

Alzheimer's disease / Dementia Module



“Changing our minds about people whose minds have changed.” –G. Allen Power

Table of Contents

| | |
|--|------------|
| About this Module/Overview/Objectives..... | Page 3 |
| Chapter 1..... | Page 4-9 |
| Normal versus Abnormal | |
| Unmet Needs | |
| Person Centered-Care | |
| Care Planning | |
| Regulatory implications | |
| Chapter 2..... | Page 9-13 |
| Screening Tools | |
| Assessment | |
| Family/Caregiver Assessment | |
| Assessing for burnout | |
| Support | |
| Engagement | |
| Abuse, Neglect, Exploitation | |
| Safety | |
| Dangers of AP Medications | |
| Chapter 3..... | Page 13-15 |
| CMS Hand in Hand Training | |
| University of Iowa | |
| Music & Memory | |
| Chapter 4..... | Page 15-25 |
| Resources | |
| Pioneer Network | |
| Videos | |
| Alive Inside | |
| Still Alice | |
| Glen Campbell | |
| Alzheimer's Association | |
| Person-Centered Thinking / Care | |
| Eden Alternative | |
| Virtual Dementia Tours (VDT) | |
| Certified Trainer; Attending a Certified Training | |
| National Council of Certified Dementia Practitioners (NCCDP) | |
| What is it; How to get the training; Become a trainer | |
| DADS Joint Training Academy | |
| VN and primary employer access | |
| Request joint trainings to be presented to VN students | |
| Case Studies | |

About this Module:

Dementia is an ‘umbrella’ term for a wide range of symptoms associated with a decline in mental ability severe enough to interfere with daily life. The most common type of dementia is Alzheimer’s dementia, accounting for 60-80% of cases. Vascular dementia, which generally occurs after a stroke, is the second most common type. The Alzheimer’s Association noted in its 2017 Alzheimer’s Disease Facts and Figures report¹ that 1 in 10 Americans aged 65 and older has Alzheimer’s dementia. As the size and proportion of the U.S. population aged 65 and older increases each year, so does the number of Americans who will likely be diagnosed with Alzheimer’s dementia. This module was developed to provide the LVN student with additional information related to the disease process as well as the resources that are available to care for individuals and their families.

Overview:

Medicare data shows that one-third of all seniors who die in a given year have been diagnosed with Alzheimer’s dementia or another type of dementia². In Texas alone, the number of deaths due to Alzheimer’s dementia is 6,772 (per 100,000) according to 2014 data. These deaths are not always the result of the disease process, but are also caused by the inappropriate usage of antipsychotic medications in these individuals to control “undesirable behaviors”. Individuals with Alzheimer’s dementia or other dementia related conditions are often the most vulnerable and are at risk for receiving substandard care and/or being victims of Abuse, Neglect, and Exploitation (ANE). Because Alzheimer’s dementia is incurable, it is important that those individuals affected by the disease receive the highest quality of care possible.

Objectives:

The objectives for this module include:

- a. Define dementia and Alzheimer’s disease
- b. Describe the progression of the disease
- c. Discuss positive ways of interacting with residents with Alzheimer’s disease or another dementia
- d. List non-pharmacological interventions used to treat challenging behaviors

¹ Alzheimer’s Association. 2017 Alzheimer’s Disease Facts and Figures. https://www.alz.org/documents_custom/2017-facts-and-figures.pdf

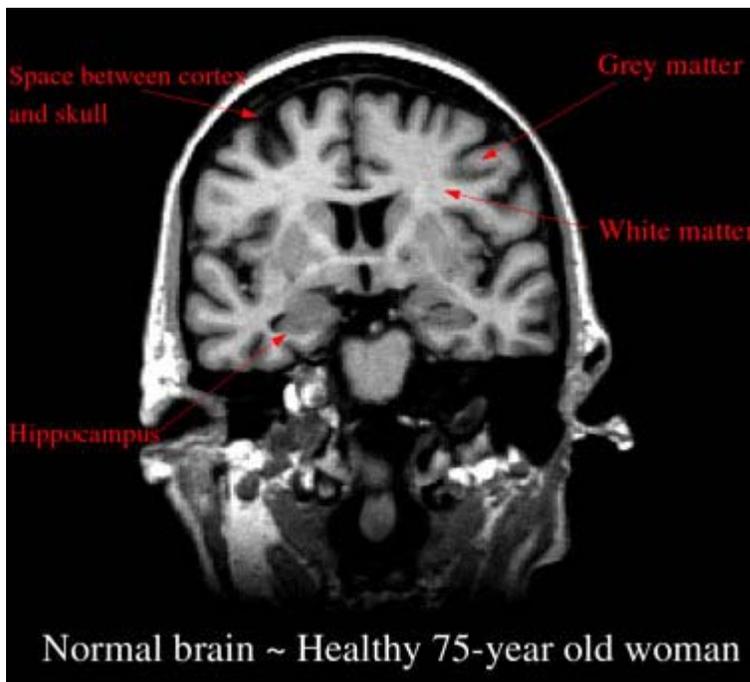
² Alzheimer’s Association. What is Dementia? <http://www.alz.org/what-is-dementia.asp>

Chapter 1:

Normal versus Abnormal³:

As individuals age, there are gradual changes that the LVN should understand may take place. Some changes in the ability to think are considered a normal part of the aging process. Most healthy older adults experience mild decline in some areas of cognition; changes may occur in the areas of visual and verbal memory, visuospatial abilities, immediate memory or the ability to name objects. Research indicates that age-related changes in the brain such as decreased hippocampal, frontal and temporal lobe volumes can occur. However, the extent to which these age-related changes contribute to cognitive decline has yet to be determined. Non-verbal memory impairments are also considered to be a common cognitive deficit associated with aging. Control and maintenance of attention and immediate memory can be affected in normally aging individuals.

With normal aging, language abilities such as vocabulary and verbal reasoning remain unchanged or may even improve. However, the ability to generate words declines more quickly than the ability to name objects. Below is an image of a normal brain:



In the normal brain image, note how both sides of the brain look symmetrical to each other. There is no discernible atrophy as there is very little space between the cortex and skull. No visible indication of significant atrophy in the hippocampi, which are thought to be responsible for consolidating memory.

³ University of California, San Francisco. Brain 101: Topics in Neuroscience. <http://memory.ucsf.edu/brain/aging/overview>.

Dementia, however, is not normal aging. It is an abnormal process that is characterized by multiple cognitive deficits with memory impairments as a frequent early symptom. These cognitive deficits include:

1. Executive functioning
2. Language
3. Working (immediate) memory
4. Spatial memory
5. Verbal memory



Here is another view of how massive cell loss changes the whole brain in advanced Alzheimer's disease. This slide shows a crosswise "slice" through the middle of the brain between the ears.

In the Alzheimer's brain:

- The **cortex shrivels up**, damaging areas involved in thinking, planning and remembering.
- Shrinkage is especially severe in the **hippocampus**, an area of the cortex that plays a key role in formation of new memories.
- **Ventricles** (fluid-filled spaces within the brain) grow larger.

In the brain that is affected by dementia, it is easy to see the changes from that of the healthy brain.

Generally, there must be impairment in social functioning and independent living for a diagnosis of dementia to be given. Independent living describes one's ability to shop alone, manage finances, perform basic household duties and monitor appropriate social behaviors. Issues with independent living often lead caregivers and families to look at placing their loved-one in a long-term care facility (nursing facility). With current residents who may not have a dementia diagnosis, it is often difficult to determine exactly when to be concerned with the cognitive changes that he/she may be experiencing. Symptoms vary from person to person, so what is normal for one resident, may not be normal for another. It is imperative that the LVN knows the baseline functional abilities of all their residents. This contributes to the challenges clinicians may face when determining whether or not cognitive decline is due to a physiological or psychological (excessive worry, depression, anxiety, etc.) condition. Some symptoms that the LVN should be aware of and watch for include:

- a. Getting lost in familiar places
- b. Repetitive questioning
- c. Odd or inappropriate behaviors
- d. Forgetfulness of recent events

- e. Repeated falls or loss of balance
- f. Personality changes
- g. Decline in planning and organization
- h. Changes in diet/eating habits
- i. Changes in hygiene
- j. Increased apathy
- k. Changes in language abilities, including comprehension

The progression of cognitive deficits observed in conditions such as Alzheimer's disease may be accelerated in the few years immediately preceding the diagnosis or may not occur until events, like a stroke, reach a threshold where the brain can no longer compensate for damage. Thus, it is important that individuals receive regular medical check-ups in order to monitor the extent and severity to which one may be experiencing cognitive decline.

Unmet Needs:

Individuals with dementia often experience unmet needs such as pain, hunger, boredom, and toileting. Pain is the most common unmet need experienced by individuals with dementia.

Pain frequently leads to behavioral issues, as these individuals are unable to express the pain that they experience. Pain is often underdiagnosed in individuals with dementia and warrants a high degree of suspicion when behavior changes are exhibited. Due to deficits in language and cognition that occur with dementia, an individual with dementia may have a reduced ability to express pain normally. Pain is likely to manifest itself as a behavioral expression, but can also lead to sleep disturbances, decreased socialization, malnutrition, impaired immune function, and impaired ambulation just to name a few. It is often necessary to observe the body language of individuals with dementia, noting other nonverbal cues, such as resistance to care, striking out, or other aggressive expressions during care that may result from pain.

Successful pain management programs include processes for completing comprehensive pain assessments, along with re-evaluations to determine the treatment's effectiveness. Standardized, evidence-based assessment tools are an important component of any pain management program. A variety of valid and reliable assessment tools are available, including tools developed specifically for evaluating individuals with dementia or other cognitive impairments. Assessing for pain in individuals with dementia can often times be very difficult due to the loss of ability to communicate. Individuals who are in the beginning stages of dementia may be able to accurately report their pain level, by using one of several self-reporting scales, such as the Numerical Rating Scale and the Faces Pain Scale (FPS). In those individuals who are in the more advanced stages of dementia, the Pain Assessment in Advanced Dementia Scale (PAINAD) is recommended. The Behavioral Pain Assessment Scale can also be used for an individual who may not be able to communicate effectively. A comprehensive pain assessment should be completed on admission, quarterly thereafter and whenever there are changes in the resident's condition. The comprehensive pain assessment serves as the baseline from which care planning will be initiated and measurable goals established.

A number of validated pain assessment scales are available; examples of the different pain assessment scales can be accessed at the following links

Numerical Rating Scale:

<http://www.geriatricpain.org>

Faces Pain Scale (FPS):

<http://www.geriatricpain.org>

Pain Assessment in Advanced Dementia Scale (PAINAD):

Instructions:

<http://www.geriatricpain.org>

PAINAD Form:

<http://www.geriatricpain.org>

Behavioral Pain Assessment Scale:

<http://www.icudelirium.org/pain.html>

For additional resources related to pain management in those with dementia, you can visit:

a. http://www.leadingage.org/How_to_Assess_Reduce_and_Manage_Pain.aspx.

b. <http://www.tmfqin.org/Resource-Center>.

Person-Centered Care:

Person-centered care promotes choice, purpose and meaning in daily life. Person-centered care means that an individual, regardless of where or how they are receiving their care, is supported in achieving the level of physical, mental and psychosocial well-being that is individually practicable. This goal honors the importance of keeping the person at the center of the care planning and decision-making process. Care plans are living documents that are revised to reflect a person's changing needs. In person-centered care, the LVN must place a premium on active listening and observing, so that he/she can adapt to each resident's changing needs regardless of cognitive abilities.

The Person-Centered approach sees the person with dementia as an individual, rather than focusing on their illness or on abilities they may have lost. Instead of treating the person as a collection of symptoms and behaviors to be controlled, person-centered care considers the whole person, taking into account each individual's unique qualities, abilities, interests, preferences and needs. Person-centered care also means treating residents with dementia with dignity and respect.

The goal of Person-Centered Care is a normal life. In order to achieve this goal, LVNs must understand that the facility needs to adjust to the care and routines of the resident, instead of the other way around. For example, when a person moves into a nursing home, typically she is given the waking time, bathing slot, and dining room seating of the person whose death freed up a bed. Typical "toileting" in an institutional environment occurs on a schedule applied to everyone,

such as “toileting every two hours.” In a changed, person-centered culture, the person who has just moved in is asked about her life-long patterns and the nursing home adapts its schedule of services to support their continuation. She and her family are asked about her customary routines for getting up and going to bed, eating meals, engaging in life activities, what helps her thrive. This is important even for someone who is only planning a short-stay in a nursing home. Maintaining normal routines will ensure an increase in the quality of care and life for these individuals. It is imperative that LVNs are taught the concept of person-centered care, as much of the care being provided to individuals in healthcare now is aligning with this concept.

Care Planning:

Federal regulations require that care plans are in place for all individuals residing in a nursing facility. LVNs are taught about the importance of these care plans while in school, however, when caring for someone diagnosed with dementia, these care plans become even more important. It is not enough to simply have a care plan; the care plan must be person-centered and based on the most current comprehensive assessment. While the LVN is not responsible for completing the comprehensive assessment or developing the care plan, he/she is responsible for ensuring that the care plan is implemented for each and every resident. The LVN should have the knowledge of the elements of a person-centered care plan, to ensure that the care plans that he/she is implementing follow the concept of being person-centered.

A person-centered care plan focuses on what is important to the resident now and in the future, with information from the resident’s family and friends as requested by the resident. A person-centered care plan is a means of treating the resident with dignity and respect. A person-centered care plan:

- a. Seeks to eliminate the assembly line approach to care and embrace a philosophy of residents as individuals.
- b. Seeks to improve quality of care and quality of life for residents and leading to a more satisfied life.
- c. Gives residents choices and decision making capabilities.
- d. Requires an alteration in work routines to accommodate resident preferences.
- e. Requires staff to have relevant knowledge and decision-making authority

The person-centered planning process requires several steps in order to be successful. They include:

- a. Preparation: Understanding the resident and their situation, gathering information, encouraging others who know the person to contribute their perceptions and ideas.
- b. Pre-planning: Working with the person/guardian to review information, set priorities, determine an agenda, and invite people to join in the planning process.
- c. Action Planning: Identifying needs and desires and developing action steps to accomplish goals. Action planning is often done in a team meeting. Action planning can also be done through a series of conversations with different people.
- d. Quality Assurance: Making sure the documentation meets standards and requirements.
- e. Implementation and Monitoring: Following through on action steps, checking progress, and revising the plan as necessary.

The LVN should be knowledgeable regarding all of the aspects of person-centered care planning; not only to ensure that the current care plans are geared towards what the resident wants but also to be able to inform the RN if there is any area of the care plan that doesn't meet the person-centered care approach. The LVN should also have the knowledge and understanding of the regulatory requirements of having a care plan for each resident as well as the implementation of each resident's care plan. F-Tag 279 details the federal requirements that the interdisciplinary team must develop, review, and revise the resident's plan of care. The care plan must include measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. This requirement also requires that an interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. Anytime that this is not completed, the facility may be cited for a deficient practice, making this an important component of the care provided to all residents in a nursing facility, and even more importantly, those diagnosed with dementia who are unable to easily make their needs known to the care staff.

Chapter 2:

Screening Tools⁴: (The LVN is not responsible for performing these screening tests/tools, but should be knowledgeable about them and understand the information that is received from them).

Dementia is very prevalent among older adults, but is often overlooked even by those with the skills to detect it. Clues to the presence of dementia may be subtle and nonspecific. Unrecognized dementia can lead to a whole host of problems that ultimately result in poor outcomes for the individual with the disease. The LVN must be aware of the tools available to teach staff to recognize dementia; recognition is a key step toward improving the care provided. The facility in which the LVN works may have a standardized tool, and may have policies and procedures that require the LVN to use only that specific tool. If the facility's policy permits, these two tools may be used to help the LVN identify signs/symptoms of dementia that may need to be reported to the physician. They include:

- a. Alzheimer's Association Ten Warning Signs (Appendix A)
- b. Resident Behavior Triggers for Clinical Staff (Appendix B)

While the LVN may not necessarily be charged with performing any specific assessments to determine dementia in a resident without a current diagnosis, there are signs and symptoms that he/she should be on the lookout for while caring for the residents.

⁴ Alzheimer's Association. Tools for Early Identification, Assessment, and Treatment for People with Alzheimer's Disease and Dementia. https://www.alz.org/national/documents/brochure_toolsforidassesstreat.pdf.

The LVN should also have some knowledge about the different cognition screening tools/tests that may be used by the physician in an attempt to make a definitive diagnosis. These different tools/tests include⁵:

1. Abbreviated Mental Test Score (Appendix C): A 10-item scale that takes approximately 3-4 minutes to complete. This test assesses orientation, registration, recall and concentration, and scores of 6 or below have been shown to screen effectively for dementia. In this screening tool, a low positive score means that there should be a second-stage assessment.
2. Clock drawing (Appendix D): In this screening test, individuals are asked to draw a clock face with numbers and hands (indicating a dictated time). It was designed as a quick and acceptable screening test for dementia. It is fast, requires no training and most scoring methods are fairly simple. It shows fairly good sensitivity and specificity as a screening test. It assesses only a very narrow part of cognitive dysfunction seen in dementia, and many other conditions (e.g. stroke) will affect it directly.
3. Mini-Cog (Appendix E): A very short test (3 min) suitable for primary care screening for dementia. It incorporates the clock-drawing test, adding a three-item delayed word recall task. It showed comparable sensitivity and specificity to the Mini-Mental State Examination (MMSE) in classifying community cases of dementia.
4. Mini-Mental State Examination (MMSE) (Appendix F): The best known and most widely used measure of cognition in clinical practice worldwide. This scale can be easily administered by clinicians or researchers with minimal training, takes around 10 min and assesses cognitive function in the areas of orientation, memory, attention and calculation, language and visual construction. Patients score between 0 and 30 points, and cutoffs of 23/24 have typically been used to show significant cognitive impairment. This is a screening test and not a diagnostic test.

As mentioned, the LVN may not be in a position to use any of these screening tools/tests; however, he/she should be familiar with them.

Assessment:

It is estimated that there are more than 15 million unpaid caregivers in America. A diagnosis of dementia not only affects the patient, it also affects the family and care givers. Often times so much attention is paid to the individual diagnosed with dementia that family members and other care givers do not receive the attention that they need. The family is critical to the quality of life that of the individual with the disease. There are many issues that family and/or caregivers experience, such as social isolation, physical ill-health, financial hardship, burnout, increased levels of stress, depression, and many others.

1. Family/Caregiver Assessment: In the long-term care setting, the LVN may not necessarily interact with many family/caregivers that are actively providing care to someone with dementia, as many of them may be residents of the facility. However, the LVN should recognize that even though the individual may not actively take care of the resident in their home, they may experience some of the same issues as those who still actively provide the care. On the other hand, the LVN may be faced with family/caregivers that do provide the

⁵ Sheehan, B. (2012). Assessment scales in dementia
<http://doi.org/10.1177/1756285612455733>.

care for the individual, but opt to place him/her in the facility for the purposes of respite care, from time to time. For these individuals, it is imperative that the LVN be knowledgeable of the signs of issues that may arise with the caregiver, and be able to recommend resources that will provide additional support to the family/caregiver. There are some caregiver self-assessments that the LVN may direct the individual toward, in an effort to assist him/her.

- a. Assessing for burnout: The LVN should know and be aware of some of the signs and symptoms of caregiver burnout, in order to be able to provide the individual with assistance. Not everyone will exhibit the same signs and symptoms, so it is important that the LVN build a rapport with the individual. Some signs and symptoms of caregiver burnout include (but are not limited to):
 - i. Denial: about the disease and its effect on the person who has been diagnosed.
 - ii. Anger: at the person with Alzheimer's, anger that no cure exists or anger that people don't understand what's happening.
 - iii. Social withdrawal: from friends and activities that once brought pleasure.
 - iv. Anxiety: about the future.
 - v. Depression: that begins to break your spirit and affects your ability to cope.
 - vi. Exhaustion: that makes it nearly impossible to complete necessary daily tasks.
 - vii. Sleeplessness: caused by a never-ending list of concerns.
 - viii. Irritability: that leads to moodiness and triggers negative responses and actions.
 - ix. Lack of concentration: that makes it difficult to perform familiar tasks.
 - x. Health problems: those that begin to take a mental and physical toll.

In the event that an LVN notices these signs/symptoms present in a caregiver, he/she should talk with the individual, provide them with available resources and encourage them to see their doctor. Additionally, the Alzheimer's Association offers a caregiver stress check self-assessment that a caregiver could take to determine if they feel overwhelmed or are putting their own health at risk. The LVN may suggest to a caregiver who is exhibiting signs/symptoms of burnout or stress that he/she take the assessment. This self-assessment can be accessed from the following link:

<https://www.alz.org/care/alzheimers-dementia-stress-check.asp>.

- b. Support: There are many different support resources available for the family and caregivers of individuals who have been diagnosed with dementia. The LVN should be familiar with the available resources, and be able to provide assistance to anyone who might need it. The Alzheimer's Association has an entire section dedicated to information that can be provided to or accessed by the family member/caregiver. The Alzheimer's Associations Alzheimer's and Dementia Caregiver Center can be accessed at: <https://www.alz.org/care/alzheimers-dementia-support-help.asp>
- c. Engagement: It is imperative that the LVN understands the importance of engaging the family members/loved ones of a resident with dementia. The family/loved ones generally possess the knowledge about the resident that can be very crucial to the care that is provided. The family/loved ones are an important source of support for the facility, to provide information about the resident's likes, dislikes, favorite items (clothes, music, foods, etc.) that they will enjoy, his/her daily routine, and many other facts about the resident that the staff may not know and that the resident may no longer be able to tell anyone. The LVN should take advantage of the resources and information that the

family/loved ones are able to bring, as these will enhance the resident's quality of life and quality of care.

2. Abuse, Neglect, Exploitation (ANE): Every year, an estimated 4 million older Americans are victims of physical, psychological or other forms of abuse and neglect. Those statistics may not tell the whole story; for every case of elder abuse and neglect reported to authorities, experts estimate as many as 23 million cases go undetected. The quality of life of older individuals who experience abuse is severely jeopardized; they often experience worsened functional and financial status, as well as progressive dependency, poor self-rated health, feelings of helplessness and loneliness and increased psychological distress. Research also suggests that older people who have been abused tend to die earlier than those who have not been abused, even in the absence of chronic conditions or life-threatening disease. Like other forms of abuse, elder abuse is a complex problem, and it is easy for people to have misconceptions about it. Elders with dementia are thought to be at greater risk of abuse and neglect than those of the general elderly population. The LVN must be aware of the factors that place a resident with dementia at a higher risk for being a victim of ANE. These include (but are not limited to):
 - a. Gender: women are more likely than men to be victims of ANE
 - b. Age: older adults are at higher risk, with the average age being older than 78
 - c. Functional capacity: individuals who are immobile or have significant decline in their physical functioning are often at a higher risk of being victims.
 - d. Mental capacity: older adults who have a diagnosis of dementia or any other condition that inhibits one's mental capacity are also at higher risk of being victims

Elder abuse occurs for a variety of reasons, and there are no definitive factors that explain all elder mistreatment. If you can identify risk factors, you'll be more likely to spot and prevent abuse. Nursing staff should be constantly working to prevent instances of ANE before they happen. ANE is however sometimes difficult to prevent, as the victim may not easily report or acknowledge the incidence of ANE. In order to prevent ANE, nursing staff need to:

- a. Recognize: Nurses must be able to recognize the signs and symptoms of abuse and believe that they can report allegations to management without suffering negative consequences.
- b. Educate: Nurses must receive education specific to caring for their residents that will improve competence, knowledge, and self-esteem. The education will prepare the nurse to respond appropriately to difficult situations, effectively resolve conflicts, and increase their empathy. By providing them education, stress and burnout in turn may decrease. Education should also be provided to the individuals being cared for, as an educated individual is less likely to be a victim.
- c. Work with staff to decrease stress/burnout: Ensuring adequate staffing in all areas of care is one of the best ways to decrease staff stress and burnout.
- d. Assist with staffing ratios: providing consistent staffing and adequate supervision are key to preventing ANE.

The first and most important step toward preventing elder abuse is to recognize that no one, no matter their age should be subjected to violent, abusive, humiliating or neglectful behavior.

3. Safety: The LVN is responsible for ensuring the safety of all of the residents that he/she cares for. In the nursing facility environment, there aren't generally many outside factors that would have a negative influence on the resident. There are a few things within the facility that may pose a safety issue to a resident with dementia, but there are some tips that the LVN can use to ensure a safe environment for the resident. These include:
 - a. Arrange furniture simply and consistently and keep the environment uncluttered.
 - b. Remove loose rugs and seal carpet edges that may be safety hazards.
 - c. Ensure that the call bell is always within reach of the resident, in the event that they need assistance.

The overall idea with regards to safety for the resident with dementia is for the LVN to have a full understanding of each resident's functional abilities. What may pose a risk to one resident may not pose the same risk to another resident. A prudent LVN should have knowledge about all of the residents that he/she cares for, in order to be able to provide the safest care possible.

In addition to environmental safety, the LVN should also understand the safety implications for those residents receiving antipsychotic medications. Older residents with dementia who are receiving antipsychotic medications are at risk for serious adverse effects. Often these medications are used to manage challenging behaviors that residents with dementia may exhibit. Many of these challenging behaviors are the result of an unmet need and can be better controlled using alternative interventions instead of antipsychotic medications. For additional information related to medication administration and antipsychotics, access the Medication Administration Module. In addition to the Medication Administration Module, there is information related to antipsychotic medications at the University of Iowa's Geriatric Education Center at: <https://www.healthcare.uiowa.edu/igec/iaadapt/>.

Chapter 3:

CMS Hand in Hand Toolkit:

The CMS hand in hand toolkit was developed for nursing homes, initially to address the need for nurse aides' annual in-service training on these important topics; however the tool-kit has become a vital training resource for all nursing home staff.

This mission of this training is to provide nursing homes with a high-quality training program that emphasizes person-centered care in the care of persons with dementia, as well as the prevention of abuse. The toolkit consists of a total of six modules that address the following topics:

- Understanding the World of Dementia;
- The Person and the Disease;
- What is Abuse;
- Being with a Person with Dementia: Listening and Speaking;

- Being with a Person with Dementia: Actions and Reactions; Preventing Abuse; and
- Being with a Person with Dementia: Making a Difference.

The Hand in Hand training allows participants to watch and discuss realistic interactions with persons with dementia and scenarios where abuse has or might have occurred. The video clips are designed to be the focal point of the training; they are impactful and memorable. Thought-provoking questions provided in the instructor guide and on the discussion screens that follow the video clips help participants to understand the learning points and to apply them to their own work experience. The training toolkit can be downloaded for free by anyone who wishes to review the modules, by simply entering some very basic information at the following website: <https://surveyortraining.cms.hhs.gov/pubs/HandinHand.aspx>.

University of Iowa Geriatric Education Center:

The University of Iowa’s Geriatric Education Center has a number of resources that can be used by many different providers in an effort to provide quality care to individuals diagnosed with dementia. There are also resources for educators that can be used to teach students in different health disciplines on geriatric care. These resources can be accessed by visiting: <http://www.healthcare.uiowa.edu/igec/>.

In addition to these resources, there is also an area that is geared specifically towards Improving Antipsychotic Appropriateness in Dementia Patients (IA-ADAPT). This area includes information and resources to help clinicians, providers, and consumers better understand how to manage problem behaviors and psychosis in people with dementia using evidence-based approaches. There are many different resources available and include: brief lectures, written content, quick reference guides for clinicians and providers, and information for families or patients on the risks and benefits of antipsychotics for people with dementia (a.k.a. Alzheimer’s disease and others). These resources can be accessed by an LVN, so that he/she is familiar with what resources are available and may use them in their practice to assist the resident as well as the family. This section can be accessed by visiting the following website: <https://www.healthcare.uiowa.edu/igec/iaadapt/>.

Music and Memory:

MUSIC & MEMORYSM is a non-profit organization whose mission is to vastly improve the quality of life of those with dementia or other cognitive disorders through the use of personalized music playlists. The organization was founded in 2006 by Dan Cohen, after he discovered that none of the 16,000 long-term care facilities in the U.S. used iPods for their residents. Through MUSIC & MEMORYSM, nursing home staff are trained to create and provide personalized playlists using iPods and related digital audio systems that enable those struggling with Alzheimer’s, dementia, and other cognitive and physical challenges to reconnect with the world through music-triggered memories. In 2012, the documentary “Alive Inside: A Story of Music and Memory” was created to showcase the work that was being done by the organization and has since boosted awareness and enthusiasm for the program. A clip of the video “Alive Inside” (the “Henry” video) can be viewed by visiting: <https://www.youtube.com/watch?v=fyZQf0p73QM>. Some of the benefits to the MUSIC & MEMORYSM Program include:

- a. Increase participation by the resident in their care.
- b. Decrease in the number of falls.
- c. Decrease in the use of psychotropic medications.
- d. Decrease in the signs of anxiety and depression in the residents.
- e. Increase in staff job satisfaction.

LVN's employed by a nursing home, and the residents who live there benefit greatly from this project. LVN students can also get involved with this program and assist the nursing facility in increasing the quality of care that is received by the residents. The multiple number of ways in which the students can get involved can be found at: <http://musicandmemory.org/get-involved/for-volunteers/>. More information related to MUSIC & MEMORYSM can be found at: <http://musicandmemory.org/>.

In addition to the information that is available through the MUSIC & MEMORYSM organization, there are success stories that have been featured in current news. One such story features a group of nursing students who brought the MUSIC & MEMORYSM Program to a local nursing home in their area. For more information about this project visit:

<http://www.12newsnow.com/story/30188419/lamar-university-nursing-students-bring-music-memory-project-to-nursing-home>. Additional videos that show some of the benefits of the music and memory program in Texas nursing facilities include the following:

- a. Reducing Antipsychotics: The Story of Hope: <https://www.youtube.com/watch?v=wjSVY3kf9S8>.
- b. Music and Memory: The Student Experience: https://www.youtube.com/watch?v=HnxJ-LM7d_0

Chapter 4:

Resources:

1. Pioneer Network: Formed in 1997, this group has called for a radical change in the culture of aging so that when individuals go into a nursing home, their care does not decline. The Pioneer Network advocates for elders across the spectrum of living options and is working towards a culture of aging that supports the care of elders in the settings in which their voices are heard and their individual choices are respected. There are many different resources through the Pioneer Network that can be accessed to provide additional education on topics such as culture change, policies and procedures, and many others. These resources can all be accessed at: <http://pioneernetwork.net/>.
2. Videos:
 - a. Alive Inside: a cinematic exploration of music's capacity to reawaken our souls and uncover the deepest parts of our humanity. Filmmaker Michael Rossato-Bennett chronicles the astonishing experiences of individuals around the country who have been revitalized through the simple experience of listening to music. The documentary reveals the uniquely human connection that is found in music and how its healing power can triumph where prescription medication falls short. This documentary follows social worker Dan Cohen, founder of the nonprofit organization MUSIC & MEMORYSM, as he

fighters against a broken healthcare system to demonstrate music's ability to combat memory loss and restore a deep sense of self to those suffering from it. Rossato-Bennett visits family members who have witnessed the miraculous effects of personalized music on their loved ones and offers illuminating interviews with experts including renowned neurologist and best-selling author Oliver Sacks and musician Bobby McFerrin. The video is available to view on Netflix, or it can be purchased from: <http://www.aliveinside.us/#land>.

- b. **Still Alice:** This movie tells the story of Alice Howland, a renowned linguistics professor who is happily married with three grown children. All that begins to change when she strangely starts to forget words and then more. When her doctor diagnoses her with Early-onset Alzheimer's Disease, Alice and her family's lives face a harrowing challenge as this terminal degenerative neurological ailment slowly progresses to an inevitable conclusion they all dread. Along the way, Alice struggles to not only to fight the inner decay, but to make the most of her remaining time to find the love and peace to make simply living worthwhile.
 - c. **Glen Campbell I'll Be Me:** A documentary featuring Country singer Glen Campbell that follows the singer as he performs in his goodbye tour, after being diagnosed with Alzheimer's disease. The film documents this amazing journey as he and his family attempt to navigate the wildly unpredictable nature of Glen's progressing disease using love, laughter and music as their medicine of choice.
3. **Alzheimer's Association:** The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support and research. The Alzheimer's Association works on a global, national and local level to enhance care and support for all those affected by Alzheimer's and other dementias. Ways in which they are able to help, include:
- a. Local chapters across the nation, providing services within each community.
 - b. A professionally staffed 24/7 Helpline (1.800.272.3900) offering information and advice to more than 300,000 callers each year and provides translation services in more than 200 languages.
 - c. Hosting face-to-face support groups and educational sessions in communities nationwide.
 - d. Connecting people across the globe through our online message boards, ALZConnected®. Our online community is ready to answer your questions and give you support.
 - e. Providing caregivers and families with comprehensive online resources and information through the Alzheimer's and Dementia Caregiver Center, which features sections on early-stage, middle-stage and late-stage caregiving.
 - f. Helping people find clinical studies through their free, easy-to-use matching service Alzheimer's Association TrialMatch. TrialMatch connects individuals with Alzheimer's, caregivers, healthy volunteers and physicians with current studies.
 - g. Their free online tool, Alzheimer's Navigator, helps those facing the disease to determine their needs and develop an action plan, and our online Community Resource Finder is a comprehensive database of programs and service, housing and care services, and legal experts.

- h. Housing the Alzheimer's Association Green-Field Library, the nation's largest library and resource center devoted to increasing knowledge about Alzheimer's disease and related dementias.

There are many resources that are available to not only providers, but to families and caregivers as well. LVN students should be aware of the vast amount of resources that are available at the Alzheimer's Association, in order to be able to provide these to the individuals that they care for once they begin to practice as a nurse. The latest Facts and Figures related to Alzheimer's Disease can be found at:

http://alz.org/facts/overview.asp?utm_source=gd&utm_medium=display&utm_content=topics&utm_campaign=ff-gg&src=ff-gg&gclid=CJ_Gvq-ajcgCFQ0yaQodfaOKTg.

4. Person-Centered Thinking: A partnership between the Texas Center for Disability Studies and the Center on Disability and Development at Texas A&M University that has established the Institute on Person-Centered Practices. They provide exceptional training opportunities in person-centered practices. The institute offers training and materials that are developed with the goal of increasing the number of participants in the use of Person-Centered Practices. Pursuing this goal increases the quality of life for all people on a larger scale than what is currently in place. The idea behind person-centered thinking is to bring the care back to what the individual wants in terms of care, incorporating them in the decision making process. There are many other person-centered thinking resources that are available to providers to ensure that they receive all of the information related to this new concept of care. You can get more information by visiting: <http://tcds.edb.utexas.edu/v/page-detail/Institute-for-Person-Centered-Practices/3d/>.
5. Eden Alternative: The Eden Alternative is an international, non-profit organization that is dedicated to creating a quality of life for elders and their care partners, wherever they live. The Eden Alternative philosophy asserts that no matter how old we are or what challenges we live with, life is about continuing to grow. Building on this new paradigm, it affirms that care is not a one-way street, but rather a collaborative partnership. All caregivers and care receivers are described as "care partners," each an active participant in the balance of giving and receiving. Together, care partner teams strive to enhance well-being by eliminating the three plagues of loneliness, helplessness, and boredom. Focused on changing the culture of care since the early 1990's, this approach to person-directed care initially came to life in nursing homes and has since expanded its reach to all care settings, including home care and residential care for people living with different abilities. The Eden Alternative firmly believes that culture change unfolds one relationship at a time, and that deep change can only take root when the entire continuum of care is involved. Through education, consultation, and outreach, it currently offers three applications of its principles and practices to support the unique needs of various living environments, ranging from the nursing home to the neighborhood street. To receive more information about the Eden Alternative, visit: <http://www.edenalt.org/about-the-eden-alternative/http://www.edenalt.org/about-the-eden-alternative/>.
6. Virtual Dementia Tours (VDT): The VDT is a unique, interactive program proven to improve communication and care. Created by P.K. Beville, a specialist in Geriatrics, this valuable, easy to follow experiential training is designed for care giving facilities and community organizations to help identify with and understand patients' behaviors and needs. This Comprehensive Program has been used for new employees, hospitals, colleges and

universities, and other caregivers. Upon the completion of VDT training, caregivers were able to identify with and better understand the behaviors and needs of those in their care.

- a. Certified Trainers: Individuals who are seeking to become certified trainers can do so by contacting Second Wind Dreams, the company who approves the training to learn how to become certified. More information can be found at: <http://www.secondwind.org/virtual-dementia-tour/certified-vdt-trainers/>.
 - b. Attending a training: Trainings are currently being provided around the state by trainers through the Department of Health and Human Services. These trainers go to nursing homes throughout the state and provide the very real, life-like training to those who request the VDT. Additionally, there is more information related to the VDT Training Programs, at: <https://www.secondwind.org/virtual-dementia-tour/vdt-training-programs/>.
7. National Council of Certified Dementia Practitioners (NCCDP):
- a. What is it?: National Council of Certified Dementia Practitioners is open to all health care professionals, front line staff and First Responders who qualify for Certified Dementia Practitioner (CDP®) certification and are interested in learning comprehensive dementia education, who value dementia education, who are committed to ending abuse and neglect and who value Certified Dementia Practitioner® CDP® certification. The Council was formed to promote standards of excellence in dementia and Alzheimer's Disease education to professionals and other caregivers who provide services to dementia clients. As the number of dementia cases continues to increase nationally and worldwide, there is a great necessity to insure that care givers are well trained to provide appropriate, competent, and sensitive direct care and support for the dementia patient.
 - b. How to get the training: The NCCDP has certified instructors who can bring the NCCDP curriculum to your facility. Upon completion of the training, the participants will receive a certificate of training, and will be eligible to apply to become certified dementia practitioners. Trainings are also offered by Certified Alzheimer's Disease and Dementia Care Trainers. Information related to trainings that are available is located at: <http://www.nccdp.org/seminars-by-approved-trainers.htm>.
 - c. Become a Trainer: To become a Certified Alzheimer's Disease and Dementia Care Trainer (CADDCT), simply visit <http://www.nccdp.org/train.htm> to access the CADDCT Class pre-registration form. This form along with the supporting documentation should be mailed in to the NCCDP for consideration. The seminar will include; overheads copies, handouts, Power Point Curriculum, Video and text books, Sample Brochure, Sample Sign-In Sheets, Sample Evaluation, Information on database development, information on obtaining approval for CEU's. Upon completion of the training, participants will receive certification as a Certified Dementia Practitioner (CDP) as well as a Certified Alzheimer's Disease and Dementia Care Trainer CADDCT.
8. DADS Joint Training Academy: The DADS Joint Training Academy is available to present trainings on different topics that affect nursing facility residents, to the staff of these facilities.
- a. When the LVN graduates from school and begins practice, the primary employer of the VN is the long-term care setting. In an effort to ensure that VNs have the most up to date training, the facility may request these trainings and require that the LVN be present for them. It is important that the LVN is aware of the areas that he/she may need additional education, so that those specific trainings can be requested for the LVN to take receive.

- b. Additionally, these trainings can also be presented to LVN students prior to their entrance into the workforce. It is important that LVN students are aware of these trainings opportunities. As the student graduates and enters the workforce, these trainings will be important for those who find themselves working in the long-term care setting. A full listing of the available courses can be found at:
<https://www.dads.state.tx.us/providers/training/jointtraining.cfm>

9. Case Studies:

a. Case 1:

Presentation and history:

A 51-year-old male real estate lawyer began to embezzle money at work, regularly listing mysterious expenses on his travel reimbursement forms, which turned out to be purchases of pornographic materials via the internet. When questioned, he claimed that he used the corporate accounts so that his wife would not find out about this sexual activity. At about the time that this behavior was discovered by his partners, a few of the female law clerks complained that he often made inappropriate comments about their physique and that he stared at them in a way that made them uncomfortable. His work had dramatically deteriorated, and rather than working with his clients, he spent most of the day at work shuffling papers, reading magazines or downloading pornography onto his computer. He was eventually asked to leave the firm, but made no attempts to find a new job. His wife and children reported that over the past year he had lost interest in them and watched television without speaking when at home. He developed a strong desire for potato chips and gained 15 lbs. His manners deteriorated, and he stuffed his mouth, often choking at the dinner table. He insisted on eating food on his plate in a specific order, often with his hands. Family history revealed that his father and first cousin had died from "Lou Gehrig's disease."

Examination:

Upon examination, the patient was profoundly apathetic and indifferent and denied any wrong-doing at work, passively shrugging his shoulders when his tearful wife described his problems. When asked about his future, he was very optimistic, stating that he could make lots of money as a real estate mogul if he wanted. Basic neurologic examination revealed pathologically brisk snout and jaw jerks. Fasciculations, as well as subtle atrophy and weakness, were evident in the arms and legs. Plantar responses were flexor.

Neuropsychological testing:

On neuropsychological testing he scored 27/30 on the Mini-Mental State Examination (MMSE), missing one point each for the name of the hospital, the season and for spelling "world" backwards. The intersecting pentagons were drawn perfectly. Speech was fluent, but the patient insisted on telling off-color jokes. He commented on the examiner's old age. He failed badly on word generation, getting six d words and nine animals with normal being 12 d words and 15 animals. On the Trail-Making Test "Trails B", he made frequent perseverative errors and was unable to abstract on proverbs, often repeating the proverb back to the examiner rather than offering an interpretation. He correctly named

55 of 60 words on the Boston Naming Test. He copied complex designs without error and remembered most of the designs after 5 minutes. Similarly, he remembered seven of nine words in 5 minutes.

Imaging and tests

MRI revealed mild right greater than left fronto-insular atrophy. EMG was normal. Blood was sent for tau, TDP-43, superoxide dismutase and progranulin mutations, all of which were absent.

Progression:

Within six months, the patient was even more apathetic and unable to speak. He spent most of his time removing weeds compulsively in his backyard. Swallowing liquids became difficult, and aspiration became frequent. He died 9 months after diagnosis as a result of pneumonia

Pathology, diagnosis and discussion:

Pathology showed extensive gliosis and spongiosis of the frontal cortex. Ubiquitin and TDP-43-positive, tau-negative inclusions were seen in the dentate gyrus of the hippocampus. FTD-MND was diagnosed.

This patient presented with classic signs of FTD, including poor judgment lack of insight disinhibition, apathy and compulsive overeating, which led him to be fired from his job and alienated from his wife. Like many patients with FTD, despite a relatively intact MMSE visuospatial and language function, he failed badly on tasks of generation and executive function. With a strong family history of amyotrophic lateral sclerosis (ALS), it is not surprising that the patient, soon after demonstrating symptoms of FTD, also went on to develop ALS with evidence for dysphagia (difficulty swallowing) and showed pathology suggestive for FTD-ALS with ubiquitin and TDP-43-positive inclusions. The gene or genes that cause FTD-ALS still remain to be discovered although a locus on chromosome 9 has been identified that will likely explain many cases of FTD-ALS with a strong family history.

b. Case 2:

Presentation and history:

A successful graphic designer began to have trouble finding names for people and objects. He continued to design brochures and logos for small businesses but had trouble filling out paper orders, making frequent spelling mistakes. Surprisingly, he was caught stealing a shiny necklace from a client's store. Soon afterward he began to comb the beach, spending many hours looking for seashells. While at home he began to play solitaire compulsively for 6 hours per day. He developed a new interest in squash, and his game steadily improved. He stopped working as a graphic designer but obtained a courier

job and learned and remembered a complex route for delivering packages. There was no family history of dementia.

Examination:

Examination revealed a bright and attentive man who spoke rapidly. Behavior was appropriate except for occasional interruptions of the examiner to complain that his driver's license had been taken away. Basic neurologic examination was normal.

Neuropsychological testing:

His MMSE score was 24/30. Speech was fluent but somewhat lacking specific nouns. Comprehension was mildly impaired due to deficits in understanding some words. The items missed were two of three words on memory, naming of the watch and pen, and two items on the three-step command. Working memory was normal with eight numbers repeated backwards. He generated only five animals in 1 minute and 9 d words. The Trail-Making Test, "Trails B", was performed quickly and correctly, but he could not interpret proverbs. Copying was precisely performed without error, and after 10 minutes he remembered 16 of 17 points on the drawing. He had trouble with learning a list of nine words, remembering only four after five trials. He retained these four words after 10 minutes. He correctly named 16 of 60 words on the Boston Naming Test, missing all of the animals except for dog. Naming for most items was not improved by category clues or multiple choices. Subtle deficits in recognizing facial emotions for fear and sadness were evident.

Imaging and tests:

MRI revealed asymmetric temporal lobe atrophy. EMG was normal. Blood was sent for tau, TDP-43 and progranulin mutations, all of which were absent.

Progression:

Subsequently, deficits in recognizing faces of others became apparent, and he was unaware when his wife became upset. Four years after diagnosis, comprehension for spoken and written language had disappeared, and he called all people and items in his environment "thing." MMSE score was 1 with the only item performed correctly being the drawing of the intersecting pentagons. Subtle problems with swallowing emerged 5-1/2 years after diagnosis, and the patient died 6 months later.

Pathology, diagnosis and discussion:

At autopsy extensive atrophy of the anterior temporal lobes, orbitofrontal and medial frontal cortex was evident. Extensive spongiosis, gliosis and neuronal loss were evident in these frontotemporal regions. Ubiquitin-positive inclusions were evident in the frontal and anterior temporal lobes.

This patient developed classic symptoms and findings of SD. Like many patients with asymmetric left-sided temporal lobe degeneration, his first symptoms related to naming people and objects. Also typical of other SD patients was his compulsive preoccupation with shells, jewelry, solitaire and squash. As his disease moved from the left to the right anterior temporal lobe, deficits in the recognition of faces became evident. His abnormalities in object naming and verbal memory in association with sparing of frontal and parietal lobe functions also typify this FTLN subtype.

c. Case 3:

Presentation and history:

A 62-year-old female retired executive began having difficulty finding words. She slowly began to lose her ability to express ideas. She became quieter and somewhat socially withdrawn. She also started to have trouble writing. When talking, she took a long time to express her ideas and communicated ungrammatically with nouns. Others told her that she had trouble "spitting out her words." Social graces remained preserved, although she expressed profound frustration regarding her speech, and she developed a major depression. There was no family history of dementia.

Examination:

On examination the patient was well groomed and polite. Neurologic examination was normal except for minor difficulty looking downwards. Subtle square-wave-jerks were evident when examining the eyes.

Neuropsychological testing:

MMSE was 29/30; she missed the repetition item. Speech was nonfluent with a decreased number of words spoken per minute, short phrase length, and a stuttering output with articulatory groping. Comprehension was normal. Working memory was slightly diminished; she could only repeat four numbers backwards. She generated 17 animals in 1 minute but only 8 d words. The Trail-Making Test, "Trails B", was performed slowly, but no errors were evident. Copying of the Rey-0 was precisely performed without error, and after 10 minutes she remembered 14 of 17 points on the drawing. She did well on verbal learning, remembering 9 of 9 words after 10 minutes. She correctly named 54 of 60 words on the Boston Naming Test and got three more with multiple choices. Recognizing facial emotions was normal.

Imaging and tests:

MRI revealed asymmetric atrophy of the left frontal lobes. EMG was normal. Blood was sent for tau and progranulin mutations, which were absent.

Progression:

Within 2 years the patient was mute and swallowing deficits emerged. She exhibited frequent falls, particularly when walking down stairs. On examination, inability to look up or down was found and axial rigidity was evident. The patient died within 6 weeks.

Pathology, diagnosis and discussion:

Progressive supranuclear palsy (PSP) was seen at pathology.

This patient began with PNFA but soon afterward exhibited findings suggestive of PSP including falls, the inability to look up or down and axial rigidity. The association of PSP and corticobasal degeneration (CBD) with PNFA is now well recognized, and the majority of patients with PNFA show PSP or CBD on postmortem examination.

d. Case 4 Activity:

Answer the following questions about the case presented below:

1. List the signs of confusion seen in this case. Which stage of Alzheimer's disease would you assign Mrs. Livingstone?
2. Why do you think the daughter failed to recognize Mrs. Livingstone's problems?
3. What are appropriate nursing diagnoses for Mrs. Livingstone?
4. What collaborative interventions are needed?
5. What nursing interventions are appropriate?
6. What patient/family teaching is needed at this time?

Case: Mrs. Livingstone has lived alone for the past several years, doing her own cooking and caring for herself. Her daughter, Judy, lives in another city and calls Mrs. Livingstone each week, although she has not seen her mother for about 6 months. During the last phone call, Judy became concerned. Her mother seemed distracted, frequently interrupted the conversation and repeatedly said that she was "so worried." When asked what worried her, Mrs. Livingstone said, "I just don't know." She repeatedly asked the same question. Alarmed, Judy drove to her mother's home six hours away. When she arrived, Judy was shocked to see how thin her mother had become. There was little in the house to eat except tapioca pudding, gelatin and applesauce. Judy was able to figure out that Mrs. Livingstone had broken her dentures and was having difficulty chewing. Her skin turgor is sluggish. Mrs. Livingstone said the coffeemaker and the TV did not work. The daughter used both and found them to be working. Mrs. Livingstone often started tasks but did not finish them, she seemingly forgot what she was doing. She often could not think of words, such as the name of the dresser in her bedroom. As evening approached Mrs. Livingstone became more agitated and was unable to sleep. She said she had to "see about the children." Judy brought her mother home with her the following day and made an urgent appointment with her family doctor to evaluate Mrs. Livingstone's condition. During the examination, Mrs. Livingstone was unable to focus on the nurse's questions and instructions. She knew her own identity, was unsure of her exact location and did not know the current date. She became visibly agitated with the questions and said she didn't want to answer or said "I don't know, well I do know but I am not going to answer." (probably because she was unable to answer). Mrs. Livingstone thought the physician was the son of one of her friends from home and asked him several

times about his mother. She complained of fatigue and epigastric tenderness. She was 20 pounds under her ideal body weight and she was pale. Lab tests revealed iron deficiency anemia, low albumin, and dehydration.

Suggested Answers:

1. Signs of Confusion

Mrs. Livingstone is showing moderate signs of confusion.

She is oriented to person, but not to place and time.

She does still know her daughter.

She repeatedly asks the same question. (amnesia: loss of ability to learn new information or recall old information, often appears as forgetfulness)

Her judgment is poor as reflected in not making good decisions about eating. She may be cognitively unable to take action to get her dentures repaired.

She is showing signs of "sundowning". She is more agitated in the evening and is unable to sleep. These symptoms are consistent with stage II Alzheimer's Disease.

Apraxia: unable to use TV and coffee pot. This could also be agnosia, which is, simply not recognizing the use of a common object.

Forgets the name of common objects. (aphasia)

* These are the 4 A's of Alzheimer's

Here are the 10 warning signs of Alzheimer's

Recent memory loss that affects job skills

Difficulty performing familiar tasks

Problems with language

Disorientation to time and place

Poor or decreased judgment

Misplacing items

Changes in mood or behavior

Changes in personality

Loss of initiative

Problems with abstract thinking

2. While it is easy to think the daughter was unaware of what was happening because she lived at a distance, failure to recognize early signs and symptoms is common. Mothers sometimes form the habit of telling children the same thing over and over and carry this over into adulthood, therefore it may not seem unusual.

Most of us get more forgetful with age.

People with confusion learn to "fake" and can be very sly about it. Like making up details of a story, asking questions to get the other person to remind them of something then saying "That's what I was thinking too"

The onset of Alzheimer's is insidious, but accelerates in the middle stage. It is not unusual for family's to look back from 1-3 years and recognize that symptoms were beginning to appear.

3. Nursing Diagnosis

Confusion (probably chronic, but acute causes need to be ruled out first) r/t unknown etiology at this time, possible Alzheimer's Disease

Nutrition less than body requirements r/t inability to chew without dentures, poor judgment about need for nutrients

Fluid Volume Deficit r/t unknown; possibly poor judgment about taking in liquids.

Risk for Injury r/t poor judgment, cognitive impairment, and forgetfulness

Risk for Hopelessness r/t possible Alzheimer's Disease

4. Collaborative Intervention

Treat iron deficiency anemia, protein deficiency

Treat dehydration

Work up for causes of acute and chronic confusion

Work up for epigastric tenderness

5. Nursing Interventions

Assessment

Ascertain the patient and daughter's goals for care. What options would be acceptable: assisted living, nursing home, daughter's home, full time caregiver in Mrs. Livingstone's home, Adult day care, respite care.

Determine what support the daughter will be able to provide, other support systems, such as friends and family.

Determine if the daughter has a medical power of attorney, financial power of attorney, living will.

Educate the daughter about the need for the legal documents.

Discuss the need for protective living with Mrs. Livingstone and the daughter

Arrange for meals to be delivered.

Arrange for repair of dentures.

Evaluate the home for safety.

Teach about Alzheimer's disease, medications that can help