Alzheimer’s 101: An Overview for Healthcare Professionals

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- [Amy] Welcome to our webinar, Alzheimer's 101: An Overview for Healthcare Professionals, presented by Megan Malone and Jenny Loehr. Megan is a speech-language pathologist working as a clinical faculty member in Kent State University's Department of Speech Pathology & Audiology and as a clinician and consultant in home healthcare. Jenny is a speech-language pathologist with over 30 years of experience working in adult neurology. She currently works for a large national home health and hospice company, providing training, education, and mentoring for physical, occupational speech-language pathologists and nurses in home health, hospice policy, procedures, compliance, and program implementation. So with that, Jenny, I'll go ahead and turn it over to you.

- [Jennifer] Welcome, everyone. Welcome to our presentation, Alzheimer's 101: An Overview for Healthcare Professionals. This is a presentation from myself, I'm Jenny Loehr, and Megan Malone. We are speech-language pathologists. This presentation really is applicable to all healthcare professionals. And you'll gain a little bit of understanding in whatever practice that you have with individuals who have Alzheimer's and dementia. These are our disclosures, for Megan and myself. Moving on. Thank you. And here are our learning outcomes. This is what we'd like you to take away from this presentation. After this course, participants will be able to: Define Alzheimer's disease and related disorders and describe their progression. Describe strategies for communicating with patients with Alzheimer's disease and related disorders. Describe methods for managing behavioral challenges related to Alzheimer's disease and dementia.

Identify current interventions for patients with Alzheimer's/dementia to promote independence and participation in activities of daily living. Describe ways to support families/caregivers of persons with Alzheimer's and dementia. All right, getting into it. This is part one, Understanding Dementia & Alzheimer's Disease. All right. Well, let's dive in. I'm gonna talk a little bit about some facts and figures. Now, the Alzheimer's Association, they publish every year facts and figures for the previous year. And Megan and I, we've been doing these presentations for many years, and the sad news is that these numbers and these facts, they don't get better, unfortunately. But I don't wanna just, you know, give you a whole bunch of facts and figures. You can look this up on the Alzheimer's Association website.

But I want you to think about that question that we asked you just a few slides ago about your role and your purpose. And I'm hoping that by providing these facts, some of these facts, you're gonna get to understand the important impact that you have on this population. And this is justification for your presence in the care plan, in working with individuals who have Alzheimer's and dementia. So more than 6 million Americans are living with Alzheimer's/dementia. One in three seniors dies with Alzheimer's/dementia or other dementias. Alzheimer's disease kills more people than breast cancer and prostate cancer combined. In 2023, Alzheimer's and other dementias will cost the nation $345 billion. So pausing here just for a moment. You know, if you are wondering what kind of impact you're gonna have, you know, remember that our role, our primary role as clinicians working with this population, is to keep people safe, aging in place, out of the hospital, mitigate the risk of rehospitalizations, and keep them functioning independently for as long as possible.

And that is directly related to the dollars that are spent to care for these individuals. Over 11 million Americans provide unpaid care for people with Alzheimer's disease and other dementias. Between 2020 and 2030, 1.2 million additional direct care workers will be needed to care for individuals with dementia. Going a little bit deeper into the definition of dementia, and this is once again from the Alzheimer's Association, it is not a single disease. So when somebody says, "Oh, you know, my husband was diagnosed with dementia," we need to dive in a little bit further because it's not just the single diagnosis of dementia. And you're gonna learn a little bit more about that. But what kind of dementia is it? What was the cause?

You know, what are the symptoms? It's an overall term to describe a collection of symptoms, essentially. Diseases are grouped under the general term dementia that are caused by abnormal brain changes. And there can be many different reasons for these changes that occur in the brain. Dementia causes a decline in cognitive skills severe enough to impair daily life and independent functioning. There is no one test to determine dementia. Unfortunately, I think it'd be so much easier if we could just go get a blood test and have that diagnosis or an x-ray, but it doesn't happen that way. Dementia is fairly complicated, and the reasons for it are complicated. But it's important to understand it's not a normal part of the aging process.

Just because we get old doesn't mean that we're going to have dementia. In fact, it's important if you're working with this population, I don't know about you, Megan, but there was a time when all of my patients had a diagnosis of some sort of dementia, and I was just under the assumption, everybody has it. You get old and you're gonna get it. But that's not the case. There are many individuals who live into their late, late years, 90s, even 100s, who have normal cognitive processes. So this is just not a normal part of aging. Diagnosis is based on A, a review of the medical history, B, lab tests, C, physical examination, D, assessment of characteristic changes in thinking, day-to-day functioning, and behavior.

Also, structural imaging, CT scans, or MRI scans, and neuropsychology testing. Overall, a specialist may need to determine the exact cause or the dementia diagnosis. So it's really important once somebody says, "I have, you know, I've been diagnosed with dementia, or, "I think I have dementia," or, "I'm having these symptoms," really important to get a specialist, like a neurologist, involved, to find out what's the cause of it. Because there are some instances, it's few and far between, but, you know, there's medications, there are treatments out there, there's things that can be done to improve cognitive processes, even though you might have a true diagnosis of dementia. So important to get your patients to a physician who can get a good, affirmative diagnosis.

Dementia is a group of symptoms that can include language disturbances. You've got your aphasia that goes on, problematic behaviors, repetitive questioning, wandering, et cetera, getting lost. Difficulties with activities of daily living. Dressing, grooming, hygiene. Those things that we kind of take for granted every day become much more difficult. And personality disorders. Disengagement, aggressive behaviors, et cetera. Megan and I are gonna talk a lot about these individual symptoms, moving forward. Causes. And this is just a few of the causes out there. This list is not exclusive here, but this comes from the National Institute on Aging. Nutritional deficiencies can certainly cause, you know, metabolic changes in the body and in the brain. When you're malnourished, you're not performing healthily, your physiology is not performing healthily, and it can have a direct impact on the brain and cognitive functioning.

Infections. You know, this is a big one to be mindful of as a clinician or caregiver of someone who's got symptoms of dementia. As we get older, it's much more difficult for us to fight infection, and the infections seem to take over much quicker and exponentially when you are older. We could walk around with a urinary tract infection and maybe just feel very minimal symptoms. But in an older adult, somebody who's maybe even medically compromised, those infections can really dominate, and they can be a paramount reason for somebody's cognitive dysfunction. So a lot of times one of the first things that I do when I'm working with and assessing a patient that has dementia or Alzheimer's is ensure that we have recent lab results so we can rule out that this may be, in fact, due to respiratory infection, bladder infection, or a wound infection.

Subdural hematomas, obviously, a blow to the head, can cause cognitive issues. Poisoning. It's things that we ingest or maybe are exposed to. I've had patients that worked with chemicals, physicists, people who worked with radioactive materials, who then through the years developed dementia. So that can certainly be a cause. Anoxia. You know, lack of oxygen to the brain. Of course, a brain tumor. If you've got a mass growing in your brain, that's gonna cause dementia symptoms. Already talked a little bit about metabolic changes in the body. Vitamin B12 deficiency has been linked to cognitive loss. And there are individuals out there who don't process, who are unable to process B12. And there's specific tests out there to determine if you've got that gene that prevents you from processing B12.

Important to get tested for that. Chronic alcohol abuse, of course. You know, we're not talking about the little glass of wine you might have on a Friday night every week, but we're talking about people who ingest copious amounts of alcohol. Of course, we say it pickles the brain, essentially. Causes brain changes. And depression. Depression's a big one. The symptoms of depression mirror symptoms of dementia. So it's really important to get a firm diagnosis. Sometimes patients that I have in assessing, and, you know, we look at the body, we look at the cognitive issues, we also look at external factors. You know, what's happened in their lives? Could they possibly have had an event in the recent past that is causing depression?

And sometimes getting good treatment, maybe pharmacological treatment for depression, can actually improve cognitive behaviors, cognitive loss. So it's important to understand the distinction between depression and dementia. General symptoms. Of course, the number one, paramount one that we think about is memory impairment. And it's memory impairment that disrupts daily life. So we all have our moments, some more than others, of, you know, just forgetfulness. And there's many factors as to why one might be forgetful. For me, if I am super busy with work, and I've got lots of things going on, and I'm very distracted, I'm not going to intake and secure pieces of information. But I can recover from that. This kind of memory impairment, we're talking about individuals who it impairs functioning.

You know, it impairs their ability to work. It impairs their ability to go to the store, find their way around the grocery store, or attend activities, remember their family members, et cetera. So it's a little bit more than just having a few little, what we may call, senior moments throughout your days. Challenges in planning or problem solving. You know, I've had patients with dementia who were, you know, fabulous cooks, you know, people whose role in the family was to provide meals. And as the dementia progresses, they're unable to follow a simple recipe, or recall a recipe that they have cooked for many, many years. And when something goes awry on the stove, they're unable to solve the problem and how to fix it.

Difficulty completing familiar tasks, confusion with time or place, trouble understanding visual images and spatial relationships. This is important to understand, once again, talking about your impact. And identifying that there are some visual and spatial issues going on with your patients, because this can be directly related to patient safety. And we wanna mitigate or prevent accidents in the home. This may be one of the main reasons that an individual with dementia or Alzheimer's disease is really at risk for falls and breaking bones and hospitalizations. New problems with words and speaking or writing. Poor judgment. Withdrawal from work, family, or social activities. A lot of times that withdrawal may be related to the fact that this patient, this person, who's got some memory issues going on, identifies that in themselves, and their concerned that somebody else might identify that.

And so they tend to withdraw from people. Because if I disappear, then nobody will identify in me that I've got this problem going on. Changes in mood and personality. We'll be talking a little bit more about this in future slides. Misplacing things and losing the ability to retrace steps. I can't tell you how many times I lose my phone here in the house, or my keys, but I am easily able to think back and retrace my steps so I can locate those items. Or I'm able to problem solve to find those items. I now have a very specific place that I put my keys so that I don't have to harass my husband in helping me find my keys all the time.

So I'm able to problem solve that, but the individuals who've got dementia are unable to do that. There are many types of dementia. This is from the National Institute on Aging. The Alzheimer's website also has a really nice, lengthy list of types of dementia. They've added to that list. In the past, I would say, like, five or six years, they've added some additional types. We've just taken the opportunity, just for the sake of time, and we wanna give you really pertinent, valuable information, so we've highlighted the dementia types that we see have seen most, that Megan and I have seen most in our practice. But once again, this is not gonna be an exclusive list. And you can refer to the Alzheimer's website or the National Institute on Aging to get the complete list of the different types and their symptoms.

One of the most common, aside from Alzheimer's, one of the most common types is that frontotemporal dementia. This is the type of dementia that has recently been highlighted in the news because of the actor Bruce Willis. He has developed this type of dementia. And the cause is abnormal amounts or forms of tau and TDP-43 proteins that accumulate inside neurons in the frontal and temporal lobes. So the front of the brain and the sides there, that's the last part of the brain that develops as we mature, as human beings mature. And so that's why before that little piece of brain finally comes together, maybe about the age of 23, you see a lot of impulsivity, teenage type of behaviors.

Lack of forethought, lack of understanding consequences. And that's all happening in the very front of the brain. And that is very similar to some of the symptoms that you're gonna see with frontotemporal dementia. This is a very rapidly progressing disease as compared to Alzheimer's disease, which is a lot slower in progression. Some of the behavioral and emotional symptoms you find are difficulty planning and organizing. Once again, I mentioned before that these impulsive behaviors, that's really a hallmark symptom, is acting without thinking. Emotional flatness. They can have just kind of a masked look on their face, or don't show emotions much. You know, you may say a joke, or there may be something that would maybe trigger typically sadness in somebody, and they're not gonna show that emotion.

It's very, very flat affect. Or on the opposite end of the spectrum, they may have this lability, this excessive emotion that they cannot control. Uncontrollable crying, uncontrollable laughter, in inappropriate moments. So that's kind of some of the behaviors and emotional symptoms you see. Movement and language symptoms. Shakiness. And it's not necessarily a Parkinson's tremor. It's really just a shivery shakiness that you see sometimes that happens in the hands and the upper limbs. Problems with balance and walking. So they're at risk for falls. Difficulty with expressive and receptive communication skills. The next type that we're gonna talk about is Lewy body dementia. It used to be you hardly heard about Lewy bodies dementia. But we as, you know, researchers on dementia have really come a long way in discovering this Lewy-body-type dementia.

And so now we see this coming up as more prevalent in the dementia types. It's not that it wasn't present before. It's just we weren't as good at diagnosing it. This type of dementia is caused by these little proteins called Lewy bodies, and they affect the messengers in the brain. So the ability of the neurons to communicate with each other. It's very similar to Parkinson's dementia because the Lewy bodies, actually, the chemical makeup is very similar to what causes Parkinson's disease. It's a very rapidly progressing type of dementia. And it really overtakes the body before it takes over the mind, which is very tragic if you think about it, to see that your body, you've lost control of your body, and then to know, you know, you've got this diagnosis, and it's going to eventually affect your cognition as well.

You find an inability to concentrate, pay attention, or stay alert. Very similar to Parkinson's. If you've had any experience working with late-stage Parkinson's, you see that they drift off very, very easily. They drift off to sleep frequently as you're working with them, and they have really a lot of trouble concentrating and attending to tasks. And this is the same for Lewy bodies. Disorganized or illogical ideas. And that kind of correlates with the visual hallucinations, which I'm gonna talk about in a second. But a lot of times it's really hard to reason with these individuals because they've got these ideations that are just very profound and really make behavior issues come to the forefront when we're working with people who have Lewy bodies.

There's muscle rigidity. Once again, that's that link to the Parkinson's. Very interesting posture that you find with these individuals. Interesting undulations of the limbs and the coordination issues and the difficulty coordinating movements, walking, feeding themselves. Staying upright, even, is difficult. They have that mass affect, like an individual with Parkinson's disease has. There's insomnia quite often involved. Once again, that can be directly linked with the visual hallucinations. And the insomnia may be related to, you know, sundowning syndrome and the visual hallucinations and sleeping at odd times. And generally not during the night, but wanting to sleep during the day. It's a kind of a vicious cycle when it comes to Lewy bodies. But these visual hallucinations, that's a hallmark symptom.

Most of the individuals I've treated with Lewy bodies have these visual hallucinations. They see things that aren't there, but they are completely convinced that they are. I've had patients who see spiders on the wall, see rodents in the corners of the room. I had one individual who was very convinced that there were squirrels living in the closet. Individuals who are diagnosed with, you know, not a specific diagnosis, but just say, "I have dementia," one of the first things I look at is their medical history. If there's a history of stroke or vascular issues, maybe they've got vascular issues due to diabetes, vascular issues that affect wound healing, maybe they have lost limbs or digits or toes because of vascular changes in the body, it could be that this is a vascular type of dementia.

It has to do with the blood flow. Disruption of the blood flow in the brain. It's common with people who have had strokes in the past. It's a much slower-progressing disease. The symptoms are memory loss. A hallmark symptom of the vascular dementia is the expressive and receptive language deficits. Maybe there's that link there, if there was a history of stroke in the past. Trouble following instructions or learning new information. Difficulty understanding written language, which is gonna be important for you to understand as you move forward, and we talk about the strengths and weaknesses in an individual. And would you be able to use written cue cards as a way to help somebody learn a new task or function more independently?

That might be something to consider. They also have hallucinations not as paramount as those who have the Lewy bodies. These hallucinations may be more visual/perceptual issues related to a lack of blood flow in certain part of the brain. Maybe it affects the optic nerve. And then, of course, poor judgment. Mild cognitive impairment is very, very prevalent, and it has kind of recently, in the last five years or so, come onto the map. For us, as caregivers, a lot of the folks that we see, and maybe we're not seeing them for cognitive-related issues. Or maybe you're a physical therapist, and you're seeing them for gait issues or ambulation. Or occupational therapists, and you're dealing with upper extremity issues.

But a lot of our older adults are suffering from mild cognitive impairment. And it's important that we address it. There's two types. There's the amnesic, and there's the non-amnesic. So the amnesic primarily affects memory and not generally other areas of cognition. And then there's the non, which affects other areas of cognition. So it could be there's some memory issues, but there's other things, like language component, perhaps, or a visual component, visual-spatial component. It's likely those individuals with MCI are going to develop Alzheimer's disease in the future. This is kind of a precursor. Individuals with MCI have twice as many hospital stays as other older adults. Once again, highlighting your impact in working with these individuals and addressing the MCI.

Even if you are a nurse or a clinician in another discipline, working with somebody, without this diagnosis, if you are seeing these symptoms come about, and you're questioning or identifying that perhaps they have MCI, it's really important to address these issues as well. Because you can have an impact on keeping these individuals out of the hospital and safe in their home. The symptoms. This is not an exclusive list, but increased forgetfulness, losing train of thought, trouble following conversations, instructions, or making decisions, poor judgment, depression, lack of interest. Depression, once again, can be caused by the fact that this is mild cognitive impairment. And it could very well be that these individuals can identify in themselves that there is something awry with the way that they're thinking and remembering.

And they may just be thrust into a state of depression and worry because they are concerned that they're, you know, maybe getting Alzheimer's disease. Also, the increased temper or aggression in these individuals, that could be a defense mechanism. So, you know, they identify that they're starting to have problems. They're starting to have memory problems, and the best defense is to be defensive. And so if I maybe become angry with somebody or aggressive, maybe they'll leave me alone. And so it's kind of like showing those behaviors will get results that they want, which is people are gonna stay away from me, so they're not gonna identify that I have these issues. So these are just some of the symptoms that you see with mild cognitive impairment.

Alzheimer's disease, the most prevalent. It's the abnormal deposits of proteins. The plaques and tangles that you hear people talk about with Alzheimer's disease that are sprinkled throughout the brain. It's interesting if you ever get an opportunity to look at brain imaging and dissections of brains of individuals who suffered Alzheimer's disease, and the atrophy that occurs because of these proteins that develop. It's a very slow progressing compared to some of the other dementias. I've had individuals who've lived with Alzheimer's disease for 10, maybe 15 years. There's wonderful treatment out there. Of course, there's no cure, but there's a lot of great medications out there and cognitive treatment that can occur, if you catch it early on, that can keep people living a fairly nice quality life with the diagnosis of Alzheimer's for many years.

The biggest risk factor for Alzheimer's disease is age. Now, there are other risk factors. You could be exposed to elements in the environment, poisons, toxins, radioactive materials. You could, you know, develop dementias due to alcoholism, you know, things that you ingest, food, dehydration, et cetera. But the biggest commonality for Alzheimer's disease is age. And once again, it's not that everybody who gets old gets Alzheimer's disease, but that is identified as the biggest risk factor for this particular type of dementia. You've got mild to severe symptoms. It runs the spectrum memory impairment that disrupts daily life. Challenges in planning or problem solving. Difficulty completing familiar tasks. Confusion with time or space. Trouble understanding visual images and spatial relationships.

New problems with words and speaking or writing. Change in mood or personality. Withdrawal from work, family, or social activities. And misplacing things and losing the ability to retrace steps. We recognize this list from a few slides back. These are really the hallmark symptoms of Alzheimer's disease. There are physical considerations with individuals who have a diagnosis of dementia, things that we all as caregivers and clinicians need to be aware of. Because this is going to impact your plan of care. This is going to impact where we're going with this individual who's got a diagnosis of dementia. And it's going to impact other things that you're doing with these individuals. So one of the number one things is swallow dysfunction.

It depends on the type of dementia, of course, but more frequently than not, as folks with dementia, and I'm thinking about the Lewy bodies dementia. I've had patients with Alzheimer's who've developed dysphagia or swallow dysfunction. If you think about, you know, Parkinson's dementia, they, more likely than not, are gonna develop dysphagia symptoms. And it's something to think about because that's going to impact their general health. It's gonna impact getting nutrition and hydration that they need. It's gonna impact their ability to take their medications. Malnutrition and dehydration are a factor, something to consider. Of course, it can cause symptoms of dementia, but also as somebody who progresses with a dementia diagnosis may develop nutritional deficiencies that are going to further impact their functioning, as well as dehydration.

And, you know, dehydration in an older adult can actually cause symptoms of dementia. So keeping dehydration, or good hydration, at the forefront of your mind when you're working with individuals who have dementia can help keep them healthier and keep them safer, and that's something to consider. And I think we talk a little bit about it when we're talking about developing a plan of care. Gum disease is something that I think not very many people think about when they're working with individuals who have dementia. And it's something all of us as caregivers and clinicians need to stay attuned to with our individual. Now, gum disease, actually, infections of the gum, can cause symptoms of dementia, but the big concern here is that individuals who have symptoms, or who are diagnosed with dementia, tend to not pay attention to their oral hygiene.

And this can cause some, I have seen some pretty horrific consequences of not attending to hygiene in the mouth. People who are pocketing or keeping food in the buccal cavities. You know, food stuck in between the cheek and the gum can cause infections in the teeth and in the gum area. Which the infections then can create a toxicity in the body and affect the brain. I've had individuals who've neglected their denture hygiene. I actually had a patient whose dentures were fused to their gums because they hadn't removed their dentures for about six months. And they had to have it surgically removed. And of course, the aftercare and the after effects of that were devastating for this individual.

It affected, of course, their ability to eat and to drink. And so it's really important that you identify if there's a possibility that somebody's not attending to their oral care. And all of us, no matter what our discipline is, we all need to play a part in ensuring they're getting good oral care. Infections we talked about. And, you know, the individual, all of these folks who have dementia diagnosis, are at risk for infections, bladder infections, respiratory infections, of course, like, gum disease, tooth infections, et cetera. And that can really snowball and cause, you know, further effects on cognitive functioning as the infection moves through the body. Gait dysfunctions. Most of our individuals are at risk. Maybe that's a visual perception issue.

Maybe it is an actual coordination issue. So they are at risk for falls, accidental injury in the home. And we need to think about that and consider that when we're developing our care plans. Heart disease. A lot of our individuals have a risk of heart disease, for one reason or the other. Sleep disturbances, which can have a snowball effect on their functioning. They're not getting enough sleep to help the body heal and find that homeostasis. It's gonna affect their attention. It can then, of course affect their ability to ambulate safely, or make proper judgments, or even can affect when they eat. And if they are eating and hydrating adequately, maybe they're too tired to have a meal, and they skip meals, because they're just not getting enough sleep.

And then, of course, we talked a lot about depression before, but depression is very common in individuals who have been diagnosed with dementia. And it's important to address with the medical team that you're working with to ensure that the dementia is being addressed as part of the treatment for the individual who has a diagnosis of dementia. Per the Alzheimer's Association, only 4 in 10 Americans would talk to their doctor right away when experiencing early memory or cognitive loss. So only just a handful of individuals wanna talk to their doctor. They don't wanna, you know, and I've witnessed it myself. You know, they're starting to see some cognitive changes, and they're paranoid. They're worried that what's happening inside their brain, and they don't want to hear the ugly news that may not news at all, actually.

And so a lot of people avoid talking to their physicians about these symptoms that they are are seeing. However, 7 in 10 Americans would wanna know early if they have Alzheimer's disease, if it could allow for earlier treatment. It's interesting. They wanna know, but they won't talk to their physicians. So that's the way we stand right now per the Alzheimer's Association on individuals getting the diagnosis early, talking to their physicians early on. All right, wow. So now I'm gonna hand it over to my wonderful friend, longtime colleague, partner in crime, Megan.

- [Megan] Thanks, Jenny. So in this section we're gonna get a little bit more into understanding memory. When we think of something like dementia or Alzheimer's disease, our primary symptom we think of is changes in memory. So we wanna take a little bit of time today to discuss how memory works so you can understand a little bit more about some of the issues that we're seeing with it in our patients, and then how we can work with it. So here's our question to consider for this section: Is having a memory problem an expected part of normal aging? So forgetfulness can be a normal part of aging. As we age, there's changes to all parts of the body, and that includes the brain.

It might take us longer to learn new things. But having a memory problem, or having dementia, as Jenny mentioned, is not an expected part of normal aging. A little bit of forgetfulness here and there, forgetting where your keys are, the name of someone you haven't seen in a little while, that's completely typical and okay. But when the memory issues start to affect how you perform in daily life, that's when it's important to talk to a physician and have things be investigated a little further. So having a memory problem here and there and a little memory forgetfulness is completely typical, but having a memory problem such as dementia is not an expected part of normal aging. What we wanna remember when we see people who have larger memory deficits, changes in their cognition, a diagnosis of dementia, is that, you know, we want to remember that these people can learn new things, right?

This is one of the hallmark kind of misinterpretations or misconceptions about persons with dementia, is that people can't learn new things. People can actually learn very new things. They have weaknesses in a number of areas of learning and memory, but a number of strengths exist as well. And as we see in our little icon for our eyes during break, you know, those strengths can be things like willingness to help and being curious and funny and having long-term memory abilities. So there's a lot of things we can work with. That also includes the ability to learn procedures and the ability to read, which we're going to learn more about why those things stick around a little longer in a few slides.

But research has shown that the learning of information and its retention depends heavily on how it's presented and how it's practiced. So there are ways that people can learn new information. We just have to think about how we're teaching it. So our key as caregivers, healthcare professionals, is to be aware of the weaknesses, but focus on the strengths. Think about the abilities that each of your individual patients has and build off of those. So when we think about memory, it's a very complex construct, and, you know, it's beyond the scope of today to get into the nitty gritty of it. But it's important to understand a little bit about how it works so you, again, can understand what happens when it's not working properly.

So what memory is, is the continued process of information retention over time. There's three main processes for how memory works. So the first is encoding. And this is how we learn things. And that is very dependent on attention. As Jenny mentioned, if we see our patients starting to have more issues with their sleep, that's definitely gonna affect their ability to attend. Also, depending on the type of dementia they have, again, that frontal temporal dementia that we talked about, that directly affects that front part of the brain, which really is responsible for paying attention. So we can see people having difficulty being able to attend to a conversation, a command, a question. And if they're not able to do that, that's going to definitely affect their ability to follow through with it.

So anytime we wanna learn something, we need to attend to it. You might think back to when you were in school and having to study for a big test. You might have turned off the TV and the radio and gone into a room where it was gonna be super quiet so that you could really focus in on the information you were going to learn. That's important because that's a direct result of how we're going to encode information. And that's how we organize incoming information. So visually, how something looks, acoustically, how it sounds, semantically, what it means, and tactically, how it feels. Those are all different ways that we have information coming into our systems. And then we organize that in such a way that allows us to remember it and make it meaningful.

And then we might use different strategies to help to organize that information even further. So we might use things like repetition. So maybe if you wanna remember a phone number, you might repeat that over and over again so that you can use it. Again, rehearsal, the same idea. Memorizing notes from a class. You might remember kind of going through those notes and saying them over and over again. That's how you're organizing the information. We could also use things like mnemonics. So that would be something like using the ROYGBIV acronym here to remember the colors of the rainbow. That's another way that we might try to organize information and make it meaningful to us in order for us to be able to retrieve it later.

So the first step is being able to attend to information and organize and encode it. That might be a problem in the system of a person who has dementia or Alzheimer's disease. There might be some direct issues going on with on with their encoding abilities. Then we get to storage. So this is how long encoded information is retained. So this is when we talk about memory, right? So you might hear short-term memory and long-term memory. And short term is something that we classically see people with dementias having trouble with. That's that only the 15 to 30 seconds of being able to remember something. Typically about five to nine pieces of information or units of information can be stored short term and in that working memory.

That's why phone numbers and so forth are the length that they are, because that is the amount of information that we can kind of hold onto for that short period of time. Long-term memory, however, has an immense storage capacity. So we could have lots of stuff stored in there. It might be more difficult to retrieve over time, and we'll talk about that. But long-term memory has a really big storage capacity from everything from things we learned in our childhood to favorite lines from movies, to what we did yesterday. Finally, we have the retrieval portion of memory. And so that's how we access stored information. So information can be stored in short-term and long-term memory, but they're retrieved a little differently.

So short-term memory, we retrieve that information like a phone number, in the order in which it's stored. So we remember all those numbers in a certain row, and then we recall them within that same sequence. Long-term memory, however, we retrieve that information through association. So you might see somebody's face, that visual information, and then be able to associate that with how you know them. And then you are able to recall that information and be able to remember that name. So that's very important. So short-term memory we see primarily affected first with Alzheimer's and other dementias. And then long-term memory can be affected by dementia over time, in both storing information and retrieving it, but aspects can be relatively spared over the progression of dementia.

So we can see that people might have difficulty with long-term memory. They might not be remembering everything from their past, but we can see that maybe some of these things they can remember over time. And then as part of that we have the declarative memory system, which is our conscious recollection of particular facts and events. And then the procedural memory system, which is our memory for learning and executing tasks, such as reading, tying our shoes, eating, things like that. Okay? Okay. So let's go ahead and take a quick look at a model of memory that will help us understand the difference between declarative and procedural memory. So as I mentioned in the last slide here, we talked about how the declarative memory system is part of long-term memory, and it's our conscious recollection of facts and events.

Whereas procedural memory is our memory for learning and executing tasks. So here we can see this model from Dr. Larry Squire from 1994. So it's an oldie but a goodie. The information here really remains true for a lot of what we're doing with our patients in understanding how memory works. So you can see here on the left, the declarative memory system is part of long-term memory, but it stores information such as our knowledge of facts and events. So who we are, who our family members are, different things that we know, events, what we had for breakfast, what we did last week, vocabulary. So how we're able to express ourselves and understand what is being expressed to us.

And then our knowledge of the world, which is our basic knowledge that we've learned throughout our lives that we just kind of know as part of life. So I always use the example of kind of knowing that, say, Paris is the capital of France. At some point in your life you learned that piece of information. You can't necessarily tie it to any particular event, but it's information that's stored because you've learned and practiced that information. Typically, when people have something like dementia, we can see that their declarative memory skills of long-term memory are harder to access. They tend to be a little bit more affected. So they may not remember what happened to them yesterday, or the names of their family members.

They might start to slip in terms of knowing what an object is called, or even some of those facts that they've learned throughout life. What's been found in research, however, is that the procedural memory system, so again, that memory for ability to execute tasks, is relatively spared through the progression of a dementia. So remembering how to really execute different skills and habits. So it could be things like eating or tying our shoes. Now, granted, those things might be a little tougher as time goes on due to other reasons. So maybe the person has difficulty with coordinating movement. So they may be able to remember the steps of how to do something, but they may not be able to execute it as easily.

I always think of this one, too, as kind of that unconscious memory, or that more automatic memory. So think about maybe your drive home from work every day. When you're getting in your car after a long day, and you're starting to think about what you're gonna make for dinner or, you know, a conversation you had earlier, all of a sudden you're driving along and then you end up in your driveway, and you don't really actively remember driving home. That's procedural memory. It's kind of scary to think about, but it's because you've done that route so many times, you can do it pretty automatically, without having to actively think about what you're doing and where you're going.

Again, it's practice. And that's this idea of priming here. It's just the idea that the more exposures you have to learning something or a piece of information, the better you're going to be able to retain it. So again, being able to drive home from work and doing that same route every day has primed you to be able to have that memory become more automatic. This is a great example, too, of looking at what happens in a dining room in maybe a, you know, a care facility. So let's say that, you know, a person's been living in a care facility for a little bit of time. They have a certain spot in the dining room. They know exactly where that seat is when they get into the dining room.

That location tends to set off that reaction of knowing exactly where to go to their seat. Now, if you sat them down and asked them to describe exactly where their chair was in the dining room, they likely would not be able to do that. But because that procedure, that priming has happened where they've learned how to go to that chair every day, at least for three meals a day, sometimes more, they're able to get to that seat. And so that's that idea that learning can still happen with persons who have dementia. Remember, they didn't know anything about that seat before they lived there. This is new information that they learned upon moving into that facility with likely a cognitive diagnosis.

So that's a really great example to give when you're talking to family members and so forth about how learning can still happen with this population, because it's heavily dependent on how that information is presented and how much it's practiced. So if we're able to expose people to different, you know, information we want them to learn and give them lots of practice with it, it can be stored in long-term memory. And then we can work on that retrieval and have them practice it frequently and kind of open up that pathway a bit more for them to be able to recall and use it. The idea of simple classical conditioning is also something that we see stored in the procedural part of long-term memory.

That's simply the idea of stimulus and response. So anytime that you see someone, say, reacting to maybe that environment of being in the dining room, and then they know exactly where to go for their seat, that's kind of a stimulus that's setting off the response of being able to locate the seat. So again, learning and, you know, being able to use this information can happen with these populations. It just depends on how we're exposing them to the information. Okay? Here's our question to consider as we move into treatment considerations and communication strategies: What are some treatments or strategies you have used or seen used with persons with dementia or Alzheimer's disease? So again, you might even think back to that question earlier where we talked about what your role is with this population or these populations.

What strategies have maybe you used to assist them with their care, or to help them remember better, or to maybe support caregivers? What kinds of things have you used, and what, you know, what do you feel about those? You probably have some things in your toolkit that you've used that are tried and true and you feel good about, and there might be some that you have seen used and you don't feel as great about, or haven't seen the results that you would like to see. So what we're gonna do right now is kind of talk through some of the main treatment trends that are out there to help you all understand, you know, what the options are.

And then, really, it's a lot of trial and error. Honestly. You're going to see some things that you might say, "Oh, that would definitely work for the patient that I have, but maybe not for another one." And sometimes we have to kind of mix and match and try things out in order to find what works. I wanted to touch briefly on some different just treatment options, starting with some of the pharmacologic ones. Before we even get into that, though, we're gonna talk about just what the stages you might see with dementia. So again, with treatments, there are drug and non-drug options available.

Again, we wanna consult healthcare professionals to navigate those many options. And the patient's needs may change over time as the disease progresses.

So they may not need medication initially, but maybe some environmental changes might take care of things. But then over time, maybe medication is something that's needed, along with some more non-pharmacologic interventions. It all depends on the person. So that's why it's really important to have a good care team involved with anyone after diagnosis, and then for those people within the care team to be communicating to understand what the best ways to treat the person are. When we look at dementia, we have these stages. So you can see the early to mild stage. Again, the symptoms aren't as apparent. So we might see people having some difficulty thinking of words, maybe losing objects here and there, trouble organizing and planning.

So, you know, they're starting to have some issues, but it's not necessarily affecting their everyday life to an immense degree. However, over time, those symptoms are gonna become more apparent, and that's when people are moving into the more middle or moderate stages of dementia. This tends to be the longest stage, where we're gonna see more pronounced difficulties overall, like persons being forgetful of their personal history or events, some confusion, people getting lost. So this is when a lot of care becomes more intense. People might have more people involved with their care. We might see people having really more safety concerns. They might be more appropriate to be living in a more care-intense environment, such as maybe a memory care unit, where they're not able to get out as easily, just for their own safety.

So we might be seeing some more of that in this stage. In the late to severe stages, we're gonna see increased severity of all symptoms. So this is when they're gonna require consistent care. They have difficulty communicating and responding to the environment. Everything just gets amplified here in that late stage. But the thing to remember is there's hope at every stage. So a lot of those strengths that we've seen in our little icon, those things are still apparent. You know, maybe not to the same degree as people progress, but a person is still there. And there are still things that we can do, even in the late stages of dementia. People can be responsive to different sensory input.

They can still be responsive for shorter periods of time. There are things that can be happening there. So we don't wanna just think that, as people progress, we just kind of stop trying to make a difference. We wanna go beyond just making people comfortable and giving them some good moments throughout their days so that they can still feel part of their families, their communities, and someone who is valued. In terms of pharmacologic intervention, there are approved medications by the Food and Drug Administration, so that's the FDA, for Alzheimer's disease. So I just wanted to bring those up really quickly so that you have some familiarity with the names. You might see them in a chart. You might hear families talking about them.

So these are drugs that ease symptoms. They target memory issues, behavioral changes, sleep disturbances. These are drugs that can slow the progression. So there could be IV infusion therapy, either given every two weeks, like with Leqembi, or once a month, with Aduhelm. So those are some different drugs that you might hear those names for, or you might see in a chart, that you wanna be familiar with. And those are really being prominent in the news as of late. And so it's important to understand that they're out there and, you know, giving us some more hope. I wanted to give you a link to the Alzheimer's Association's website that talks about the different treatments for dementia, including medications for memory.

That can be a really great resource if you wanna dig in a little bit more and understand some of the drugs that are out there and how they actually work on mitigating some symptoms and changing some of the issues that are happening in the brain. Okay, so we'll talk a little bit more about behavioral treatment options, since that tends to be the big spot where most of us as caregivers are going to be intervening, to try to care for people in their day-to-day. So in terms of behavioral treatment options, here's a great quote here. The behavioral and psychological symptoms of dementia include psychosis. So it could be delusions and hallucinations. We talked about those earlier.

We might see aggression, agitation, irritability, anxiety, depression, apathy, mood lability, disinhibition. Boy, that laundry list is big, huh? Intrusiveness, impulsiveness, restless motor disturbances, and sleep disturbances. It's important to put that all into perspective. Again, we wanna really focus on the idea that there's ability left. But we can't ignore the idea that there's some weaknesses that are happening. And those might take the form of these behavioral and psychological symptoms here. So those are going to be present, likely. Maybe not all of them, maybe not all of them initially, maybe some things come and go, but we need to know what's there so we can figure out what we're gonna do. Behavioral or non-pharmacologic approaches include those that focus on the individual, and those that focus on the caregiver, and some that focus on the environment.

So we're gonna divide up our discussion today into those three sections. So we're gonna start with individual ways that we can treat, and then we'll get into more about how to assist the caregiver and environmental changes we might wanna consider. All right. As we talk about that, let's just kind of frame this up by talking about how dementia care is typically discussed and used in this country. We usually look at activity-focused dementia care. So that's incorporating meaningful activities into the daily lives of persons with dementia. That's part of person-centered care. So focusing on individual wants and needs. A lot of you are probably instituting that in the environments that you're working in, that we really wanna focus on the person.

Interactions are based on knowledge and deep respect of care recipients as human beings. So we're gonna talk about one treatment philosophy here that's called Montessori-based intervention that really looks at that idea of looking at an individual and focusing on who they are and what they need. But even without using Montessori, a lot of these types of interventions we're gonna discuss here really do focus on how we can capitalize on who the person is and what they need and what's meaningful to them. Abilities-focused and strength-based care is a lot, again, of what we've been talking about. So this is when caregivers deliberately identify and encourage the use of an individual's retained skills and capacities, including physical, motor, cognitive, and social and communication ones.

So we wanna look at really building up those skills. And we really wanna compensate for those dementia-related limitations and focus on using remaining abilities. So again, everything we've been talking about thus far, focusing on the strengths, circumventing the deficits, trying to work so that we can really help people to maintain that individuality for as long as possible. And also that independence. Really important for people to still be able to be active in their care for as long as possible, because the less that people are active, the less that they are doing things related to their everyday life, the faster those things are going to start to fade. Behavioral treatments for dementia can be direct or indirect.

So direct means when professionals intervene directly. So something that we're doing to help a person. Or indirect is when we might train caregivers in an intervention. So you might play those roles in your work environments in different ways. So, you know, it's important to kind of realize how these work, and that some of these treatments can definitely be either direct or indirect. All right, so some things we might do for individuals is increasing their sensory stimulation. So music and art therapy can be a big part of that. Again, I mentioned how even in the late stages of dementia persons can really be affected by sensory stimulation. So being able to listen to music, to be able to respond to touch, to have, you know, a hand massage given to them, or being able to smell different, you know, essential oils or something like that.

Those can be triggering memories. They can allow people to engage and connect. So they really are important parts of being able to look at individual treatment. There's communication strategies we might use with individuals. So that idea of reassurance, empathy, direct communication, validation. So when a person is maybe struggling to communicate, or is maybe getting agitated by a particular situation, being able to reassure them that they're safe, being able to empathize with how they might be feeling, being able to tell them directly what's happening and make them feel okay about it. And I'm sure a lot of you are already doing those things naturally when you interact with someone who has Alzheimer's or a dementia diagnosis. But it's important to get you validated on how important those things are, and that you're doing the right thing when you're doing those things.

We might also come up with personalized activities. So things like the Montessori method, like I mentioned earlier, or reminiscence therapy might be something that sparks a memory for you all. That idea of being able to think about what the person is interested in and give them the opportunity to interact with it. So maybe with reminiscence therapy, you are going to provide them objects to look at and hold and discuss, maybe an old record album that they really loved, and that might trigger a memory. Or, you know, a rotary phone. Look at it that way. Those aren't things you see very often, but maybe a lot of our patients might react to. And being able to use that as a way to spark some memory.

The Montessori method we'll discuss is this idea of kind of breaking down activities to allow people to engage with them and really capitalize on their abilities. So thinking about what they might be interested in. I had a patient one time who was an interior designer, and so we worked on her looking at and identifying and sorting different wallpaper samples and different types of carpet that might go well with the wallpaper. And things like that that would really be interesting and exciting for her. Whereas another patient who I had who maybe was a mechanic might not be as interested in those wallpaper samples, but maybe we come up with something where he was using different tools and so forth, things like that.

The use of visual and graphic supports is another way that we might interact with individuals. So that might be using something like a memory book. So you all might be familiar with those, where it's kind of having a picture on a page and a book for a person that maybe talks about their family and has simple statements underneath it that identifies who's in the picture or where that picture is taking place. So not actually making the person have to look at a picture and have to access those memories that might be hard for them to get to of the names of the family members, but having it easily stated underneath so that they can really understand what's going on in the picture and then interact with it.

We might also increase and maintain routines with people. You know, routines are really important for all of us. But that can be really important for a person with dementia. And then we might also use redirection to alter their focus. If they're really fixated on wanting to leave a locked unit, or really worried about where their family member is and why they haven't come to visit, we might provide some redirection to help them change focus a bit. Again, here's some more individual treatments. And we've already gone into a little bit of them in the prior slide, but just a few bullets on each of those. So for validation therapy, it's the process of communicating with someone by validating and respecting their feelings and whatever time and place is real to them, even if it doesn't match our reality.

So let's say one of our patients is really struggling with why their husband isn't coming to visit, but their husband has passed away. It might not be the best move to go ahead and remind them of the death of their husband, because that could set off a lot of other emotions, clearly a lot of trauma, for a person. So we might acknowledge how they're feeling and then try to help them discuss a little bit more about their husband. Tell me about him. And put her or him into a better position in terms of being able to remember them and validate how they're feeling. It could be that, you know, a patient is waiting for their kids to get off the bus, and that they don't wanna go to lunch because their kids might be getting home from school.

They might be thinking a little bit more back in the day when their kids were younger, and not really recognizing their current age or condition. So if they're worried about where their children are, validate that. It doesn't mean that we have to say that their kids are grown and they're not coming. We might go ahead and just say to them, "Okay, we understand. Yeah, we know that you're waiting for those kids. How about we leave a note for them so they can know that you're eating, and then they'll know to come?" And then that's validating their current reality. So, you know, sometimes the reality that people have is better than the real one. And so, you know, you have to, you know, decide what makes sense for each of your individual patients.

Sometimes knowing the truth about something is something that people might need. But it all depends on the individual, okay? The goal is to understand the meaning behind a person's behavior and validate their beliefs. As we mentioned with reminiscence therapy, this focuses on facilitating the patient with dementia to remember experiences from their life and assisting that person and sharing those memories with others. So a lot of times you'll see this in group activities in facility settings, where people are looking at objects or discussing a particular time and place, and helping that to spark memories and communication. That really helps to promote that social interaction, the conveying of positive emotions, and promoting self-awareness. Here's the slide on Montessori programming.

So we've already touched on it a bit, but I wanted to give you a little more detail in terms of it using Montessori principles to provide constructive engagement, meaningful activity, and the practice of skills. And you might be saying to yourself, "Well, isn't that, you know, mainly for, you know, young people and children?" Well, you're right. We see Montessori schools all over the place. And those principles that teach children to learn can be directly applied to older adults and have been really researched to see that people can use these principles to be able to maintain skills. Whereas with children, we might be teaching them new things, we might be able to use Montessori principles to be able to help people maintain skills.

So there's a lot of good research out there that's seen this used with persons with Alzheimer's disease and really helping them to participate more fully in activities. And staff really enjoys being able to implement this programming method as well,. As we mentioned with visual and graphic cues, so when we talked about memory books a few slides ago, this is an idea that is really important because that reading ability is sometimes maintained. Now, we did talk about how vascular dementia could affect people's ability to respond to written stimuli or written words. So those are things we wanna take into consideration. Persons also may not have ever learned to read. So if they never learned to read, they're not gonna be able to access that skill now.

But reading sticks around for a while because it is something that, if it is learned, we practice over and over again and use repeatedly throughout our lives. And those are those skills in that procedural memory that tend to stick around. You might, again, have seen even people who learned to play the piano early on in life, have a, you know, a piano in front of them, say actively that they can't play it, but then when you put them, you know, they go ahead and sit down in front of the piano, they're able to play a beautiful song. That's that procedural memory coming out. So this idea of using visual and graphic cues is capitalizing on a preserved skill like reading.

And it can be a really successful treatment strategy to use. So things like memory books and wallets can be great. So again, having pictures and having simple print underneath it, explaining to the person what to do, or who they're looking at in the pictures. Maybe even just being able to have pictures and words so people can get through a care task, like brushing their teeth. Maybe you have up on their mirror, you know, the steps written out of what to do. Take out your toothbrush, get it wet, go ahead and put the toothpaste on it, then brush your teeth. Very simple directions posted on their mirror could be essential. And then being able to follow through with that care task more independently.

Maybe a care member can help to point to each step as they go and might assist them, but then that person is able to be more independent in that task versus somebody else fully brushing their teeth. If they have the ability to participate, we need to be able to promote the ability or the idea that they can do that. And then provide them with systems and support that are gonna allow them to do those things more independently. So again, memory books and wallets use meaningful pictures, short, clear, concise sentences to describe pictures to help a person recall important information and routines. Spaced retrieval training is something some of you may be familiar with. Basically, this is just the idea of being able to teach people to remember information that they may have forgotten.

And this helps them to retain information for long periods. So days and weeks and months. So it could be being able to remember their room number, or their wife's name, or maybe that they need to lock their wheelchair breaks before they stand up. So it consists of having a prompt that elicits a response and an answer that the patient gives. So the question we might ask them might be, what should you do before you stand? And the answer might be to lock their wheelchair breaks. And then we might give them practice in locking those breaks. So the idea of spaced retrieval is spacing out the retrieval of that information. So if a person can remember the answer to that question when you immediately give it to them, you can maybe wait 10 seconds, ask the question again, see if they can recall the answer, then wait a little longer and ask again.

So this is kind of in direct opposition to the idea of rehearsal, where people are kind of remembering something and repeating it over and over again. In this case, we're waiting a little bit in between trials and letting them practice, which has been found to allow people to remember information for longer periods of time, because it's going to allow that information to be stored in long-term memory. In that procedural memory. That idea of that priming, the simple classical conditioning, a stimulus and a response. In this case, the stimulus is the question or the situation, and the answer or response is what the patient should say or do in that situation. So that could be related to transfer strategies, swallowing strategies, maybe hip precautions after a hip replacement.

Again, family members' names, where they are, even things like being able to take their medications. What time do they take their medications? What do they do when they hear the pill reminder go off? What do they check to know what appointments they have coming up? Their calendar. We can work on all kinds of things using this training technique. So that might be something to investigate further for use with your patients. In terms of caregiver and environmental treatments. So caregiver-focused ones are really based on education. So teaching people about understanding how to work with individuals with dementia, understanding about how memory works, what the symptoms might be, how to react, aspects of person-centered care. Again, communication strategies.

How to support their mental health, because it is so stressful for a person to be a caregiver of a person with declining in cognitive ability. That could be us as care staff or family members. So it really is stressful. And how to understand and manage behaviors. And we're gonna talk about that in our next section. In terms of environmental changes, we might look to reduce overstimulation, or even understimulation, in the environment. Looking out for safety issues and those lack of routines. So it's recommended that we look at addressing things like clutter or excessive noise, too many people around. Maybe people are just overstimulated, and that's triggering some behavioral or some unrest with the patient. Maybe they're understimulated.

So if they're just plain bored, they're gonna find ways to keep themselves interested, engaged, and entertained. So a lot of times when people are trying to, say, leave a locked area or leave their home, or maybe going into other people's rooms or into unsafe areas, one question we might wanna ask is, well, what else could they be doing? Because kind of that mind that's left to its own devices can sometimes come up with some ideas that may not be ideal for a person's overall safety. If they're deprived of sensory stimulation, we might want to think about, all right, if they can't see or hear well, how can we adapt and make sure that they can? Can we make print larger?

Can we make sure they have their glasses and their hearing aids are maintained well? Can we turn up the volume of certain things or change the volume of our voice so they can be heard better? Safety-wise, we wanna stay away from sharp or dangerous materials in the environment, of course. Making sure that patients are safe so they're not able to leave the environment, because that might put them in an unsafe situation. So these are some of the things that are recommended in terms of behavioral treatments that can help out with the caregivers and changes to the environment. In terms of communication strategies, it really depends on the stage of disease that the patient is in.

So if they're in early, middle, or late, we might alter how we're communicating with them based on that. So in those early stages, we don't wanna assume about a person's ability to communicate. So don't automatically start slowing things down, or talking really loud, or not telling them things, or having them engage in conversation. Those things, you know, are assumptions. And just because a person has a memory impairment doesn't mean that their intellectual abilities have declined. It just means they can't remember things as well. So we don't wanna make any assumptions about a person's abilities. We wanna include them in conversations, speak directly to them, give them time to respond and process. So don't necessarily just throw in an answer or assume a response from a person.

Give them a second to respond to and think about what you said before jumping in or assuming that they can't answer the question. In the middle stages, one-on-one communication is usually the best. You wanna speak slowly and clearly, maintain eye contact, allow for response time, again. Maybe support things with visual supports, if possible. So you might go ahead and give a direction for a person to do, maybe they're gonna fold and put away their clothes, but maybe you then wanna put out a little, you know, piece of paper that just says, "Fold your clothes and put into the basket." And that's gonna support them in remembering what to do as they perform the task.

So you're going to communicate with them clearly, but you might also supplement that with some written supports. In the late stages, you wanna approach the person from their front, identify yourself. They may not remember who you are. But tell them your name, tell them what you do there, what you're going to do. Don't come up and scare them on the side or in the back 'cause that can set off a whole other string of reactions. Treat them with respect and dignity. Of course, we wanna see that at all stages. You don't wanna talk down to the person. So talk to them and acknowledge who they are. Again, just because they have a cognitive impairment doesn't mean that they can now be treated as a child, or that they don't have something to say or contribute.

They do, maybe it's just in a different way. Try to infer the emotion of the person by the tone of their response. So again, reading some of those nonverbal things. You can tell a lot by the tone of voice that a person is using, you know, what the look on their face is. That might really tell you a lot about how they're feeling, and then you can respond to that. Verbal compensatory strategies. So we might use some of these kinds of things to help. So we might describe or spell a word that can't be recalled, or ask a clarifying question if a person isn't able to express themselves clearly. We might go ahead and ask some more questions to see if we can get some more information.

We might use things like pointing and gesturing, or I recommend that the patient themselves, you know, kind of pay attention to different facial expressions to see what they're trying to communicate. Written compensatory strategies. Writing down a word or using finger spell for a word can help somebody start to think about what they wanna say. So if they're getting stuck on being able to think of a word they wanna use, you might try to narrow the focus. So they might say that they want you to pass the salt, but they can't think of the word salt. So you might say, "Okay, let's think about what it is. What's on the table here? Is it something that we put on our food, or something that we use to eat our food?

Let's think about what sound it starts with." And then maybe trying that. And that might be helpful to help to trigger for the person the recall of the word "salt." So there are some strategies that we can help to assist. Structuring conversations and interactions to utilize questions that incorporate choice. This is a big one. You know, you wanna narrow that focus. Instead of what do you want for dinner tonight, which is a very broad question, and is requiring the person to have to kind of find that file in their brain that has dinner options listed in it, and then be able to retrieve that information and express it. That's tricky. But maybe giving just simple choices, like would you like spaghetti or pot roast for dinner tonight, is going to elicit a much simpler response.

So coming up with questions that are less broad and incorporate choice. Asking simple yes/no questions is always a good route to go with people, so they can easily answer for themselves. Using open-ended questions that allow people to share opinion. So this is a big one and I think can be such a great thing to help to engage a person in conversation. Instead of asking what you had for breakfast, which we know is probably gonna be tough to retrieve, why don't we ask, how do you feel about the food here? What's your favorite breakfast food? I love pancakes. How about you? People can give their opinions still. And you're helping to support that by asking questions in that way.

One of my favorite things to do with people is ask their advice. What would you do about this? You know, I'm thinking about, yeah, I have a party I have to go to this weekend. What should I take as a hostess gift? What are you taking to parties before? What did you appreciate people bringing to your house? Or do you think people should bring different foods to holidays if you're hosting, or would you rather just cook everything yourself? Get those kinds of questions out there. That can really help to spark memory. And remember, an opinion is something that maybe you don't agree with, but it can never really be wrong. It's your own thing. So it sparks good discussion.

But, you know, people with dementia and Alzheimer's disease might be feeling like everything they say is wrong on any given day. Let's give them the opportunity to be able to share something that, you know, their opinion is on. And then they can be able to feel good about what they're saying and feel more confident in being able to communicate with others. All right. So now we've reached part four here, so we're gonna get into patients and supporting them in activities of daily living and care planning. So I'm going to turn that back over to my great friend, Jenny.

- [Jennifer] Well, so let's talk about some keys to success. All right? I think, number one, the most important thing is to learn about who this patient is and find out their behavioral patterns. One of the best, you know, resources is to go into... Many

Alzheimer's units or locked units have specific information that's been gathered about these individuals. And some of the best facilities, they gather that information through a questionnaire that's given mainly to the family member. The family or the persons that are closest to the patient. And they ask them questions like, you know, does the patient prefer a bath or a shower? What's their favorite food? What time do they like to wake up in the morning?

Right? What time do they like to go to bed at night? So finding out behavioral patterns is really going to be beneficial for you in working with your patient. If it were my husband and Megan was gonna see my husband for some cognitive therapy, I'm gonna tell Megan, don't come to our house until after 12 o'clock noon. Because my husband, on the weekends when he's not working, he doesn't get up till noon. And at the same time, she could come late in the evening 'cause he stays up on the weekends until two in the morning. So it's important to understand those behavioral patterns to get more benefit, to get the most out of what you're doing with your patient.

So I really like a nice questionnaire. All kinds of questions about foods and, you know, like I said, tub versus shower. Don't put me in a bathtub tub when I get Alzheimer's disease because I have an aversion to taking baths. I love showers. So keep that in the back of your mind. The idea should be to give back as much control to the patient as possible. They have lost control. Oftentimes, it depends on the stage of the dementia that they're in, but by the middle stage, honestly, they are losing control fast. They don't have control over the medications they have to take, when they take their medications. Oftentimes they don't have control over the food that they eat.

It depends on if they're in a facility or not. They don't have control over the days that they get a bath, or who gives them a bath, et cetera. So we want to try, as we interact with these individuals, we wanna try to give them back, like, that feeling of control. Educate as much as possible. It's super important, for many, many reasons.

Remember, we're not in there for the long haul. We're not in there for months and months and months. We need to identify areas of need and educate every day that we are in, working with the patient. It could be educating the patient, but most likely we need to be educating the family members and the caregivers, because they're going to carry on after we are finished working with the patient.

Include the patient in decision making. Megan already talked about this and the importance of that. And once again, that gets them that sense of control. They might not be making the absolute decision with regard to their care, et cetera, or finances, but it doesn't hurt to include them in the dialogue, and include them to make them feel like they're being a part of these decisions. Praise, praise, praise. It's classical conditioning, my friends, as Megan alluded to earlier. Positive reinforcement. If you want to get further in your treatment with these individuals, you are gonna make it a positive experience for them. And don't hesitate to go back to classical conditioning. And when you see a behavior that is positive, that we wanna see happen again and again, for instance, they're using spaced retrieval technique, and we're trying to teach them to avoid going out the exit door, and you see it working, give them something positive.

And it could be, you know, a hug. It could be just a verbal reinforcement. It could be a little sweet, maybe. I had a patient that every time I would come for therapy at the house, the wife baked snickerdoodle cookies. And we each got a cookie at the end of the treatment session. She really wanted to make sure that I would be invited back by the patient, 'cause he was kind of cantankerous and not a fan of me at first. But by giving those positive reinforcements, I was invited back time and time again. Validate feelings. And Megan talked about validation, but, you know, I think the gist of this is choose your battles. And we're not going to get into arguments about what is right and what is wrong with a person who has dementia.

If my patient is just very convinced that there are squirrels living in the closet, I'm gonna validate by saying, "Oh my gosh, how does that make you feel?" Or that must be, to me, that would be funny, but, you know, maybe, does that scare you? And talk about it, validate it, but don't bother with the argument of that's impossible. There are no squirrels living in the closet. All right? Keep information simple, to the point. Ask questions that offer choices or allow the expression of opinions, obviously. And Megan had talked about that before. I mean, try to avoid those open-ended questions and just offer a choice of A or B. And that will once again go back to giving control back to the patient, making them feel like they have some control.

And let them express their opinions. You might find out a little bit more about this patient and how they think. And it's a wonderful thing to learn more, beyond the surface, about our patients and their lives. Optimize the treatment environment. Always end on a successful note. Once again, the snickerdoodle cookies. And do something that you know that the patient can do well. You know, even if you're backtracking to something that you had touched upon in earlier sessions, but you know that the patient's going to come away saying, "I did that. That felt good. I was successful." That, once again, goes a long way toward the making the patient feel successful and ensuring that you're gonna be invited back, because we're making it a positive experience for the patient.

So don't end your session with a really hard task that might, you know, elicit some frustration and anxiety in the patient. Eliminate distractions. Often, you know, in home care, I call my patient the night before, call the family member, just to verify and validate the appointment. And I always remind them, please, turn off the television before I come in. We want the environment to be nice and quiet. A lot of people have their televisions on, and they are turned up to 11, because people tend to be a little hard of hearing. But I ask everyone, please, turn off the television before I come, all right? We wanna set a comfortable mood. Get the patient to come sit in their favorite comfortable recliner chair.

Maybe, you know, have the lighting perfect for the patient so that they can see well. Have, you know, the wife bake some snickerdoodle cookies. Get a nice aroma going in the room. Have everybody looking forward to a nice relaxed atmosphere for whatever you're going to be doing with the patient. And then have this done each and every time. So baking those snickerdoodle cookies. This guy knew when he smelled the snickerdoodles that it was gonna be time for therapy. And he knew that he would be sitting at, in our case, at the kitchen table, in his chair at the kitchen table. And he was ready to go. And the consistency builds familiarity, which also adds to success in your routines and your therapy and your goals, and invites you back to this experience time and time again.

Use meaningful tools. All right? We kind of talked a little bit about that earlier. It's kind of just like Megan was talking about, these different strategies. And you'll notice we don't recommend, you know, bringing in your workbooks. You know, I am really feel very strongly that the therapy, or whatever you're doing with the patient, has to be meaningful to them in order to make any progress. All right? So putting a workbook in front of them and challenging them with word finding exercises, or challenging them to fill out a check and work on checkbook balancing activities, is that really meaningful to the patient? For someone with moderate to severe Alzheimer's disease, absolutely not, all right? And so I don't go into the room, into the home, or to the treatment environment with anything.

I use what is in the environment? Photo albums, those familiar items and pictures, things that bring joy to the patient. I oftentimes use music. You know, I had a patient who was an elder in the church, and they've really had some behavioral issues. And there was an issue with them getting to bathe and having the facility staff be able to convince the patient to get in the bathtub. And so we found that using church hymns was a fabulous way and very motivating. And she would do anything if everybody saying "Amazing Grace" for her. So tap into your creativity there. Pets are great. They really elicit and bring out responses that you wouldn't normally find. Those pets have a little magic ability in them.

And find out their hobbies or interests. I think Megan talked about the interior designer. I had a patient who was a master plumber, and although that wasn't a hobby, that was his lifelong job, there's nothing that made him more interested, more engaged than sitting down with his toolbox and some PVC pipes and some, you know, little screws, nuts, and bolts. And we could work for hours, seriously, together on tasks just using those items. So leave the workbooks behind. Come into the home equipped only with your creativity and using the items that are most meaningful and functional to the patient. You might be working with activities of daily living items, your toothbrush, your toothpaste, soap, a washcloth.

You may be working in the kitchen with sorting utensils. Physical therapists might be standing at the kitchen sink, working on balance activities while washing the dishes. Or maybe just some dance lessons, listening to favorite music. So be creative to optimize the treatment environment. We wanna use a holistic approach. So, you know, looking at the patient as a whole, not just in your silo. Your speech therapy silo, maybe, and I'm just working on language or PT silo. I'm just working on lower extremity functioning, OT silo. I'm just working on toileting. No, we all need to work together. And it's not that I'm going to overstep my boundaries and I'm gonna incorporate, I'm gonna start to plan, you know, physical therapy goals.

That's not it. I can help my physical therapy nurse, dieticians, CNA brothers and sisters out there in supporting their goals and getting their care plans in order, and I can support them with the stuff that I'm doing with the patient. So we need to all work together and look at the common goal, and look at the patient from all aspects of the body and the mind and the environment, and all those exterior things that are affecting the patient and their functioning. I'll talk a little bit about care plan development. It's important when you're developing your care plan to keep the goals realistic. I should put on that slide realistic and functional. Very important to be functional.

Keep the goals simple. You know, if they're realistic, they're likely going to be very simple. Long-term treatment is not an option. You're not in there for weeks and weeks and weeks and months. You're in there for just a few weeks to establish the foundation and a lot of education, and then you're out of there. Use the environment, as I said before, as your toolkit. Build on the patient's strengths. And remember, safety is the priority here when you're working with these individuals. Keep that at the forefront of your mind when you're building goals. Is it important that the patient learn how to balance a checkbook or read the newspaper? Bring it back to, how is what you're doing affecting their safety and their functioning in their immediate environment and keeping them safe, aging in place, and out of the hospital?

So we look at things like adequate nutrition, hydration, eliminating falls, mitigating injury due to wandering behaviors, reducing aggressive behaviors. Build an education moment into every treatment. So education should be built into the care plan. Honestly, this is what Medicare really looks for when they're looking at our treatment plans and what we've been doing with the patient in treatment and reviewing our documentation. You need to make sure that you are passing on information to the family members or the caregivers every single treatment. It should be documented thoroughly. A lot of clinicians, caregivers, give the education, but they neglect to document it. And documenting thoroughly means you're saying, "As evidenced by," in your goal writing. We'll show you some examples.

It's not just I taught this caregiver. It's I taught the caregiver, and they demonstrated knowledge, as evidenced by being able to teach it back to me 100%. Include the patient caregiver in the goal planning. As much as you possibly can, we wanna, you know, establish goals that are meaningful and purposeful to those individuals that we're working for. Goals should be measurable, attainable, and functional. Goals for dementia patients typically fall into one of three categories. When you're working with speech-language pathology, it's communication, oral intake, and cognition. Of course, if you're a physical therapist, that's going to be mobility, safety, of course. Occupational therapy might be mobility as well, balance, to participate independently in functional activities of daily living.

So these are just some examples of goal examples. Long-term goal examples. Here's just some, you know, samples for you. And these are long-term goals, all right? so these are the big, broad umbrella goals. Patient to recall and demonstrate safe use of cane to ambulate independently in the facility and reduce fall risk. Patient recall and demonstrate safe bite size while eating to reduce choking risk. Patient will recall facility room number to reduce wandering behaviors. Patient will use memory book to locate and recall personal information and routines. The next slide is about paring that down. And that's where we get more quantitative information in our goals. Patient to recall reasons for needing the cane at the beginning of three consecutive treatment sessions using the spaced retrieval technique to reduce fall risk.

So spaced retrieval, as Megan had talked about, is a wonderful modality. But it is a modality. Spaced retrieval is not the goal. It's getting the patient to recall the information and demonstrate that that information is used with a modality of spaced retrieval. Demonstrate use of smaller bite size while eating 80% of trials during meals with use of visual cue and minimal verbal queuing. Correctly recall facility room number and locate room independently during three consecutive treatment sessions using the spaced retrieval technique. Read and utilize personal memory book to recall important personal information and daily routines, 80% of trials, with minimal verbal queuing. Document the education, as mentioned before. More often than not, people don't do a very good job at this.

And it can be something like caregiver demonstrated understanding of swallow precautions as evidenced by follow through with recommendations without the need for cuing. Caregiver requires additional education regarding the importance of enforcing safe ambulation in assistive device by patient as she continues to keep the walker in the closet. So you've gotta be documenting. The education really justifies a lot of why you're in there, because we're passing on this information after we... You know, because after we exit, the patient's gonna continue to decline, and we want the caregiver to carry on with what we have taught them. So it's really important to document that it happened, and document it every single time you're in the home. All right, that was fast and furious.

I'm gonna pass it over once again to my dear friend, Megan.

- [Megan] So let's understand and manage behavior a little bit, because that tends to be one of the biggest caregiver stresses that are out there, and obviously puts the patient at risk for a lot of possible safety issues. So it's important for us to touch on some strategies there and trying to understand it a bit. So big things you wanna keep in mind when understanding and learning to manage behavior is to ask the question why. This is probably the first step that everyone should take. Ask this simple question: Why is the behavior occurring? And then try to brainstorm all the possible reasons for the behavior. So there could be a lot of things going on, and we might have to do some trial and error and some just kind of crowdsourcing and brainstorming to figure out what might be the root cause.

Are there physiologic things going on with the patient? Are there any changes in their health? Maybe all of a sudden they're starting to show some aggressive signs or increased memory loss. Maybe we need to check and make sure that they're not experiencing a UTI, a urinary tract infection. Perhaps something's going on orally with their dentures or their teeth, and that's leading to some reasons why they're spitting their food out, or choking more frequently because they're not able to chew as well. So brainstorming those things, that's usually the first place to go when trying to understand why a behavior might be happening. You wanna, first of all, you know, be able to narrow down what the behavior is and then think about these reasons.

And then use this as a checklist. Are there physiologic reasons that this might be occurring? Are there environmental triggers happening? Could we go ahead and take care of some of those issues we mentioned in prior slides? Working with understimulation or overstimulation. Removing things like clutter. Removing distractions that might be inhibiting the person from being able to hear well or understand what people are saying. Maybe glasses, maybe hearing changes. Maybe we have to get hearing aids. What's happening there? So maybe changes to the environment. Lighting can be a big one, everyone. So remembering that the aging eye has changes in how it can process visual information. So on top of things like macular degeneration and glaucoma, things like that, the eye is changing just like the rest of the body is.

So maybe people can't see as well. So again, we might have to make some alterations to the lighting in the environment so they can see the food that's in front of them, that they're able to see the faces better of who's caring for them. So there might be some simple changes there that can help to reduce a behavior that might be coming up. A lack of meaningful engagement. Like we said, if people aren't really engaged in interesting things to them, they might start to consider other things that they might be doing. So if people are bored, think of those bored teenagers, right? When they have nothing to do, they go out and get themselves into a little bit of trouble sometimes.

So it could be the same thing. We're people. If you don't have anything interesting on your mind, you might overthink. You might start to fixate on, why did this happen? Why did this person say that? Or you might go looking for something to do. The more we can give people interesting and engaging things to do throughout their day, the more likely it is they're gonna have a more full life and be able to, you know, really not focus on some of those negatives, possibly. So giving people interesting things to do and options is a great way to work on possibly reducing some behaviors. Is it a personal need? So maybe the person is seeking attention. Maybe they're seeking social contact, maybe reassurance.

So they might ask the same questions over and over again so that someone comes in and talks to them. They might hit their call button over and over again, not because they actually have a need, but because they just want someone to visit with them. So it could be possible that we could provide that stimulation at times when the behavior isn't being exhibited and start to reduce that behavior actually being seen. So there might be other reasons going on, and again, you might have to try out different things here. One size doesn't fit all. There might might not be one answer for every kind of behavior. You might see trends, you know, between people, and you might say, "Oh, this worked for this other person when they asked this question.

Let's try that first. Or let's use some of the environmental changes first and see if that fixes things before we come up with a bigger plan." Those are completely normal and actually recommended things to do. But, you know, you might have to go back to the drawing board a few times. But just don't give up; you might be able to figure things out. Also figuring out who owns the problem. Is this a them problem or an us problem? So it might be that the person is dressing in clothes that are not appropriate for the season. Is that a real problem if they're still able to get themselves dressed, right? Maybe we can environmentally switch up how their clothes are arranged, or what's available to them in their rooms, so that they have a better chance of choosing the right items to wear.

But, you know, we have to look at like, is it a real problem for the person, or is it more of a problem that's making it difficult to manage their care? We can meet in the middle somewhere there. I always recommend doing this first, too, is asking the person directly. The person who might be exhibiting the behavior might give you an answer that's a little in left field, but it's gonna be, you know, interesting to hear. Jenny mentioned about hallucinations people might have. I had a patient who really thought there were spiders on their wall. And, you know, people thought, "Oh, they're hallucinating. They clearly aren't seeing things clearly. Maybe they need some type of medication.

" But then the staff started to think, "Well, let's make some changes to the environment." And they were gonna jump to that conclusion, but the staff then said, "Well, wait a minute. Let's ask the patient first. Like, what's going on?" And so the patient actually said, "There's spiders on my wall. Look." And it was at a certain time of day where the way the light was coming in through the blinds in their room, it looked like there was some movement on their wall. So that allowed them to really understand that they could just change, you know, close the blinds more thoroughly or change where the bed was in the room, and just that change helped the person to feel better and not see those things.

So asking the person directly what they're seeing, why they're feeling the way they are, that might open up some understanding and be able to allow you as staff and family members to come up with a solution that really helps manage the issue directly. We wanna maximize remaining abilities to overcome challenges and develop appropriate interventions. So again, think about how we want to really think about what remains and how we can use that information to be able to help people to deal with some of these challenges. So find those individual strengths and build on them. Another way to kind of understand what might be happening with a patient is observing them. Figuring out if there's certain triggers to times of day when something might happen.

So it doesn't mean you have to sit for 30 minutes and watch a patient. But you might have staff at different times during the day when a particular behavior arises to look at what was happening before. What's going on with the person beforehand and tracking that, you might be able to see some trends that will change things. I remember having a patient who would really get distracted by coming down to meals too soon. When she was left at the table with perhaps a couple of other residents with nothing in front of her, after she had been told she was gonna come down and eat, but then had to wait 25 minutes for her tray, she would start to act out.

And I would too. You told me there was gonna be food. Where is it? So maybe it's better for that patient to not be brought down immediately to the meal, maybe sooner to the meal, or to be able to give something for her to engage with at the table. Being able to look at family pictures, or engage in conversation with maybe some conversation starters or something with the people at her table. That was able to engage her brain in a different way so that she wouldn't get quite as aggressive, wondering where her food was. Asking family and staff about different things that might occur, or the person's personal preferences and how that might impact why a behavior is occurring.

Providing opportunities for the person to engage in activities and have different roles. So sometimes if a person can feel like they're part of a community, that's going to make them feel more just attached and engaged to where they are. So being able to be in charge of something. And perhaps maybe that was how they were in their life. So they could maybe be assistive in passing things out to the residents, or assisting others with activities. Or even at home, being able to put away the silverware. Or being able to clip the coupons. Something like that where they can feel like they have a role. That might really change how a person feels, because as we mentioned earlier, that lack of control can be a real reason why people act out sometimes.

Coping strategies. So we wanna monitor the patient's personal comfort. We wanna avoid confrontation when the person is displaying a behavior. Respond to the emotion being conveyed, not the behavior. And this is so huge. We've mentioned it earlier, but look at what's behind what they're doing, why they might be acting out. Are they scared? Are they fearing for their safety because they don't know who's taking them to take a bath? Maybe the caregiver needs to have their name tag on, describe who they are, discuss a little bit more about, you know, how they might connect on liking a certain thing that the patient likes. Getting them comfortable before being able to put them in a situation where the patient might feel really vulnerable.

Looking at why the patient might be saying or doing what they're doing and responding to that emotion, maybe not necessarily what the behavior is. Allowing rest between stimulating events. So we don't want people to be back to back to back and doing things. I think after, you know, a lunch or a meal or something, it might be good for them to have some time to be able to just kind of come down from that overstimulation. It doesn't mean that they have to go to sleep, but maybe people want a little bit of silence, or maybe to not be around a lot of people. So giving that rest between things and trying not to take behaviors personally.

Know that behavior is a form of communication. Typically when those things are happening in, you know, in the presence of other people, it's because a person is trying to express themselves, but they don't necessarily have the words or ability to share what that emotion is or what they need. So it's important to not take that personally and understand that it's a communicative behavior happening. It's telling us something about how that person feels or what they need. And responding to that versus taking that personally. Okay? So one of the big, you know, behaviors we might see in persons who have dementia or Alzheimer's is asking that same question over and over again. I wanna go home. Where's my family?

When's dinner? All of that. So we might wanna start by doing that exact thing we mentioned a few slides ago, which is asking why. Why are they asking this question over and over again? Then start brainstorming the possible answers, right? So we might, again, ask the person directly. You know, what? What are you nervous about? Why are you waiting for them? Are you hungry right now? Trying to get to the bottom of that. Sometimes it might be because they're seeking the attention that comes with asking the question. Think about it. The more times you ask the question, eventually someone's gonna come over and help you and give you the answer, right? So they might be learning that the more they ask it, the more they're going to get some kind of interaction with someone.

They also might just wanna straight know when the meal is. And that would be my main reason for asking that question. I wanna know when I'm going to eat. So you might be asking that question to discover or find out information. So in terms of repetitive question asking, the root of the problem might be because a person is seeking attention, or they might be seeking information. Easiest way to know the answer to that question is to ask the person themselves. Well, what time do you think we eat? If they're able to answer with the correct time, then they're likely seeking attention for that by asking that question. But if you ask, "What time is lunch?" If they're asking all the time what time do we eat, or what time is lunch, and you say, "Well, what time do you think lunch is?

" and they say, "I don't know, that's why I'm asking you." that's telling you that they're seeking information. So then we might want to maybe write down the meal times and attach them to their walker and teach them to look at the cards on their walker to find the mealtime. So we're giving them a way to access that information more independently. So you wanna try some things out when people might be asking the same question over and over again and think about what the root cause might be. Again, expect that things might not work out eventually, or initially with people. You have to try some things out. And trial and error is okay. Going back to the drawing board can be sometimes frustrating, but eventually you'll probably figure out what the best means is to help this person with the behavior be able to express it in a more safe and communicative way.

This is a great link to understanding behaviors that I wanted to provide from the Alzheimer's Association. So you can snap a pic of this and go to this link, and it will give you some nice ideas about how to look at different behaviors persons with dementia might exhibit and some possible ways to manage those or to brainstorm about them. So please check out this resource for more information on understanding behavior. Oops, I skipped ahead too far there. Let's go back. All right, final stretch here. We're gonna get into Counseling, Educating, & Supporting Families.

- [Jennifer] So for the family, my mantra is start from day one. All right? The moment that I walk into the home or meet with family members, I am going to start educating and counseling the families. You know, I'm not a certified counselor, but all clinicians, we learn about counseling, we learn about family interactions, how to identify issues and work with these individuals. So I start immediately, from the first day that I walk into the home or meet the family, in starting to kind of peel the onion and find out what are the needs of the family members. They are just as important as the individual, the patient, that has the dementia. And, you know, they're going to have to live with this.

You know, once we walk out the door, down the line, when we are discharging them, or we're finished with our treatment plan, they're gonna have to continue on. So we wanna make sure that they've got the tools and resources to continue to deal with this terminal illness. Give the family members a little time. So it may take some time for things to sink in. And I'm gonna talk about the, very briefly, the stages of grief. But sometimes it just takes repetitive information over periods of time for them to finally get that aha moment and come to realization of what the reality is. I always keep information very simple, and I have it always in writing. I think family members, they're extremely overwhelmed.

And so if I give a lot of technical information, or a lot of information in general, I also am able to hand it to them in a document or a brochure or a, you know, handout so that they can refer back to it later. They can share it with other family members. But all the information is usually just bulleted. Not, you know, big, long paragraphs. Just very bulleted, simple information. I'll give it more time. You know, I said that previously, but we've gotta allow time. And this really means allow time in your treatment session. Allow for there to be time to spend with family members. So I build that into my treatment session. I always make sure that I have at least 10 to 15 minutes to spend to talk to the caregiver or the family member.

You may discover in that conversation, maybe it's just a little simple conversation, but you might discover signs of caregiver burnout. You know, a caregiver might tell you, "I'm just exhausted. You know, my husband's not sleeping at night anymore." And that will, you know, hopefully trigger in your mind some interventions that you need to put into place in the future. I'm always realistic. This is a really delicate dance. You don't want to squash hopes and dreams. You don't want to, you know, blow out the flicker of flame for hope in the future, but you don't wanna sugarcoat it, either. And I often find, as difficult as it is to give the realistic, kind of down and dirty information about what's to come, the more appreciative the family members are.

So I really try to be extremely realistic and honest and transparent with what's happening with the patient and where we're looking in the future. I always encourage, from day one, the family members to come up with an alternate plan, particularly if they're living at home. And I, you know, try to, of course, in my treatment plan and working with the team, we try to do everything we can to put things into place to make sure that patient's safe, that the caregiver is safe. But, you know, realistically, this is a terminal illness, and preparing for the future may be to have a discussion about hospice, or it may be to have a discussion about alternate placement for the patient.

That also takes time sometimes to sink in as well. Research and educate on local support groups. There's tons of great support groups out there, and the Alzheimer's website is a great place to start. And if you can plug that family member into going to a support group, that can do wonders, not just for caring for the individual, but also for after the individual passes. A lot of people continue with their support group family that they've built, and they lean on them during the grief period as well. So that's another great resource to give family members. For the patient, we've said this before, this is not new information, but always try to include the patient in the conversation as much as possible.

Never assume, as Megan had talked about, emphasized in slides backwards. Just don't ever assume that they don't understand what's going on. And always speaking to them, with them with respect. And a lot of times I've had to pull family members away to have little separate conversations because, and helping the family understand that, you know, your loved one may still understand what you're saying. So when you, you know, lose your temper, when you speak above them, over their heads, that might not be making them feel good. And so I try to identify that also for the loved ones as well. Choose the appropriate time for discussions. You know, there's times that are appropriate, and times that are very inappropriate.

The patient's really super tired. They didn't get a lot of sleep the night before. Or they're agitated, angry. You might not wanna have a little sit-down to talk and educate. So use your best discretion for that. Grief needs to happen, not just for the family member, but for the patient as well. Particularly in the early stages of dementia, they're going to be going through the stages of grief as well. It's important to identify and understand that. Don't force through denial the patient, or for the family member as well. I should put that on the previous slide. But a lot of times family members have a denial going on. And I don't force it, and I don't force it for the patient.

Like I said, it's a delicate dance. You don't wanna squash hopes and dreams. It's likely just denial that's coming through. I just validate, and I just give little, tiny pieces of reality a little bit at a time. They can choose to take it, or they can choose to not take it. But it's important that you do give the reality conversations, both to the patient and to the family member. Choose your battles wisely. You know what, we should not be arguing with a patient, and we need to teach our family members the same thing. It just doesn't do any good to argue with the patient that, you know, no, you know, my mother, your wife, died three years ago.

When are you gonna get that through your head? Well, they're not. They have dementia. So choose battles wisely. And for me, it's a no battle zone when I'm working with the patients. Just briefly, most everyone in the caregiver profession is familiar with the five stages of grief: denial, anger, bargaining, depression, and acceptance. This is the Kubler-Ross model. So most of us are familiar with it, but I really like to share this with family members as well, because a lot of our, you know, lay people are not familiar with the five stages of grief. And I find when I share this with them, it helps validate what they're going through. It gives them a sense of calmness and understanding and ah, and I'm not going crazy.

And so I, you know, frequently I have little handouts I give to my family members when we start talking about, you know, what they're going through, how are you feeling, et cetera, and maybe identifying where they are. And let them understand you may not reach, you may not hit all of these stages in successive order. You may skip a stage or two. But it's perfectly normal to go through this. And it makes them feel, oh, almost a sense of normalcy in the crazy world of having to deal with a loved one that has dementia. All right. Whew. That was a lot of information, wasn't it? But we're really hoping that it was beneficial to you. And go back to that very first question that we, one of the first questions we offered you.

Like, what's your role? I hope now you clearly see that your role is extremely important in working with this population of people. The Alzheimer's and dementia is not going away. It's becoming more prevalent. Your impact can keep patients safe, aging in place, mitigate the risk of rehospitalizations. You're going to be saving precious, precious, dwindling Medicare dollars in the future by what you're doing. And honestly, this quote is so wonderful, and I owe kudos to Megan for finding it. "The simple act of caring is heroic." So just having a desire to step forward and step into the world of dementia care is a very heroic act because there's not many people out there who are brave enough to make an effort, to take care of these individuals and their loved ones.

So thank you so much for joining Megan and I today. Thanks for all you do. And looking forward to future presentations. Thank you.