day, I spent some time getting to know Hannah and her family. Hannah had stage 6 dementia and, like so many other residents at the facility, her family was concerned about her wandering away from home. She was very quiet and rarely said much, preferring to remain in her room most of the day.

Occasionally, Hannah's family brought her grandchildren to visit. The interesting thing about Hanna was that she knew she was "Grandma" to the children, but also saw herself as a young child. It seems that her perception of her age was the reason she had come to sit in my lap in the morning; this was something she did as a child. It was a habit that became the usual routine whenever I was there. Hannah just really seemed to need a hug each morning before starting her day. I soon realized it was something I enjoyed as well.

I remember having a meeting with a potential family one morning when Hannah sleepily shuffled up the hall to come and sit in my lap and hug me. She stayed there while I finished the interview. When it was over, the family member smiled at me and said, "I know my mom is going to be happy here."

One of the most powerful acts of love occurs when a woman gives birth and cares for her child. The love given and received is unconditional and lasting. So it is not at all unusual to find women in the later stages of dementia worrying about their babies.

A person with dementia has little or no memory of their recent life circumstances. They are living in the past. It is kinder for us to acknowledge their reality. The need to nurture and love one's children is so strong it lingers long after other memories have faded. Since the advent of dementia units and specialized dementia care programs, the use of baby dolls has been an acceptable way to temporarily fill that need. The person with dementia is changing almost daily, so the woman looking for her baby will do so for only a short time, and then that memory, too, will be erased.

Doll therapy also has the potential to bring back happy memories of early parenthood and help make seniors feel useful and needed.

A study using dolls to alter behavior in dementia patients (Ellingford et al., 2007) found that doll therapy can increase positive behaviors in doll users and can help to decrease negative behaviors and incidences of aggression.

We All Need Something Important to Do

GUIDELINE 11 We all need something important to do each day.

> Jobs empower people to realize their dreams and improve their lives.
>
> Anonymous

It is thought that people in nursing homes don’t die of chronic disease as often as they die of loneliness and boredom. A memory care unit can offer many activities during the day, but for the person who has had a lot of responsibility and something important to get up for every morning during their working years, this may not be enough. As memories fade, the person with dementia sometimes reverts to the routines that were followed every day for years. However, as attempts are made to maintain routines such as catching the bus, clocking in, finding the office, or fulfilling perceived responsibilities, confused residents become frustrated and even angry because they cannot do their jobs. Sometimes delusions or hallucinations can be the result.

John

A good example of this behavior was seen in John, who walked around the memory care unit trying to screw his cane into every opening he could find including spaces between chairs, partly opened doors, and trash cans. This became an extremely obsessive behavior and all efforts to distract him or assist him with personal care were met with agitation.

Eventually John was becoming combative even when the staff tried to toilet him, preferring to work with his cane. John’s quality of life was declining and his health began to suffer.

Soon he started to refuse meals, preferring to find places in which to screw his cane and doing so until he was so tired he would stagger and fall if the staff could not stop him.

A call to his family and a discussion of John’s behavior revealed the fact that he had been a factory worker whose job included screwing large bolts deep into airplane engines. Because his behavior was so obsessive, a psychiatric consult was done and he was put on an anti- anxiety medication.

The staff also worked out a care plan that would fulfill John’s need to work. Each morning they would approach him for morning care by asking if he would like to get ready for work. When meals were served, they reminded him to have a good breakfast because he had a busy day ahead, or told him it was time for a lunch break. They also found another “job” for John—sorting bolts of different sizes, something he seemed to enjoy. In the early afternoon they convinced him that his work day was over and it was time to go home.

While this plan did not work perfectly every day, most of the time it kept John busy at an activity he liked that did not wear him out. It’s important to point out that this behavior did not last long. In a few weeks John no longer seemed interested in doing his “job” and the staff was able to engage him in a few other activities. Although it was expected that John would soon forget about his job, it was important to address his need in the moment. All dementia patients are constantly changing, which means the care plan has to be altered frequently to accommodate those changes.

- **Put yourself in John's place. You have late mid-stage dementia. How would you spend your day if you had nothing important to do?**

Even people in the later stages of dementia need to feel useful by doing something they can feel good about. Simple jobs they can still do will often bring smiles and enhance self- worth. These are some common sense ideas to think about:

- Filling bird feeders. The reward is watching the birds.
- Helping to hand out snacks. The reward is eating them with the other residents.
- Folding napkins for meals. The reward is seeing the table set and ready for dinner. Feeling you have contributed.
- "Visiting" with other people who have dementia. The reward is sharing stories and memories.
- Anything that a person is still capable of doing that leads to a positive feeling of accomplishment can go a long way to enhancing their quality of life, especially if they get compliments on a job well done.

Don't Be Judgmental

GUIDELINE 12 Don't be judgmental.

> Be kind, for everyone you meet is fighting a battle you know nothing about.
> Anonymous

Sometimes when we see things we do not understand or can't find a reason for, we become judgmental. This is something we all need to think about. There are always circumstances and situations we may not be privy to or understand. To avoid being judgmental about the person with dementia, use the common sense approach:

- Put yourself in his shoes, and try to understand what he is feeling, seeing, and hearing.
- Educate yourself about the fact that dementia causes brain damage, and understand that the person with dementia may not have the resources to respond appropriately to all situations.
- Keep your sense of humor, but never embarrass the person with dementia.
- Preserve the dignity of the person who is displaying bad behaviors or acting out by removing her to a private area if possible.

Harriet

Almost a year after I started working primarily with people who had dementia, I met Harriet. I was not prepared for Harriet at all. In retrospect, I'm very glad I met Harriet. I learned more from her than any of the other residents I cared for up to this point.

Harriet was admitted to our facility in 1991. Because many of our residents had early-stage dementia and were still able to watch television, we had a large one installed in our living room. On the day that Harriet was admitted, the activity aide had the television on waiting for a program to begin. The 5 o'clock news was on.

I met Harriet and her family at the door and discovered that she was an attractive, well- mannered woman in her early seventies. We spoke for a few minutes and my first impressions of her were that she would fit very well into our group. However, as we passed through the activity room where the TV was playing I heard her say: “Well, hello! Aren’t you the gorgeous one!” and I realized that Harriet was talking to Tom Brokaw who was reporting the evening news. I had never seen a person with dementia do that before, so I was intrigued.

As time went on, Harriet continued to talk to the TV, and at times became so agitated that we eventually discontinued regular use of the TV. Harriet had what we called mixed dementia. Her doctors suspected that she had Alzheimer’s disease and multi-infarct dementia. Later on I found out that one of her doctors suspected she might also have had untreated bipolar disease, as she exhibited signs of an agitated depression.

Over the next few weeks I realized that Harriet was experiencing disinhibition to a great degree. She had begun trying to touch male residents, and even male visitors, in inappropriate ways. Obviously she needed help with this behavior.

Disinhibition is a process caused by the progression of dementia. It results in an individual’s having a reduced capacity to react normally to a situation. Patients who are disinhibited often blurt out what they are thinking, act impulsively, and behave in socially unacceptable ways. We learn to inhibit our impulses as we grow and mature. Dementia reverses this process.

Actually, most people with dementia become disinhibited to some degree, but depending on a multitude of factors, the frequency and severity of inappropriate behaviors varies.
Harriet was experiencing sexual disinhibition to a significant degree.

We asked for a psychiatric consult for Harriet, and a week later a young geriatric psychiatrist came to evaluate her. While the doctor tried his best to administer the mental status exam (MSE), Harriet, in turn, tried her best to get hold of the doctor. He was obviously having a hard time with her and kept gently pushing her away but with little success. Harriet had become so sexually aggressive, he was unable to complete his evaluation and scheduled a return visit for the following Tuesday. On the way out of the facility, he asked the administrator and me to help him complete his exam at that time.

When the psychiatrist made his return visit, we went with him to Harriet’s room and actually stood in front of him so she could not touch him and he could complete his evaluation. He was a good sport about it and took time to explain to us what was going on. He was able to prescribe some medication to help with Harriet’s sexual disinhibition and treat her for agitated depression. However, although the medications helped control her behaviors most of the time, his return visits to see Harriet still required two people to stand between them.

With the psychiatrist’s help, Harriet was eventually able to participate in some meaningful activities, and her quality of life did improve.

Sometimes it’s hard to remember that the symptoms of dementia can be so different from person to person. Caregivers may become judgmental at times because they see behaviors that are bizarre or inexplicable. When this happens, the cause may be related to a mixed dementia or to a specific event in the person’s life that is troubling to them. People who exhibit disinhibition should be protected from embarrassing situations and may need a psychiatric assessment and medication to manage their symptoms.

Use Humor Wisely

GUIDELINE 13 Keep your sense of humor. Use it wisely.

> Laughter is the most inexpensive and most effective wonder drug. Laughter is a universal medicine.
>
> Bertrand Russell
> British Philosopher and Political Activist

➤ Think about how you feel when you laugh.

Laughter has long been regarded as beneficial for human health. Some of the benefits attributed to laughter including improved immunologic and endocrinologic responses and increased pain tolerance. One study found a 20 percent reduction in agitation using humor therapy, an improvement comparable to that of antipsychotic drugs, including reductions of tension and stress (Takeda et al., 2010). The study found this held true well into the late stages of dementia.

Lots of things can seem funny on a dementia unit. We used to blow bubbles and one of the residents would sing “I’m forever blowing bubbles,” a song from her childhood, and laugh at the fun of it. It’s important that the staff understands it is OK to laugh **with** the person who has dementia, but never **at** them.

There are a few tricks to giving medications to people with dementia who don’t want them. Because they have little memory of the medications they took over the years and lack the ability to understand why they were necessary, we tried various techniques. The most common was simply to put the medications in pudding or apple butter. We also tried bribery with special treats. These tricks worked most of the time, but there were still some feisty individuals who didn’t quite trust the staff and hated swallowing pills.

It is important that people not lose their rights just because they have dementia. Even though these individuals lack the ability to understand the importance of medications, it is up to us as caregivers to convince them to take their pills. However, if someone flatly refuses to take medication, we cannot force them to do so, and this can be a major problem.

After doing some research, one of our nurses came up with a solution that did work for several of the patients who consistently refused their medications—clown noses! She sometimes resorted to wearing a ridiculous looking red clown nose, which made the residents laugh. We found that laughing people are usually happy people, and they are also more cooperative. Humor helped solve our problem, and because people with dementia have little short-term memory, this trick worked over and over again.

Humor is a tool we can use, much like feel-goods, to change a person’s mood. It’s common sense that people are more likely to allow treatments or take their medications if they are happy.

Grandma

Grandma was an 82-year-old resident with late mid-stage dementia. She was called “Grandma” by the staff at her family’s request because she had become a grandmother at age 40 and loved being a grandma for most of her life. Unfortunately, she had suffered two hip fractures in the five years before admission to our unit.

When she fell and broke her hip the third time, rehabilitation was difficult. She had little motivation and seemed depressed; the staff was afraid she would become permanently wheelchair-bound.

At the time, a number of rescued turtles lived on the patio that adjoined the dementia unit. At various times staff had rescued the turtles when they wandered onto a busy road near the facility. By summer’s end we had five or six turtles, and the residents were always surprised and pleased to see them in the gardens.

When the cold weather came, they burrowed deep into the ground. The following spring, while Grandma was recovering from her fractured hip, they came out of hibernation.

I happened to be on the unit when Grandma saw one of the turtles lumber across the sidewalk. For the first time in a long while, she smiled. The aide with her picked up the turtle and showed her how to hold it by the shell. Its feet started rapidly pumping air and the aide snatched it back just in time for the turtle to urinate on her shoe instead of Grandma's lap. Grandma broke out into great gales of laughter. (So did the aide and I!) When the aide put it down and it slowly lumbered away, Grandma wanted to stand up to get a better look.

Each day after that, the nursing assistants took Grandma out on the patio to look for turtles. They would assist her to stand up, and then take a few steps, to follow the turtles. Each day Grandma got a little stronger. By summer's end, with the help of a walker, Grandma was mobile again. Turtle therapy works!

Laughter lowers the level of stress hormones in the blood and thus reduces feelings of stress. It lessens feelings of depression and helplessness and helps foster a positive attitude. Here are some common sense suggestions to try:

- A video of babies smiling and laughing
- Cute pictures and displays, especially at holidays
- Old movies (Laurel and Hardy, W.C. Fields, Keystone Cops) Wind-up
- toys
- Funny stories

Understand the Comfort of Religion

GUIDELINE 14 Religion is a comfort, even for people with dementia.

> Faith is the bird that sings when the dawn is still dark. . .
> Rabindranath Tagore
> Nobel Prize-winning Indian Poet

In the course of dementia, a time will come when the patient stops going to her place of worship, stops reading the Bible or other literature important to her faith, and stops praying. With poor attention span and memory loss problems, people with dementia simply lack the personal resources to fulfill this need themselves. We found, however, that given the opportunity to participate in religious services, even in small ways, our residents received some comfort. This was a benefit we could not deny them.

Walter

Our administrator occasionally joined the residents if she was available and would often bring music from home. One afternoon, she brought the Statler Brothers' Radio Gospel Favorites, which we played for the group. The residents who were able, sang along. As usual, Walter walked through the room several times, seemingly oblivious to the music. However, when Amazing Grace was playing, I heard someone whistling along beautifully. It was Walter.

Obviously, Walter knew Amazing Grace well and, although unable to speak or sing, he was able to whistle along. When the song ended, Walter went about his business wandering from place to place. We all wondered how a gospel hymn could reach into the parts of Walter's mind that held his fading memories and bring him back to reality, even for just a few minutes.

Many of the professionals I've worked with tell stories about residents in the later stages of dementia suddenly having a moment or two of clarity. Walter's was triggered by *Amazing Grace*, and his brief accompaniment truly did amaze us all. Considering his response and our residents' love of gospel music, I realized we were remiss in not addressing the religious needs of the residents on the special care unit.

Spiritual and religious activities may be an important part of a person's life and imbedded in their long-term memory. People who have no short-term memory often remember the words to familiar hymns and many are still able to recite prayers. These individuals may be comforted by their faith and respond well to occasional religious services; however, people with dementia come from different backgrounds and cultures and any services offered should reflect this.

Unfortunately, it is not unusual to find that the religious preferences and needs of the individual receiving dementia care have been forgotten. Religion does play an important part in the lives of many people. Patients should not be denied access to the comfort it offers just because they have dementia.

Expect the Unexpected

GUIDELINE 15 Expect the unexpected.

> Society is always taken by surprise at any new example of common sense.
>
> Ralph Waldo Emerson
> Transcendental Philosopher and Writer

Certain stressors can trigger agitated or catastrophic behaviors in people with dementia. Caregivers must be aware that this is a possibility, understand why it happens, and be prepared. Using a common sense approach helps us to understand that stressors include:

- Fatigue
- Change of environment, routine, or caregiver Depression
- Misinterpretation of stimuli in the immediate environment Illness
- High expectations from caregivers Delirium
- Hallucinations

➤ **Think about the things that make *you* stressed out. People with dementia are like you and me in many ways. They will be affected by many of your stressors.**

Stressors can lead to negative behaviors such as screaming, rummaging, wandering and pacing, and disinhibition. Planning for these behaviors and learning how to manage them can reduce catastrophic reactions from the individual and nearby residents. Still, there are times when dementia caregivers are taken by surprise.

Impulsive behavior is often seen in individuals with dementia. Other visitors and residents may find the person's social and personal conduct embarrassing or frustrating. These behaviors are often associated with a lack of inhibition, resulting in impulsive or inappropriate behavior.

Callie

Callie was a resident in an assisted living facility that had a memory care unit. She often preferred to sit quietly by herself in the living room. She rarely interacted with other residents and preferred simply to watch visitors and family come and go. Callie rarely smiled and rarely spoke. However, on occasion she would have a very negative reaction to large crowds or noisy environments and staff always tried to remove her from these stressors.

One weekend, on a very warm day in August, a family member had arranged for a birthday party in the living room. All the residents were invited but the weekend staff forgot to take Callie to a quiet area. With everyone's attention on the celebration, no one noticed that Callie had begun removing her clothing. A staff member turned just in time to see her take off her slacks.

➤ What is the first thing you would do to help Callie and avoid a catastrophic reaction?

When something unexpected happens, the safety and dignity of the resident must come first. Rather than immediately trying to get Callie dressed, which might have caused a negative reaction, the staff simply asked everyone to leave the room for a few minutes. Jennifer, a nursing assistant sat next to her and asked if she could help Callie get dressed. The response was a definite no, and she pulled off the remainder of her clothing.

Another staff member had brought a sheet to cover Callie, but stood by the door to maintain privacy and see if her help was needed. After a few minutes Jennifer again asked Callie if she could help. Callie's response this time was that she was cold. Promising her some birthday cake if she would get dressed, the aide was able to help her do so; after Callie had gone, the party goers were brought back into the room.

Callie could not explain why she took off her clothes but it was clear that she felt no embarrassment when she did it. Disinhibition, the loss of awareness of what is appropriate behavior, affects many individuals with dementia. If the staff had gotten upset and embarrassed for her, Callie may well have acted negatively. Temporarily removing the others from the room gave Callie a few moments to experience physical discomfort without her clothes and brought her to a point where she accepted assistance and a "reward" for getting dressed again.

While most people on memory care units have a diagnosis of Alzheimer's disease, patients with mixed dementias, frontotemperal dementia (FTD), and others may have a higher incidence of hallucinations, delusions, and paranoia. Additionally, those who have behavioral-variant FTD may experience delusions that bring on extreme jealousy, or their reactions may be religious or bizarre in nature.

The response of the staff may determine whether these problems become catastrophic or are quickly defused. Remaining calm, keeping other residents and staff safe, removing distractions, and preventing the person from hurting herself should be the goal. It's just common sense.

Conclusion

The goal of this course was to emphasize the importance of caregivers' putting themselves in the place of the person with dementia and then using common sense to figure out what they need.

Without this understanding, staff responses in caregiving situations are often partial and inadequate. Getting to know more about your patients—and taking the time to learn about what they experienced in their earlier lives—increases the tools you can use to prevent or manage problematic behaviors.

Knowing why someone would behave strangely, or understanding the reasons for their delusions or negative behaviors, means you can address these issues without causing distress to the person with dementia. "Getting into their reality" often leads to simple, common sense solutions to potentially harmful situations. It also helps to improve the quality of life of the individual by fostering trust in the caregiver and reducing the dependence on medications to manage negative behaviors.

Author Note and References

Author Note

Geriatric nursing was not my goal when I graduated from nursing school in 1961. But after working three years as a public health nurse, doing home visits for the chronically ill, I realized how much I enjoyed working with elders, especially those with cognitive loss. I began to realize how fragile and needy this population really was, and how my interventions could help families to understand their care needs and perhaps make their lives a little better.

At the same time, George Mason University began offering an MSN in geriatric nursing. I graduated from this program a few years later, just at the time the idea of separate dementia units for nursing homes and assisted living facilities was becoming a reality.

Shortly after I graduated I was asked to coordinate the development of a dementia unit for a nearby assisted living facility. That took a year, and it was during this time I met Elizabeth and several of the other dementia patients I wrote about in my book. Their problems, behavioral issues, and the ways in which they responded to the type of care we provided were not taught in the classroom. The staff and I had a lot to learn, not only about our patients but also about the ways our own behaviors and responses affected our patients. We quickly discovered that to solve some problems we had to think outside the box, and I loved the challenge.

It should be clear from the stories that the guidelines for common-sense care came from my responses to what the residents in various facilities taught me. Even today I can clearly see Elizabeth's face light up after she got her kiss, and I can still feel the hugs from Hannah. This is what made dementia care so important and so enjoyable for me. A friend once asked me how I could work with people who had dementia. "Isn't it depressing?" she asked. How could it be depressing to make someone's life a little better?

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Post Test

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

1. The Omnibus Reconciliation Budget Act (OBRA) of 1987:
    a. Was passed after the Congress nearly shut down the government.
    b. Published standards for physicians and physician assistants for the first time.
    c. Fell far short of an optimal outcome for patients in memory care settings.
    d. Reflected new regulations for public transportation.
2. People with dementia become more and more childlike as their disease progresses.:
    a. True
    b. False
3. Maslow's hierarchy is in the form of a pyramid that reflects our physical maturation over the years.:
    a. True
    b. False
4. You really can't put yourself in the place of a person with dementia and you must find solutions based on scientific studies.:
    a. True
    b. False
5. When Alice was in the police car, she was in her own little world and unaffected by the crowd around her.:
    a. True
    b. False
6. All dementia patients have the same needs.:
    a. True
    b. False
7. Speaking clearly, in short sentences, helps the person with dementia to understand you.:
    a. True
    b. False
8. When a person with dementia hears a positive message from the caregiver, but sees negative body language, they usually pay attention to the body language.:
    a. True
    b. False

9. Use of positive body language is nice but it won’t reinforce your message.:

   a. True
   b. False

10. Background noises should not affect communication with the person who has dementia.:

   a. True
   b. False

11. A person with dementia may revert to his language of origin.:

   a. True
   b. False

12. If the staff had tried harder to convince Obie that it was his own wheelchair:

   a. They could have taken advantage of a teaching moment.
   b. They would have shown Obie who was in charge.
   c. He may have responded with combativeness and anger.
   d. They wouldn’t have had to disturb the maintenance man.

13. Sometimes it is necessary for the caregiver to challenge the feelings and beliefs of the person with dementia.:

   a. True
   b. False

14. It is important for Henry to know that his wife had died and he should be reminded of that when he asked for her.:

   a. True
   b. False

15. Delusions are always treated because it is important for the person with dementia to accept reality.:

   a. True
   b. False

16. Who developed Validation Therapy?:

   a. Alexander Luria.
   b. Abraham Maslow.
   c. Stephanie Zeman.
   d. Naomi Feil.

17. Good care focuses attention on the dementia; the *person* will just naturally benefit.:

a. True

b. False

18. People with mid- to late-stage dementia lose all memory of events that took place in their childhood.:

a. True

b. False

19. The emotions of the person with dementia are not relevant to their care because they cannot express them.:

a. True

b. False

20. If we do not recognize the cause of bad moods in people with dementia, we can't work to change them.:

a. True

b. False

21. Reality orientation is an important part of dementia care throughout all stages of the disease.:

a. True
b. False

22. Many people with dementia do not recognize their own reflection.:

a. True

b. False

23. It is never OK to use "little white lies" to help a person with dementia.:

a. True

b. False

24. Most memory care units today use full spectrum lighting to:

a. Help patients to read more easily.

b. Diminish the psychological impact of television shows.

c. Avoid scary shadows and reduce glare.

d. Help people recognize themselves in the mirror.

25. Taking the time to guide a person with dementia through a task steals another patient’s time for care.:

a. True
b. False

26. Contrary to common wisdom, loss of independence may actually enhance a person’s life by providing feelings of safety.:

a. True
b. False

27. Guided choices are provided to teach dementia patients how to make decisions on their own.:

a. True
b. False

28. Activities should reflect, if possible, the earlier interests of the person with dementia.:

a. True
b. False

29. Sensory stimulation for late stage dementia patients should always be done by the activity department.:

a. True
b. False

30. A recent study showed that mental and physical activities do not delay cognitive decline in older persons with dementia but we should do them anyway.:

a. True
b. False

31. Staff should be aware that some activities will be too loud or too stimulating for some people with dementia.:

a. True
b. False

32. Any contact with a person who has dementia is an opportunity for positive activity.:

a. True
b. False

33. With all the activity around them, it’s rare that new residents feel abandoned and unloved.:

a. True

b. False

34. Families of new residents should not visit for a few weeks so the person with dementia can become accustomed to their caregivers and adjust more quickly to their new home.:

a. True

b. False

35. Women with dementia who worry about their babies need a psychiatric consult.:

a. True

b. False

36. As memories fade the person with dementia sometimes reverts to the routines that were followed every day for years.:

a. True

b. False

37. When a dementia patient formerly held a demanding job, offering him simple jobs will often result in anger or combativeness.:

a. True

b. False

38. Caregivers can’t help feeling judgmental when they see behaviors that are bizarre or inexplicable day after day.:

a. True

b. False

39. A person who shows sexual disinhibition should be ashamed of herself because it reveals her inner desires.:

a. True

b. False

40. Researchers found humor therapy did not result in an improvement when compared to the common use of antipsychotic drugs:

a. True

b. False

41. Laughing people are usually happy people, but they are not necessarily more cooperative.:

  a. True
  b. False

42. With poor attention span and memory loss problems, people with dementia cannot participate in religious activities.:

  a. True
  b. False

43. While spiritual practices and religious services may have been an important part of a person's life, they are forgotten with dementia.:

  a. True
  b. False

44. Unrecognized stressors can trigger agitated or catastrophic behaviors in people with dementia.:

  a. True
  b. False

45. Screaming, rummaging, wandering and pacing, and disinhibition can all be caused by stress. The response of staff has little effect on these problems.:

  a. True
  b. False

Answer Sheet

Dementia Care: Common Sense Guidelines

Name (Please print your name):

Date:

Passing score is 80%

1. ________
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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

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

a. Explain the Omnibus Reconciliation Act of 1987 and how it has led to better care for patients in residential care settings.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

b. Discuss the importance of putting yourself in the place of the person with dementia to figure out what she needs.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

c. Name 3 new dementia communication skills you have learned.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

d. Give 4 reasons for avoiding arguments with your dementia patient.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

e. Explain the importance of validation and how to use it.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

f. Say what it means to "consider the whole person."

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

g. Define "feel-goods" and explain how to use them to change the mood of the person with dementia.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

h. Explain why reality orientation is not appropriate for residents in mid- and late-stage dementia.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

i. List 4 ways to encourage independence in your patient.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

j. Suggest 3 ways to determine appropriate activities during care.

○ ○ ○ ○ ○

5 4 3 2 1

k. Explain the importance of love and other positive emotions for the person who has dementia.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

l. Discuss how important it is for people with dementia to feel they have something important to do and suggest five activities designed to satisfy their need.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

m. State 4 examples of judgmental behavior and how to move past them.

○ ○ ○ ○ ○

5 4 3 2 1

n. Explain the wise use of humor in your work.

○ ○ ○ ○ ○

5 4 3 2 1

o. Discuss the benefits of religion for dementia patients who practiced it when they were well.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

p. State what it means to expect the unexpected.

○ ○ ○ ○ ○

5 4 3 2 1

* The author(s) are knowledgeable about the subject matter.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) cited evidence that supported the material presented.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* Did this course contain discriminatory or prejudicial language?

○ Yes ○ No

* Was this course free of commercial bias and product promotion?

○ Yes ○ No

* As a result of what you have learned, do you intend to make any changes in your practice?

○ Yes ○ No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

○ Yes, within the next 30 days.

○ Yes, during my next renewal cycle.

○ Maybe, not sure.

○ No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

○ Yes, definitely.

○ Possibly.

○ No, not at this time.

* What is your overall satisfaction with this learning activity?

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* Navigating the ATrain Education website was:

○ Easy.
○ Somewhat easy.

○ Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

○ 60 minutes (or more) per contact hour

○ 50-59 minutes per contact hour

○ 40-49 minutes per contact hour

○ 30-39 minutes per contact hour

○ Less than 30 minutes per contact hour

I heard about ATrain Education from:

○ Government or Department of Health website.

○ State board or professional association.

○ Searching the Internet.

○ A friend.

○ An advertisement.

○ I am a returning customer.

○ My employer.

○ Other

○ Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

○ 18 to 30

○ 31 to 45

○ 46+

I completed this course on:

○ My own or a friend's computer.

○ A computer at work.

○ A library computer.

○ A tablet.

○ A cellphone.

○ A paper copy of the course.

Please enter your comments or suggestions here:

Registration Form

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

* Name:

* Email:

* Address:

* City: ____ * State: ________ * Zip: ________

* Country:

* Phone:

* Professional Credentials/Designations: ________________________

Your name and credentials/designations will appear on your certificate.

* License Number and State: ____

* Please email my certificate:

○ Yes ○ No

(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.**
3.5 contact hours: $29

Credit card information

* Name: ____

Address (if different from above): ____

* City: ______________________________________ * State: _______ * Zip: ________________

* Card type:

○ Visa ○ Master Card ○ American Express ○ Discover

* Card number: ____

* CVS#: ____

* Expiration date: ____