





TIME REQUIRED:

Approximately 2 hours 45 minutes

If dividing into sections:

- Normal Changes of Aging and Memory - 30 min
- Dementia, Depression, Delirium – 15 min
- Dementia Umbrella - 30 min
- Alzheimer Disease - 1 hour 15 min
- Dementia Stages – 15 min

SUPPLIES NEEDED:

- LCD/Laptop or overhead projector and screen
- VIDEO - “The Alzheimer Journey: Understanding Alzheimer Disease: The Link Between Brain and Behavior” (17 min. long)
- Video: “Delirium In the Older Person
- Flip Chart/ Markers/ Masking tape
- ‘Circle – Pie’ for Normal Aging Challenge game (included in training package) - 1 per group
- Candy / Pens / Buttons for prizes for Normal Aging Challenge game (optional)
- Articles on Types of Dementia (no more than 2 articles for each of the 4 diseases) Best Source: Alzheimer Society web site



BEST PRACTICE

Staff who are knowledgeable of normal aging changes and the disease processes related to dementia will utilize this knowledge for planning care.

Objectives

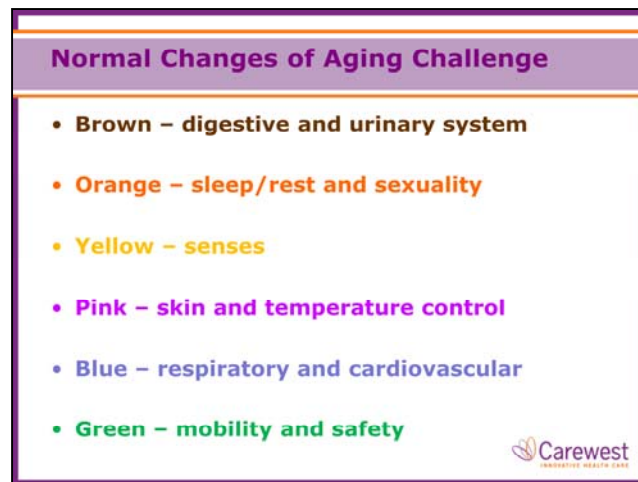
To increase knowledge of normal aging changes

To increase knowledge of the types of dementia

To discuss the stages of dementia



TRAINER NOTE: Just read the objectives.



(Normal Aging section takes 30-45 minutes) After 30 min the instructor should go over the remaining questions/answers with the whole group due to time constraints

Before beginning a discussion of the normal changes of aging point out that although we like to speak of “the aged” as a group there is a wide variety in how an individual ages. Environment, diet, and cultural expectations may all have an impact. The changes noted are ones that are commonly found in older people and are not thought to be disease related.

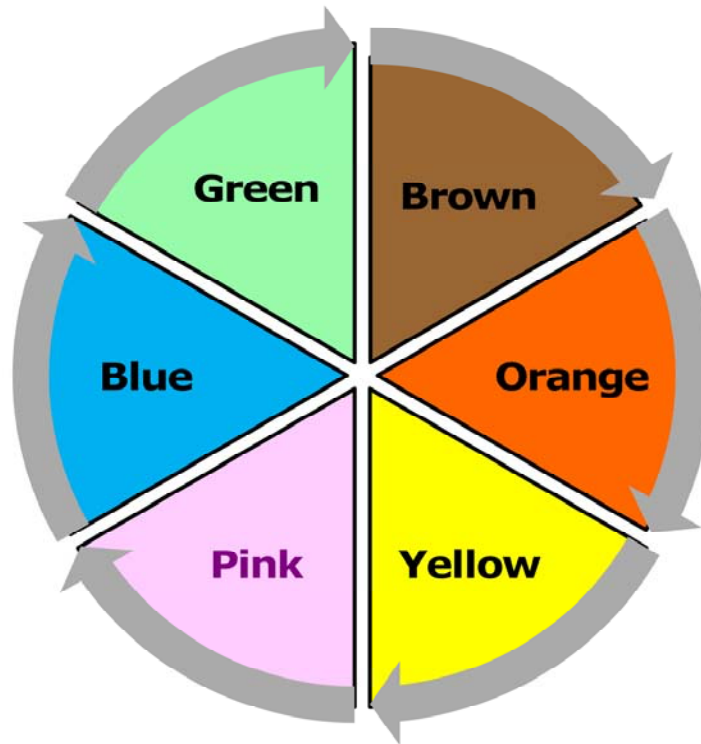
GAME - NORMAL CHANGES OF AGING CHALLENGE

Refer to the list of coloured pages for the choices of game categories (on overhead).

1. Divide the participants into teams of 3-6 people.
2. Give each group a circle ‘pie’ to track their progress (modeled after the trivial pursuit game). Have the first team choose which colour category question they want to answer. When a team answers correctly, they can mark off that colour on their ‘pie.’ The object of the game is to mark off all the sections of the pie. The first team to do this, wins a small prize (candy works well as they share it with the group). You may have a tie between teams so have an extra prize handy.
3. Limit the time given to decide on their answer to ensure you cover sufficient content in this section.
4. As the answers are given try to incorporate the care implications as indicated on the chart in the “participant’s handout.”

Offer prizes to everyone in the end (candy works good – a sugar fix) - optional

Normal Aging Changes Game



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Questions for Trivial Pursuit Normal Aging Game

Answers from Miller (1999).

Nursing Care of Older Adults – Theory and Practice (3rd edition) ***

Pink - Skin and Temperature	Answer	Asked
Older adults produce as much sweat as other adults.	False – the sweat glands produce less sweat –especially in area where bacteria growth adds to the body odour (under arms and between the legs)...How often should the older adult have a bath or shower? <i>Less often is usually fine considering they don't produce the sweat that creates body odour.</i>	
Older adults have a lower "normal body temperature"	True – when do we need to remember this? <i>If they have an infection we might NOT see a raise in their temperature because an increase from a normal LOW might not look very high to us. A client with a UTI may have a change in behaviour and first signs of pneumonia might be a slight increase in respirations.</i>	
There is a decrease in blood flow to the skin.	True – The skin may feel cool because of this. Slower growth of finger and toe nails. Affects thermoregulation– can't dissipate heat as well.	
The skin of older adults is much drier than the skin of younger people	True – their skin produce fewer oils that help keep the skin moisturized. So: What do we need to do help their skin stay more hydrated or moist? <i>Put on moisturizers (except between the toes where the cream can be a source of bacteria growth cause I doesn't absorb there easily.</i>	
When cold, older adults shiver more than younger people	False – Shivering might not occur – they might not feel cold – even in very cold temperatures. They may get hypothermic more easily due to problems with circulation.	
Hot packs and heating pads are good for keeping older adults comfortable?	False: Hot packs and heating pads can be dangerous as they have less sensation in their skin and can get burned.	
Bathing older adults daily is a good way to maintain hygiene in older adults?	False: The skin of older adults produces fewer oils to help keep skin moist so bathing less often and applying moisturizers help keep the skin more hydrated and moist.	
Older adults have an increased amount of subcutaneous fat though out their bodies?	False: Older adults have a decrease in subcutaneous fat. This can lead to skin breakdown over bony prominences .	
Sliding or boosting older adults up in a chair or bed is a good way to reposition them and avoid skin breakdown.	False: Sliding or boosting a person instead of lifting them with a lift or using a slider sheet risks skin tears. The bed should be put in a flat position if possible. The shearing force is very dangerous for older fragile skin as the connection between the dermal and epidermal layers is significantly weaker in older adults.	

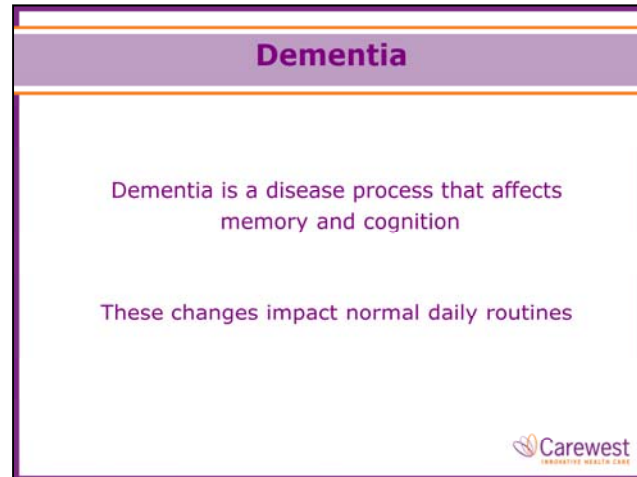
Blue Respiratory and Cardiovascular	Answer	Asked
Older adults breath more quickly and with more “shallow” breaths	True – the lungs become stiffer, the rib case more stiff, so the lungs can’t expand as much as in younger adults – Use the diaphragm more to assist in expansion. <i>Elevating the head of the bed if having difficulty breathing takes abdominal contents away from the diaphragm. This change may add to the older person’s risk of developing lower respiratory infections, like pneumonia.</i>	
The same amount of oxygen passes into the blood with each breath as in younger adults	False – There are fewer alveoli in the lungs where the gases exchange (oxygen into the blood and carbon dioxide out of the blood) – How might this affect the older adult? <i>Less oxygen in the blood (diminished PO2 levels), less energy to do things.</i>	
The arteries in the older adult are more relaxed than in younger people	False – the arteries stiffen, making it harder to push blood through – What vital sign might change as a result of this? <i>Increased blood pressure is common in older adults – anything above 140 / 90 is considered hypertension though and should be monitored and treated if it goes much higher.</i>	
The veins in older adults are smaller than in younger adults	False – the veins are more dilated, meaning the blood can “pool” in the veins. The body has a harder time getting blood back to the heart – The veins may become more bulging (varicose veins) – or the blood may pool in the legs leading to edema, which can result in skin breakdown and result in ulcers from venous stasis. What action helps move the blood back to the heart? <i>Walking – exercise (the muscles contracting around the veins help them push the blood back to the heart.)</i>	
The rib cage may change to be more rounded than oval shape (increased diameter between the front and the back of the lung –more barrel shaped)	True – as more air is trapped in the lower lungs (as it is harder to breath out through stiffer lungs) the rib cage changes shape – similar to COPD, although not as much as in that disease.	
The heart in older adults is often larger in size than in younger adults?	True: Narrow arteries make it harder to pump blood through the body and heart muscle is weaker and less effective than in younger adults therefore the heart often enlarges in an attempt to push blood into the body.	

Yellow – Senses (vision, hearing, taste, touch)	Answer	Asked
Older people have an increased ability to taste sweet and salty foods	False – As an individual ages, there is a progressive loss in the acuity of the sense of taste. In particular the ability to detect sweet and salty decreases. <i>The person may need more sugar in order for things to taste sweet.</i>	
Older adults have a decrease in their sense of smell but this does not affect the older adult.	False —the sense of smell is closely related to the sense of taste so appetite can be affected. Also the older adult may be unable to detect spoiled food or a gas leak.	
With the changes in skin elasticity and tissue loss beneath the skin, the sense of touch is increased.	False , there is also a decrease in the nerve endings so there is a decrease in touch sensation and this alters their sensation for temperature, pain and movement.	
Hearing loss in older adults often increase due exposure to loud sounds and noise pollution over a life time.	True . Noise pollution and loud industrial sounds damage hearing and increase the loss of hearing with older adults	
Older adults loose the ability to hear sounds in the high range (children’s voices, soprano notes)	True – make your voice LOWER (more like a man’s deep voice) to help the older person hear you better	
Older adults see you best if you stand in front of the window and look at them	False – Backlight makes it difficult for the older adult to “see” the speakers – stand so the light is on your face	
The lens of the eye lets in more light as the person ages	False – the lends lets in LESS light so the older person needs 3 to 5 times MORE light to see well than a younger adults <i>(Older adults might benefits from flashlights in dark restaurants!)</i> - <u>Indirect light</u> is better as the lens has difficulty with glare – what are some examples of glare <i>(shiny floors, light on shiny table tops, etc.</i>	
Older adults can move easily from a dark room to a light room	False – the eye takes longer to adjust to the change in light – dark to light or light to dark – when might this be a risk for clients? <i>Getting up at night to use the bathroom – bright light, difficult to see – increased risk of falling</i>	
Hearing aids bother many people because they hear all the background noises as well as the conversations that they WANT to hear	True – it takes people a while to become accustomed to using hearing aids for this reason. To help a person new to hearing aid use, suggest they use the aid for a few hours each day – gradually increasing the amount of time they use the aid each day until they are used to the aid	
Older adults build up more wax in their ears that block the sounds entering their ears	True – The older person’s ears should be checked regularly by the RN / LPN for signs of wax build up – and it should be treated when noticed. What might you notice in a client who has wax blocking their ears? <i>Might not answer you when you call their names, spend more time in room if they can’t hear what is going on around them.</i>	

Green- Mobility and Safety	Answer	Asked
Falls are more likely in older adults than in younger people	True – there are a number of age related changes that increase the older persons risk of falling: •Change in the persons ability to keep their balance (decrease sensitivity in the part of the brain that controls balance) •Many older adults take lots of medications that have side effects of dizziness. •History of falls (fall once, more likely to fall again – even the FEAR of falling can increase the risk of falling).	
The way a person walks does not change as they age	False – the persons steps tend to widen slightly (<i>increasing their base of support and helping them avoid falls</i>).	
Medications are the only reason why older adults experience dizziness when rising quickly.	False: The ability of the blood vessels to react to change in position, postural hypotension, can also contribute to dizziness on rising in older adults.	
Once over the age of 70, it is too late to do anything for osteoporosis.	False: weight bearing exercise, calcium and medications can help at any age.	
If a person is restrained, they are at decrease risk for a hip fracture.	False. A restrained older adult is more prone to a fracture than an unrestrained adult due to the loss of calcium in the bones and loss of muscle mass and strength that occurs with a restrained adult.	
Studies show that an increase in exercise even in older adults can increase their muscle mass?	True: Use it or loss it. Exercise and physical activity can help maintain and increase muscle mass in older adults.	
Broken hips is older adults are often caused by osteoporosis?	True: Osteoporosis has many risk factors including age, being postmenopausal, medications such as steroids, thyroid pills, anticonvulsants, heparin and lasix. Adults at highest risk for osteoporosis are white women over 65 and men over 80. Weight bearing exercise and calcium and vitamin D are preventative measures to reduce bone fractures.	
The fear of falling can increase an older adults risk of falling?	True: Anticipation of falling makes adults more fearful of falls but also increases their chances of falling. Hip protectors may give the older adult a sense of security and allow the elderly to walk more and exercise more- thus decreasing the risk of future falls.	

Orange – Sleep/Sexuality/ Nervous System	Answer	Asked
Older adults need less sleep than younger adults	False – the amount of sleep needed doesn't change much throughout life – the older person should count both the time spent napping and nighttime sleep to get a total number of sleep hours in 24 hours.	
Older people dream more than younger adults	False – the REM (dream sleep) is LESS as are the stage 3 and 4 deep sleep stages. This means the person is more easily woken up during the night as they are sleeping more lightly. How might this affect how you are doing rounds? <i>Try not to wake the person up – incontinence products are designed to hold a lot of urine. When you check them, try only changing the person when they are awake (They might need to be disturbed if they are incontinent of bowel movement or need to be disturbed to re-position for skin care needs).</i>	
Older adults don't think about sex anymore.	False – there may be less opportunity to have sexual activity, but it doesn't mean the person has no need or desire.	
The reproductive organs are slower to respond and don't work as well in older adults.	True – they can work, but there are normal changes: the vagina is smaller, thinner and drier and the penis takes longer to respond to stimulation and may be smaller when erect.	
The number of neurons decrease as we age	True – the aging brain shrinks. This does not affect function under normal circumstances. There is a decrease of reserve capacity that may result in delirium if the system is stressed. Cell loss in the cerebellum may contribute to falls.	
With the decrease in sperm and semen production, there is no desire for sexual expression.	False. The desire for sexual expression remains throughout life.	
Older people tend to get up earlier and go to be earlier	True – There is a change in the timing of the body clock as we age.	
Learning and processing information takes place at the same speed thorough a life time?	False: There is a slowing of central processing of information so older adults may need more time to process information. We need to allow older adults to absorb and think about new information as learning occurs at a slower pace.	

Brown – Digestive Tract and Urinary System	Answer	Asked
The kidney's in the older person make the same amount of urine as in a younger person	False – there is less blood flow to the kidneys and fewer cells to make the urine, so production is less.	
Older adults need the same amount of food as younger adults	False – the caloric needs decrease BUT the nutritional needs stay the same – so, they need to focus on eating really healthy, nutrient “dense” food to get the nutrients they need in fewer calories – some vitamins are not absorbed as well in older adults (B12, iron, folic acid).	
The bladder in an older adult holds less urine than in younger people	True – The capacity is less, so the person may have to urinate more often. The time between the feeling of need to urinate and actually urinating is reduced so they may have to get to the bathroom more quickly (or risk incontinence).	
Being incontinent is a normal part of aging	False – there are special challenges to keeping urine in the bladder in older adults, but it is not “normal” to loose urine – causes of incontinence should be investigated.	
Older adults may not feel as thirsty as younger people	True – the message “I’m thirsty” is less in older persons, so it is very important for staff to encourage lots of fluid intake because the person may not think of it himself or herself – why? <i>Helps with constipation, urine problems like concentrated urine that is very irritating to the bladder and may cause urge incontinence, etc.)</i>	
Older adults are slower to absorb most medications so they require higher doses than younger adults.	False: Due to decreased kidney function (glomerular filtration) drugs may not be excreted as well and can build up in the body therefore a lower dose may be necessary.	
Food moves more quickly through the digestive track in older adults therefore there is less absorption of nutrients.	False: There is decreased motility of the esophagus, stomach and intestines and this can lead to constipation and indigestion. There is also less efficiency in the digestion and absorption in the digestive tract of older adults.	
Older people have less saliva.	True – There is a decrease in salivary flow resulting in drier mouth. Need good oral hygiene as poor hygiene will contribute to loss of taste.	



- A person is not born with dementia, it results from a disease process, usually during later life
- Common and under diagnosed
- Slow progressive brain disorder
- (Usually) irreversible. Irreversible 90% to 95%; reversible 1 – 5% - infection, metabolic problems 11
- In 2010, more than 500,000 Canadians were living with dementia¹.
- Within a generation, the numbers of Canadians living with dementia will more than double to 1.1 million¹. Alzheimer Canada

In 2011, the first wave of the baby boomers turned 65. The risk for dementia doubles every five years after age 65. By 2038 demand for LTC will increase 10 fold.

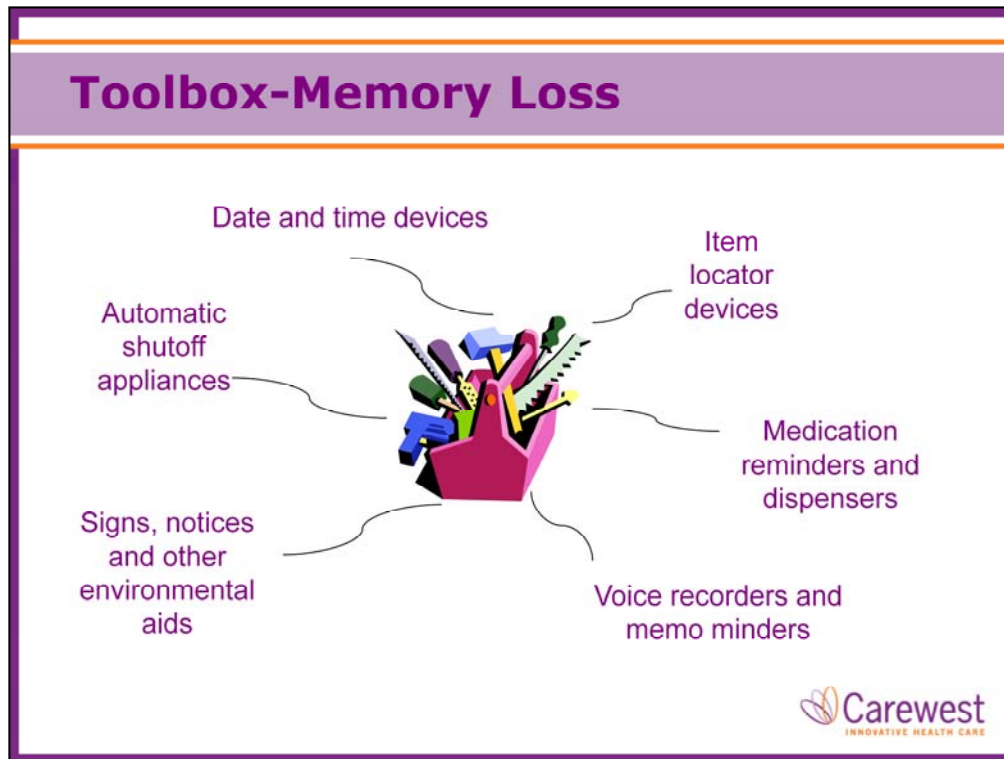


Early Alzheimer's related brain changes are usually seen in the hippocampus, the "control center" of memory related activity

Older people often fear memory loss. When we are young and forget where we left our car or leave the oven on we just think we weren't paying attention or busy. Older person's may be stressed that it is a sign of dementia.

Memory and Normal Aging Changes

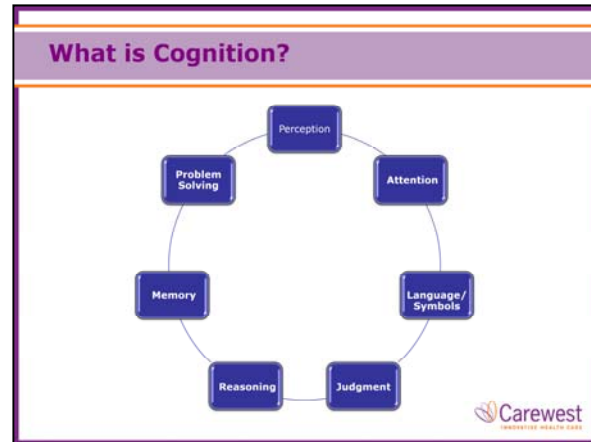
- **Immediate** - Remember a small piece of information over a few seconds.
Not affected much by age.
- **Recent Memory** – Ability to remember from minutes, hours, days ago.
Some decline in normal aging.
- **Prospective Memory** - Ability to remember to do something in the future
May decline in normal aging – visual and environmental cueing may be helpful (calendar or lists)
- **Semantic Memory-**
Facts you have learned, language, knowledge, **rote memory. E.g. Carols**
Unchanged with normal aging.
- **Long Term Memory** – Things that happened years ago.
Unchanged in normal aging.



COMPENSATING FOR MEMORY DEFICITS

Early in the disease process, memory aids may be helpful to maintain the person's independence.

- Date and Time- use a calendar and mark off the days and note appointments and special events. Clock calendars that show date and time. Some use Post-it notes as reminders
- Item locator devices can help locate phone, keys, wallet, glasses.
- New technology can assist with electronic reminders for pill taking. Family can remind from remote location and observe with video on computer. Punch out pill packaging or dosettes allow them to know if they have already taken their dose.
- Some use voice recorders to tell themselves to do something. Memo minders record a short message and are triggered by infra-red device when person walks by E.g. reminder not to go out alone.
- Environmental- Signs (e.g. Turn off stove). Set the timer when using the stove or oven. White boards to write reminders on.
- Have appliances like irons and kettles that shut off automatically. Induction stoves.



Define Cognition - Discuss that the term cognition is important, as cognition is more than memory. Thinking involves integration of all areas.

Perception - Recognition and interpretation of what is received through the senses. Meaning is assigned to what we receive.

- **Altered perception**
 - misinterpret the information your senses are giving you (a bigger problem in the late afternoon or early evening when light changes).
 - loss of depth perception—the ability to see in three dimensions. It becomes harder to judge how high, deep, long, wide, near or far things are. For example, if the floor and furniture are the same colour, it may be difficult to judge when one is close enough to a chair to try to sit.

Attention – mental concentration E.g doing math in your head. MMSE subtracting 7's from 100.

Language/ Symbols - ability to speak, understand, read, write.

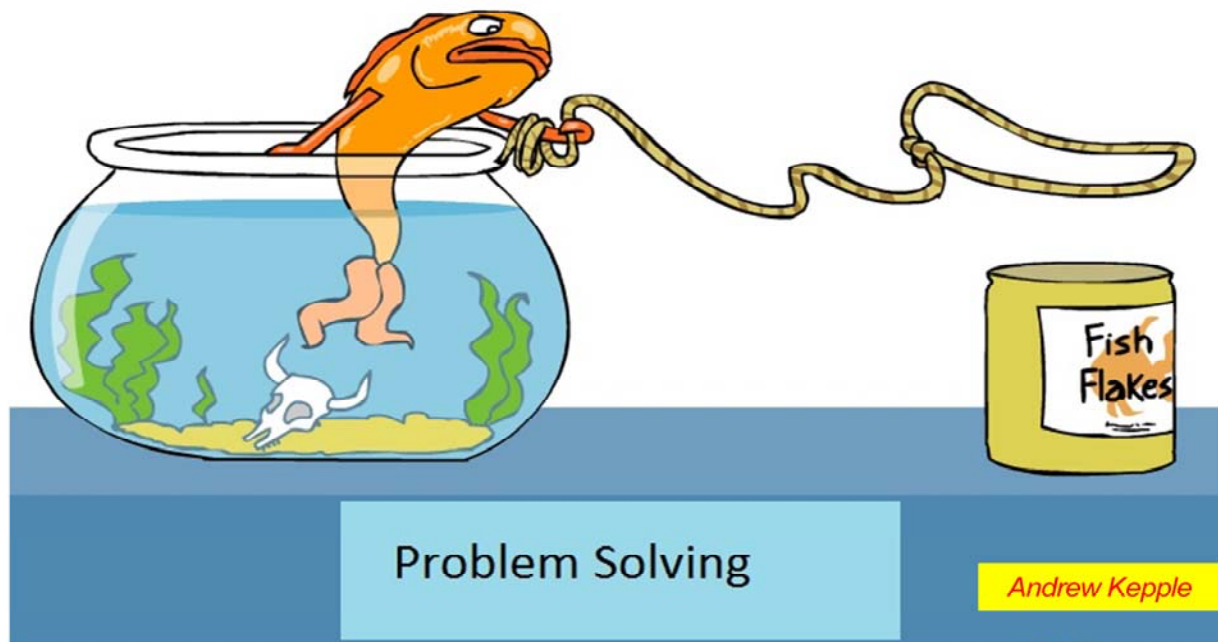
Aphasia means you lose the ability to use language. This includes the ability to speak, understand, read and write. Alz. Canada

Judgment- good sense, the capacity to assess a situation and draw sound conclusions. "I can't see very well so I shouldn't drive anymore."

Reasoning – The process of drawing conclusions from known or assumed facts. Thinking is coherent and logical. "The stove is hot so if I touch it I will get burned."

Memory - Capacity to recall or recognize previously learned information.

Problem Solving – ability to use multiple data sources to solve a problem. E.g. I can't drive now so how am I going to get to my appointments? Requires reasoning, memory and judgment.



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An example of problem solving

Medical Work-up for Cognitive Problems

- Not all memory loss is dementia
- Other possible causes include:
 - Low B12
 - Low thyroid
 - Brain tumours
 - Side-effects of medications
 - Alcohol abuse
 - Poor vision and/or difficulty with hearing
 - Delirium
- Correcting these conditions may result in improved memory/cognition



Trainer tip: There is an increased emphasis on encouraging people to seek a medical assessment – soon after early signs appear.

There is no single test that can determine if a person has Alzheimer's disease. The diagnosis is made through a series of tests that help eliminate other possible causes. Other conditions not listed include: depression, chest and urinary infections, severe constipation, vitamin deficiencies and emotional changes and upsets, such as moving or bereavement.

Screening tools such as: MMSE (Mini- Mental State Exam), MOCA (Montreal Cognitive Assessment) and CPS (Cognitive Performance Scale) are often used.

MRI and CT scans can be used to rule out causes of dementia other than Alzheimer's e.g. tumors and it is being proposed they could be used to measure the brain shrinkage in Alzheimer's.

Early diagnosis :

- know source of symptoms, rule out reversible causes
- allows for future planning
- knowing type of dementia is important to treatment

Screening tools include:

MMSE (Mini- Mental State Exam)

- Looks at memory, attention, etc.
- Not 'best' screen for early dementia
- Old tool, widely used to track decline

MOCA (Montreal Cognitive Assessment)

- May be better at finding early problems

CPS (Cognitive Performance Scale)

Used as part of MDS data set

Studies underway indicate that the loss of body mass maybe the first sign of decreased cognitive abilities. The greater the loss of Body Mass Index (BMI), the increased chance of developing Alzheimer's.⁷ It was recently reported that the steady weight loss normally associated with aging doubles in the year before even the mildest Alzheimer-like symptoms become evident.

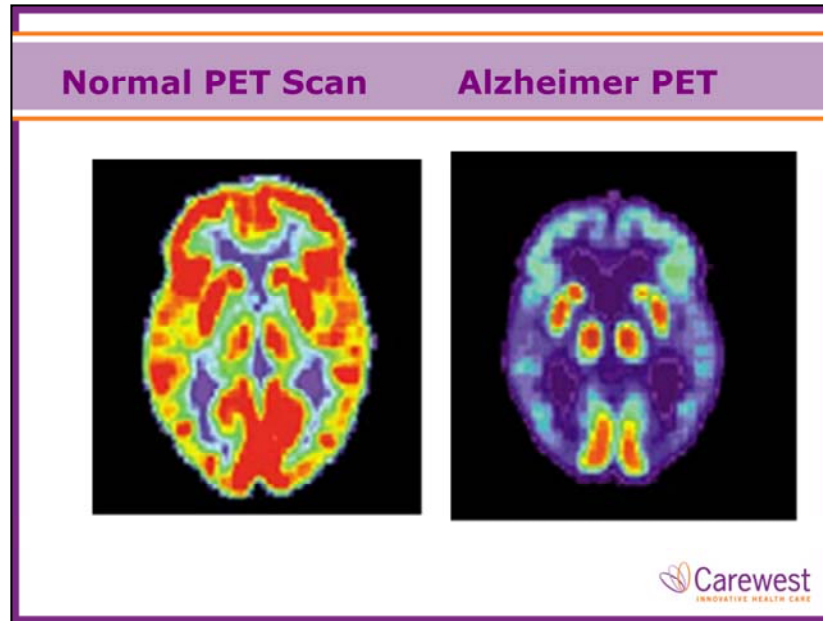
Alz research report p9

Recent research study suggests that, in some people, changes in gait and balance may appear as early indicators of Alz. , even before memory changes. " Research advances ...Alz. Assoc.Intern. 2011 p2

Trainer: Discuss if more professional staff level

Future of Alzheimer Diagnosis- "A revised diagnostic testing protocol has been recently proposed which includes imaging evidence for shrinkage of key brain regions, evidence of reduced glucose utilization in the brain, the presence in the cerebrospinal fluid (the CSF, the fluid which bathes the brain and spinal cord) of abnormal levels of A-beta, evidence of the existence of a genetic mutation for Alzheimer's disease within the immediate family, and of course indications of dementia. Discussion continues on whether this newly proposed set of criteria should become the universal standard." p9 A report on Alz....

New Research-A recent small pilot studied blood vessels at the back of the eye. "The reseachers found that the width of certain blood vessels in the back of the eye were significantly different for people with Alzheimer's compared to healthy people, and this correlated with brain imaging that is indicative of Alzheimer's." p5 Research Advance from AAID Conference 2011



PET = Position Emission Tomography.

- mostly just used in research and is not available for diagnosis. Researchers at the University of California, Los Angeles combine PET with a chemical marker (FDDND) to detect tangles and amyloid plaques.

For interest, this overhead shows the difference in the brain of a person with Alzheimer disease (right) and one without (left). The areas of red indicate which parts of the brain are working. As you can see in the image on the right, these areas are very much diminished in the person with Alzheimer Disease.

Mild Cognitive Impairment (MCI)

- Have problems with memory that are noticeable to themselves or others but do not interfere with daily life
- Not everyone diagnosed with MCI will develop Alzheimer's Disease but their risk is increased



We now know the early warning signs of the disease can begin some 15 years before symptoms of a Mild Cognitive Impairment or when the beginning signs of a dementia surface. Reisberg Alz.org

Mild Cognitive Impairment (MCI)-

“However, research has shown that individuals with MCI have an increased risk of developing Alzheimer's over the next few years, especially if their main problem is memory. 1

1- p4 Research Advances from the Alzheimer's Association International Conference 2011

New Research-A recent small pilot studied blood vessels at the back of the eye.

“The reseachers found that the width of certain blood vessels in the back of the eye were significantly different for people with Alzheimer's compared to healthy people, and this correlated with brain imaging that is indicative of Alzheimer's.” p5 Research Advance from AAID Conference 2011

Dementia/Delirium/Depression

- Often referred to as the 3 Ds
- It is important to know the differences as individuals may have one or a combination of two or three of these conditions
- They all can effect memory and cognition



Let participants know that we will review the 3 Ds further in future slides.

The next three pages of notes cover information for the instructor but are not part of the slide show so participants won't see them. The information will be in the 2015 handouts and a brief one appears in the 2012 handouts. .

Comparison of the 3 D's

	Depression	Delirium	Dementia
Definition	A change in mood which lasts at least 2 weeks and includes sadness, negativity, loss of interest, pleasure and/or decline in functioning.	An acute or sudden onset of mental confusion as a result of a medical, social, and/or environmental condition.	Progressive loss of brain cells resulting in decline of day-to-day cognition and functioning. A terminal condition.
Duration	At least 6 weeks, but can last several months to years, especially if not treated.	Hours to months, dependent on speed of diagnosis.	Years (usually 8 to 20)
Thinking	May be indecisive and thoughts highlights failures and a sense of hopelessness.	Fluctuates between rational state and disorganized, distorted thinking with incoherent speech.	Gradual loss of cognition and ability to problem solve and function independently.
Mental status testing	Capable of giving correct answers, however often may state "I don't know"	Testing may vary from poor to good depending on time of day and fluctuation in cognition.	Will attempt to answer and will not be aware of mistakes.

Delirium in the Older Person: A Medical Emergency. (2006) VIHA



Comparison of the 3 D's

	Depression	Delirium	Dementia
Diagnosis	May deny being depressed but often exhibit anxiety. Others may notice symptoms first. Increased complaints of physical illness. Social withdrawal is common.	Diagnosis on rapid onset of fluctuating symptoms. Can be mistaken for progression of the dementia.	Usually diagnosed approximately 3 years after onset of symptoms. Must rule out other cause of cognitive decline, e.g. depression or delirium
Care approaches	Identify the symptoms of depression early. Help person to follow treatment plan & offer them hope.	Early recognition is key. Keep person safe, find cause of the delirium and treat as quickly as possible.	Maintain and enhance abilities that remain. Focus on the positive and support the lost abilities.
Prognosis	Treatable and reversible condition.	Treatable and reversible with early diagnosis but can lead to permanent disability or death.	Progression can be slowed but not reversed.

Delirium in the Older Person: A Medical Emergency. (2006) VIHA



Comparison of the 3 D's

	Depression	Delirium	Dementia
Memory	Generally intact, though may be selective. Highlights negativity.	Recent and immediate memory impaired.	Inability to learn new information or to recall previously learned information.
Sleep-wake cycle	Disturbed, usually early morning awakening.	Disturbed. Sleep-wake cycle is reversed (up in night, very sleepy and sometimes non-responsive during the day)	Normal to fragmented.
Hallucinations & Delusions	Can be present in a severe depression. Themes of guilt & self-loathing	Often of a frightening or paranoid nature	Can be present. May misperceive. In Lewy Body dementia visual hallucinations are present.

Delirium in the Older Person: A Medical Emergency. (2006) VIHA

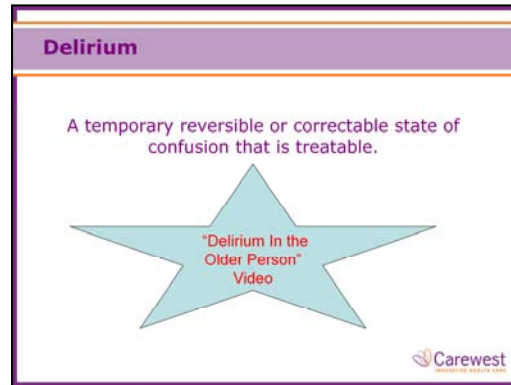


Comparison of the 3 D's

	Depression	Delirium	Dementia
Treatment	Antidepressants, ECT, interpersonal therapy, behavioural-cognitive therapy. Assist person to improve confidence and self-esteem through conversation and activity.	Treat underlying cause. Monitor response. Be alert for relapse; occurs in 90% of cases.	Cholinesterase inhibitors slow the progression of some dementias. Symptomatic treatment with environmental & staff approaches.

Delirium in the Older Person: A Medical Emergency. (2006) VIHA





DELIRIUM is a medical emergency

Delirium often goes unrecognized because health care providers see confusion as a part of being old or dementia

It may be difficult to diagnosis in the person who has dementia.

Show the Video Clip from:

"Delirium In the Older Person" Vancouver Island Health Authority 2007

Suggest they try look for information in the video that differs it from dementia

SEE NEXT SLIDE for debriefing

Delirium and Dementia Quiz

1. Can delirium occur in people with dementia?
2. What could cause delirium? (give 4 examples)
3. Is it reversible? (How long could it last?)
4. What are the presenting signs that help us recognize it is delirium not just dementia? (How are they different than dementia?)



Ask participants to discuss these questions with a person next to them. Give them 3 minutes – then bring the group back to discuss the following answers.

1. Yes
2. Some examples:
 - Drugs (side effects or interactions)
 - Bugs (infection)
 - Constipation
 - Dehydration
 - Pain(80% experience delirium during the dying process)
3. Yes – early intervention is vital – treating the cause
Usually short lived once interventions are in place
Untreated delirium can persist months after discharge from hospital
There is a 90% chance that delirium will occur again
4. Answers are on the next slide

Signs and Symptoms of Delirium

- Starts **suddenly** and changes throughout the day (often worse at night)
- **Inattention**: can't focus on instructions
- **Disorganized thinking**: jumps from topic to topic
- **Change in awareness**:
 - hyper-alert (wide eyes, jumpy), OR
 - very withdrawn, sleepy (may have both)

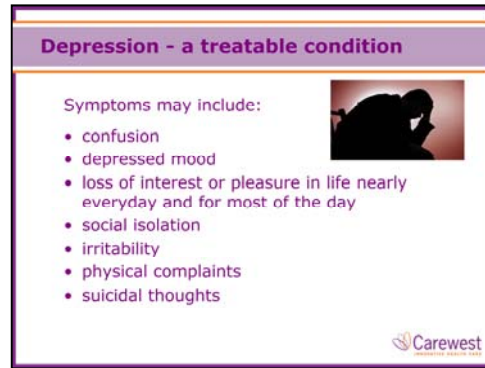


Differences from Dementia include:

- Sudden onset
- Changing topics in the middle of the sentence
- Changes in their level of awareness

A study indicated that 70% of the cases of hypoactive delirium (withdrawn or sleepy) were missed

Role Play by instructor: Hypo Active delirium in resident
i.e. 'someone in their own world'



Remind everyone that a person can have both or all three D's

DEPRESSION:

- A depressed older adult can appear to have the same cognitive and memory problems as someone with dementia, but when their depression is treated, they regain their mental abilities.
- 20% of people age 65 and over suffer mild to severe depression
- 5-10% of older adults in the community have depression
- 30-40% of older adults in LTC have depression

Depression is very common in people who have other illnesses.

Examples: cancer, heart disease, MS, Parkinson's,
strokes, Alzheimer's Disease

SIGNS AND SYMPTOMS:

- Often no complaints of a depressed mood
- More social isolation
- Decline in ability to care for themselves (ADLs)
- Confusion
- Increase of physical complaints-aches and pains
- Use of alcohol and store bought drugs increase
- Repetitive questions
- Irritability
- Increased loss of self esteem
- Talking about suicide or wanting to die

A study by Dr. Lilian Thorpe at the University of Saskatchewan shows guilt and worthlessness are significantly less common in dementia than in depression.

Depression and Dementia

Depression is common in persons with dementia
but what are the differences?

With depression:

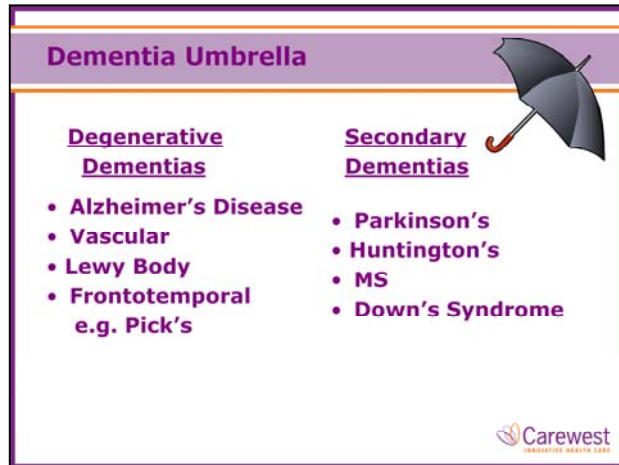
- There is a change in their level of interest
- Treatment can be effective
- Likely to be concerned about their memory impairment
- Frequent physical complaints are common
- Sleep is often affected

(e.g. early waking or sleeping excessively)



Discuss how difficult it is to recognize depression when someone has dementia but we should always keep the possibility in mind

Remind them as well that we need to be aware of the risk of suicide.



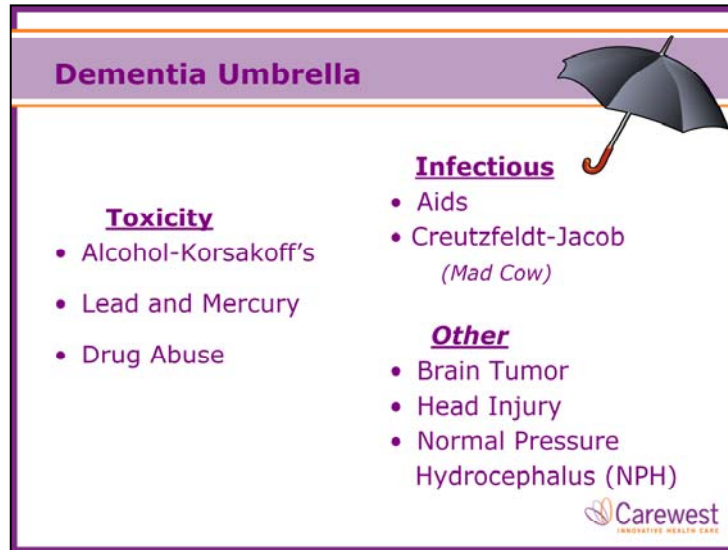
Use the dementia umbrella overhead:

Highlight the many causes of dementia. It is important to know what type of dementia the client has as it may help in planning care and knowing what is part of the disease process. Some clients may have more than one type of dementia as Alzheimer's and vascular dementia can often occur in the same person.

TRAINER TIP: later in the module, participants do an exercise to learn more about Lewy Body, Vascular, Pick's, Korsakoff's so don't explain each disease in any detail at this time. The point of this slide (and the next one) is 'there are many causes of dementia.'

- Alzheimer 50% to 60% of dementias over age 65;
- Vascular and Lewy Body are the next most common forms of dementia.

If you can, give examples of individuals that you have looked after with some of these types.

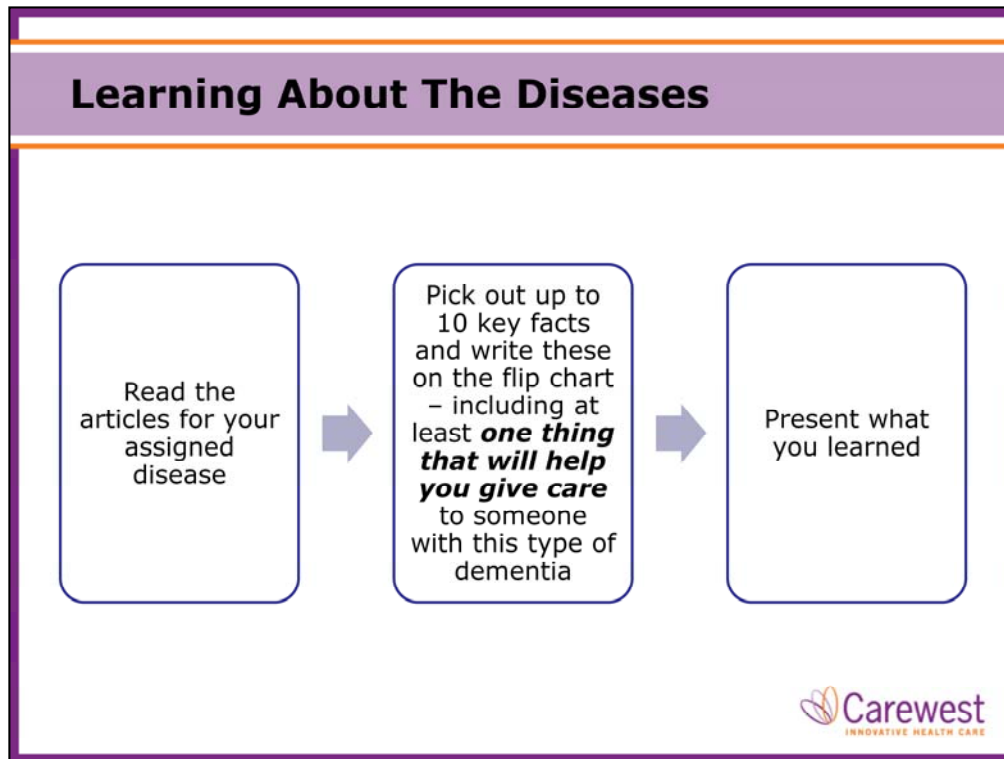


Lead toxicity may be found in a person who used lead paints as an artist and now has dementia.

In history, 'mad as a hatter' came about because people making hats becoming demented due to heavy metal exposure.

The three items under the "other" category may, or may not, be reversible.

Hallmark signs for NPH are unstable gait, falls, early incontinence.



GROUP WORK

The purpose of this exercise is help the staff learn about ONE of the causes of dementia and then ‘teach’ the rest of the group what they learned. This “participation” helps cover ‘dry’ material in a more interactive way. *Tell them we will discuss Alzheimer’s disease in more detail later.*

Break the participants into at least four groups. Give each group a couple of flip chart pages/ felt marker(s) or note paper and ask them to record the 10 items and the 1 care strategy from the articles on their assigned type of dementia. Each group will have articles on ONE of: Lewy Body, Vascular, Picks, or Korsakoff’s. (Suggestion – limit the number of articles to 1-2.)

Allow about fifteen (15) minutes for them to pick out key facts about that type of dementia to present to the rest of the group. Also ask for one thing they have learned that will help them care for someone that has that type of dementia. Ask each group to share their report with the others. Add any content you think they missed or ask questions about that content to cue them to teach it (See the next page for trainer information – don’t feel you have to re-teach this material).

This is in participants' handouts. You can use it to ensure basic points are covered by the group teaching exercise on the previous page.

ALZHEIMER DISEASE

- believed to be caused by abnormal proteins collecting in the brain (plaques and tangles) that cause brain cells to die and interfere with the transmission of messages throughout the brain
- decline in function is generally described as a gradual loss of abilities over several years.

VASCULAR DEMENTIA (MULTI-INFARCT DEMENTIA)

- is caused by a single or multiple small infarcts (strokes) that interrupt blood flow causing the brain tissue to die.
- described as progressing in a step-wise manner. The person may have a sudden decline, level out or improve for awhile then decline again if a new infarct occurs. Deficits seen will depend on the areas of the brain affected. Some of these infarcts produce no obvious symptoms and a person may have several before noticing changes in function.
- Sometimes it is difficult to distinguish multi-infarct dementia from Alzheimer disease as the symptoms are similar and it is possible for a person to have both diseases at the same time. A CT scan of the head may be ordered to detect small areas of infarct.

DEMENTIA WITH LEWY BODIES

- thought to be a frequent cause of dementia
- no test to diagnose dementia with Lewy Bodies, so diagnosis is based on clinical features. It usually progresses more rapidly than Alzheimer disease.
- Hallucinations (usually visual)
- early gait disturbance and falls are a feature of this type of dementia.
- Abnormal cells called Lewy bodies are found in an area of the brain stem also affected in Parkinson's disease as well as in the cerebral cortex. They may exhibit many of the features of Parkinson's disease but are milder than classic PD.
- The client with this type of dementia may experience fluctuations in their mental status, level of alertness and syncopal spells. Because confusion is not always there, caregivers may think they are pretending or may ask too much from them thinking they are more capable.

- Psychotic features such as delusions and sleep disturbance (excessive sleep or abnormal movements during sleep) are also features of the disease.
- These clients may benefit from cholinesterase-inhibitor agents such as Aricept. Neuroleptic drugs should not be used or used with extreme caution with this type of dementia as they may cause a dramatic worsening of the condition.

Frontotemporal –

Caused by damage or disease in the brain's frontal lobe

Common presenting behaviors:

- craving of carbs
- socially disinhibited
- sexually inappropriate
- no understanding of consequences
- often labelled 'manipulative'
- memory can be fairly intact

PICK'S DISEASE

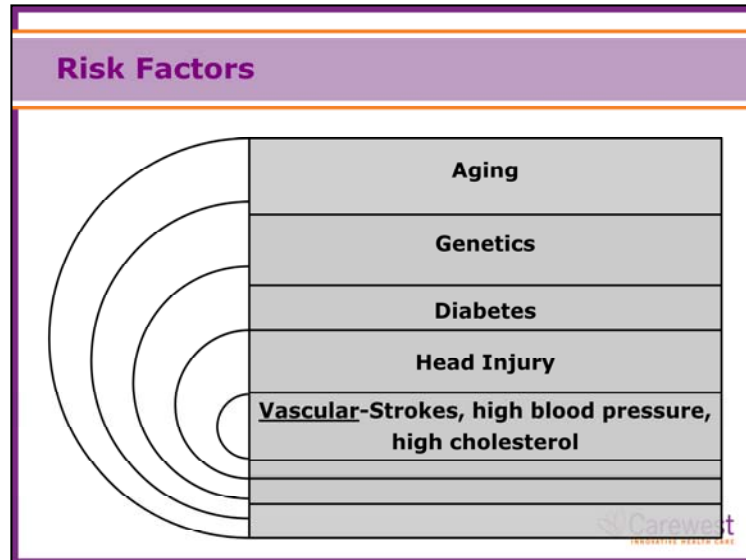
- is a rare disorder which has an early onset (age 40 to 60)
- brain cells are found to be swollen and abnormal (Pick cells)
- affects mainly the frontal and temporal lobes
- less memory loss and more personality change and socially inappropriate behavior
- failure to recognize objects, changes in sexual behavior and sometimes there is a craving for carbohydrates. There is early language loss and eventually mutism. There is no cure or treatment.

KORSAKOFF'S SYNDROME

- is caused by a lack of thiamine (Vitamin B1), which affects the brain and nervous system, rather than by alcohol directly.
- Brain damage occurs in the mid part of the brain resulting in severe short term memory loss.
- Many other abilities may remain intact. They may have a lack of insight re: their memory loss.

DOWN'S SYNDROME

- increases in this population group are likely due to enhanced life expectancy with many living into their fifties and some into their eighties
- 10% – 40% have hypothyroidism which when untreated can contribute to dementia.



Trainers Tip: go over the next risk factors (2slides) and reducing your risk (1slide) very quickly due to time restraints

Aging: Thought to be related to deterioration in the body's self repair mechanism. What is most important is brain age not chronological age.

Genetics: The most important genetic risk factor for early onset Alzheimer disease is the apoE4 gene. If you carry two apoE4 genes (one from each parent) the risk increases ten times the normal risk. You can have no apoE4 genes and still get Alzheimer's or you can have two and not get the disease.

Diabetes-

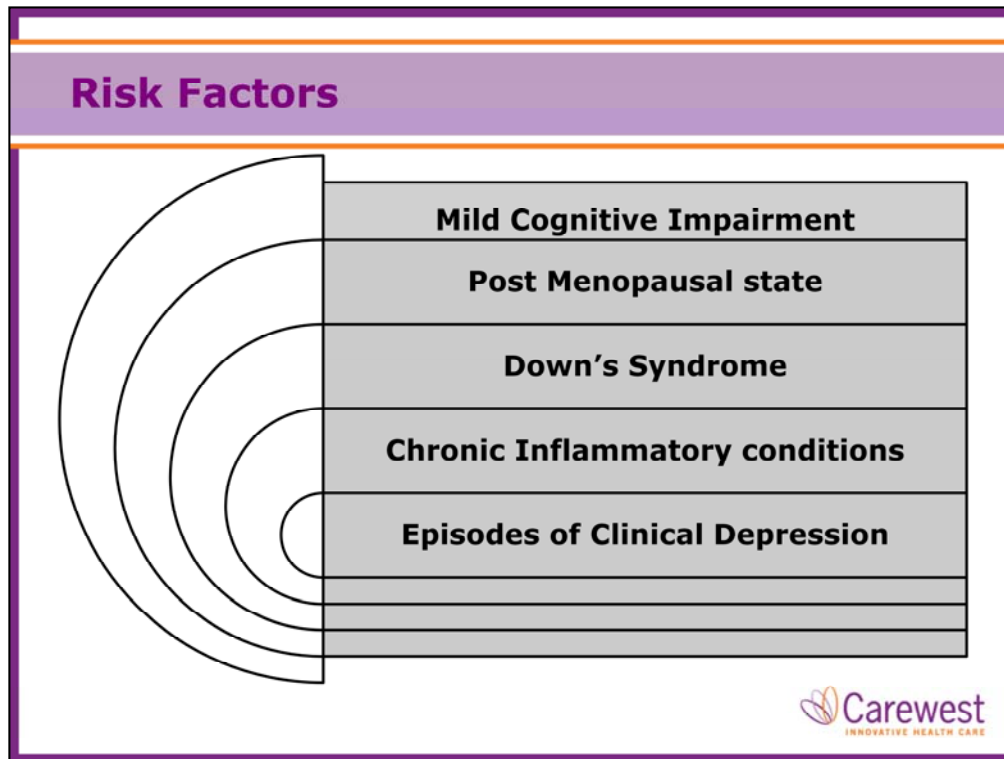
- Type 2 diabetes is a risk factor possibly due to vascular disorders
- Unknown mechanism- lack of insulin or decreased sensitivity to insulin
- Glucose utilization impaired in Alzheimer brain. New studies are looking at use of inhaled insulin or new diabetic medications to treat.

Head Injury- Also known as TBI (traumatic brain injury). A study on veterans who experienced traumatic brain injury showed a two-fold increase in risk of developing dementia. Mention items in news re dangers of concussions for football and hockey players. Alz. org

- **Vascular-** studies have found, for example, that heart disease and stroke may contribute to the development of AD, the severity of AD, or the development of other types of dementia. Studies also show that high blood pressure that develops during middle age is correlated with cognitive decline and dementia in later life. ADEAR

Other Vascular Research

- Strokes and “ministrokes” cause increase in enzymes called caspases that ultimately result in increased build up of A-beta in Alzheimer’s disease.
- The brain’s ability to rid itself of toxic beta-amyloid by sending it out into the body’s blood circulation is lessened. Some scientists now think that poor clearance of beta-amyloid from the brain, combined with a diminished ability to develop new capillaries and abnormal aging of the brain’s blood vessel system, can lead to chemical imbalances in the brain and damage neurons’ ability to function and communicate with each other.



MCI- discussed earlier

Post Menopausal

A number of clinical researchers continue to regard Hormone Replacement Therapy as worthy of further study, especially because of studies showing that estrogen treatment of postmenopausal women effectively reduced the incidence of Alzheimer's disease. Animal studies are also pointing to the possibility that testosterone treatment could benefit men in this regard. Alz Report ALZ canada

Down's Syndrome-

Almost all who live beyond 40 show brain changes similar to Alzheimer Disease but not all will develop dementia.

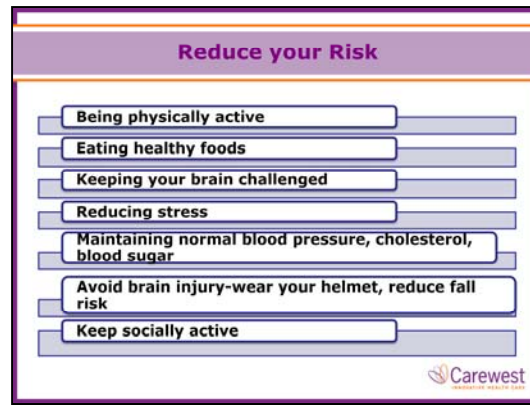
Have earlier onset of dementia- 40' or early 50's.

Chronic Imflammatory Conditions

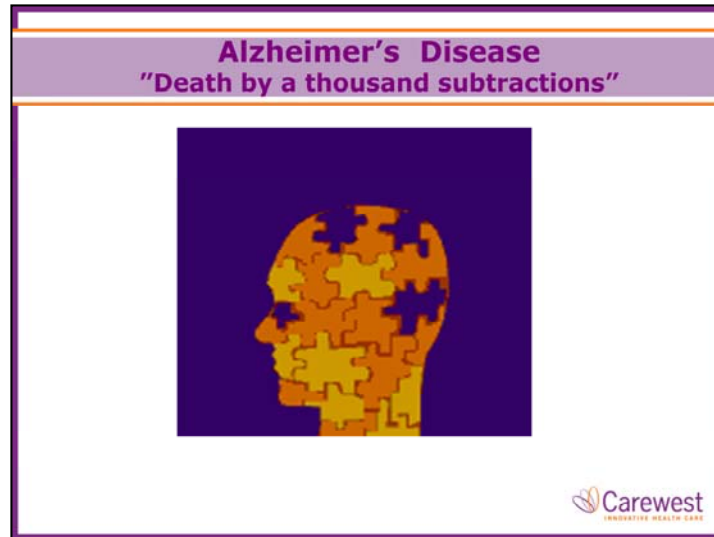
- Evident statistically

Episodes of Clinical Depression

- Evident statistically



- **being physically active-** in one Canadian study people exercising three times a week were 40% less likely to develop Alzheimer's. May be related to its benefits for Cardiovascular health
- **eating healthy foods** including fresh fruits, vegetables and fish e.g Mediterranean diet.
 - Certain spices used in curries, especially curcumin, have been implicated in the lower than average incidence of Alzheimer's disease in curry eating populations and research is actively under way to identify drugs that would mimic the active ingredients of the spices used.
- **keeping your brain challenged-** Studies show that regularly challenging your brain may reduce your likelihood of developing Alzheimer's disease, so it is important to give your brain a regular work out.
 - Play games to challenge your mind -chess, cards, word or number puzzles, jigsaws, crosswords, and memory games
 - Pursue a new interest, learn a language, take up a musical instrument, take a course, go to a museum, enjoy hobbies
- **reducing stress-** learn positive coping skills, resilience
- **maintain normal blood pressure, blood sugar and cholesterol levels.**
- **avoiding traumatic brain injury-**
 - Wear an approved helmet when engaging in sporting activities such as skating, skiing, skateboarding, rollerblading and cycling.
 - Protect against concussions by using safety features like handrails to avoid falls.
- **keeping socially active-** Loneliness in seniors has been linked to a higher risk for dementia. Social interaction appears to have a protective effect against Alzheimer's disease.



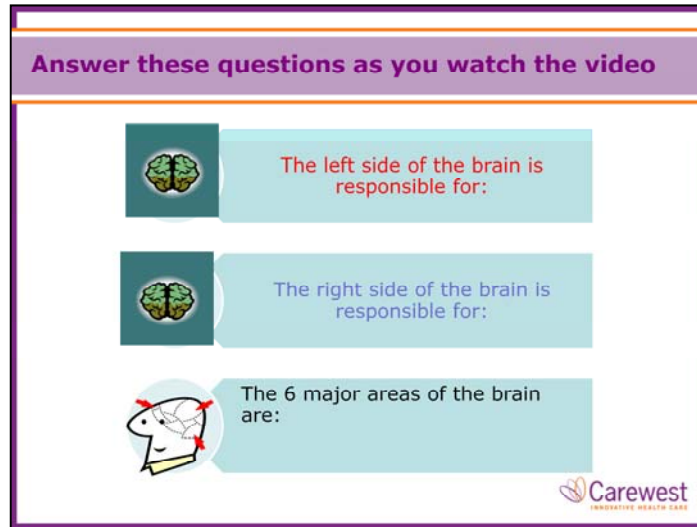
The following section will focus on Alzheimer Disease as it is the most common form of Dementia. The term “Death by a thousand subtractions” describes the losses the person with Alzheimer Disease experiences- loss of friends, independence, job, abilities, family, memories.

Show video but first introduce the activity on the next slide

Facts:

- New studies of the incidence of Alzheimer's disease are in progress, but at present it appears that some 5-8% of Canadians over the age of 65 have Alzheimer's disease, rising to an alarming 30-50% of those over 85. p2
- Alzheimer's is a fatal disease and death occurs within 7-10 years after diagnosis.p1

Alz. Canada research report A Report on
Alzheimer's Disease and Current Research
by Dr. Jack Diamond, Scientific Director
Alzheimer Society of Canada



This video will give some idea of the changes that happen in the brains of people with dementia. **Ask participants to answer the questions in their handout as they watch the video – worksheet in the handouts**

Show the video – Module 4- The Alzheimer Journey: Understanding Alzheimer Disease: The link between Brain and Behavior (17 min. long)**The notes below are a REVIEW of the material in the video and should be used ONLY to highlight information that might be pertinent to your audience.**

As Alzheimer Disease spreads through the brain, parts of the brain become unable to perform their usual functions. As neurons are lost or lose their ability to transmit messages effectively the loss of ability is compounded. As we discuss changes in the brain think of clients you care for that may show signs of these losses. As important as it is to know what is lost, it is equally important to know what is retained until late in the disease process. We will discuss this later.

For instructor info only - do not cover in the training – they will get this info from the video etc.

It is thought that AD starts in the Hippocampus and limbic areas and spreads out from there. The hippocampus plays an important role in storage of memory. Early signs of AD are problems with short-term memory. The limbic system mediates emotions, learning and memory. Early in AD people may experience a flattening of emotions. Later in the disease apathy is a common feature.

A. BRAIN PARTS AND CARE IMPLICATIONS

TEMPORAL LOBE - *Responsible for hearing, acquisition of memory and some visual perceptions. The right temporal lobe controls visual memory- people's faces, landmarks. The left temporal lobe controls verbal memory - what we hear. Categorization of objects.*

Changes Seen - Care Implications

- Getting lost - may need more rehearsal and familiar landmark to find their way.
- May forget faces of family and not recognize them
- May not recognize self in mirror and react like there is a stranger in their room.
- Difficulty understanding the spoken word- staff to use gestures to convey meaning.
- Memory difficulties both short and long term- may forget many things from the past. May not remember children/wife.
- Not remembering to wash or eat.
- Increase in aggressive behavior.
- Increase or decrease interest in sexual behavior.

FRONTAL LOBE - *This part of the brain is responsible for personality, speech, skilled muscle movement, mood, planning, judgment, initiation, and inhibition.*

Changes Seen - Care Implications

- Change in personality. Increased apathy, less spontaneity.
- Inability to plan- May first manifest in inability to plan complex tasks so have problems at work early in disease; then even tasks like making coffee become too complex. May require step-by-step instructions to complete a task. Difficulty dressing e.g. Shoes on before pants.
- More inflexible- responds well to structure/routine
- Inability to focus on a task.
- Difficulty problem solving.
- Inability to initiate. May turn on a tap and not be able to initiate an action to turn it off.
- Perseveration- stuck on an action, repeating a word or thought, tapping all the time (distract, try to break the pattern with a different action).
- Inability to express language (Pick's Disease, stroke in this area)
- Disinhibition- swearing, aggression, sexual behaviors, saying what they think

PARIETAL LOBE - *This part of the brain receives and processes information about temperature, taste, touch, and movement coming from the rest of the body. Reading and arithmetic are also processed in this area.*

Changes Seen - Care Implications

- Difficulty naming an object (anomia) but they may describe its function (the thing that holds water).
- Difficulty doing math (financial management problems) Trusteeship needed.
- Difficulty drawing objects (MMSE tests this)
- Difficulty distinguishing right and left (don't ask them to lift their left foot)

- Inability to attend to more than one object at a time (if more than one caregiver present just one person talk; make your plan before you enter the room (who will provide care, who will distract, interact with the client). If resistive to changing incontinence products, ask client to wash their hands while you do the change – they may not be able to attend to both the hand washing and what you are doing.
- Apraxia- Inability to carry out purposeful movement (decreased ability to dress, feed self)
- Decreased hand eye co-ordination (feeding difficulties, reaching for objects, catching ball)
- Difficulty with spatial relationships (sitting down too soon, increased fall risk)

OCCIPITAL LOBE - *Processes visual information.*

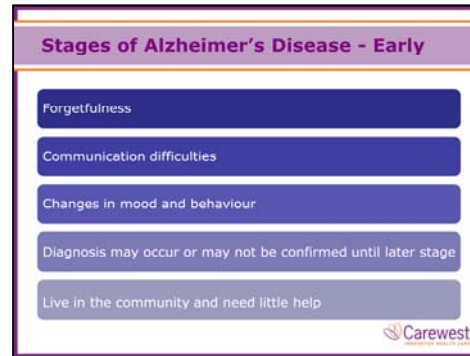
Changes Seen - Care Implications

- Hallucinations- may be frightened, upset
- Visual defects- visual field cuts- may not see food on one side.
- Difficulty locating objects in the environment (sweater on the bed if the bedspread is same colour)
- Decreased color identification-need good contrast between colors
- Inability to recognize words- unable to read or write
- Inability to track an object. Staff may startle the person as they haven't tracked your progress toward them.

CEREBELLUM - *Co-ordination of voluntary movement/ balance*

Changes Seen - Care implications

- Loss of ability to walk
- Unable to co-ordinate fine movement- unable to feed self
- Dizziness
- Inability to make rapid movement
- Slurred speech



Stages of Alzheimer's disease

The disease affects each individual differently, the symptoms, the order in which they appear and the duration of each stage vary from person to person. In most cases, the disease progresses slowly, and the symptoms of each stage may overlap, often making the move from one stage to another quite subtle.

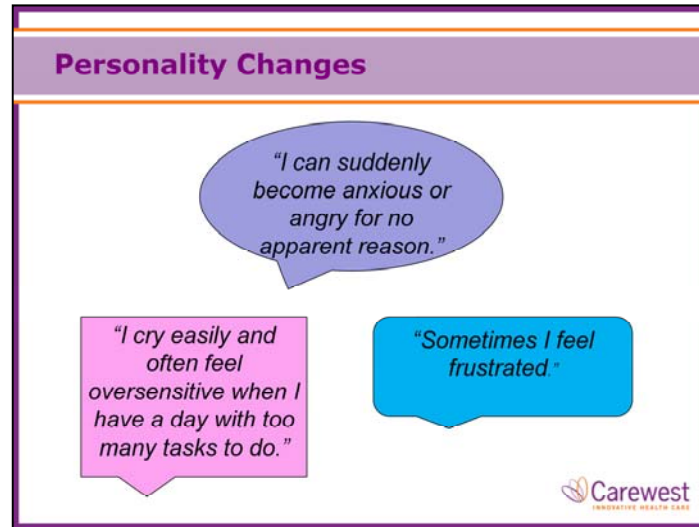
Early stage

- also referred to as "mild Alzheimer's disease" refers to people of any age who have mild impairment
- some people aren't aware that they have the disease during this stage
- forgetfulness, communication difficulties, and changes in mood and behaviour
- need little help. Live in the community.
- they may understand how they are changing and be able to talk to others about their experience of living with the disease
- may also wish to help plan and direct their future care

Planning for future:

- Disease knowledge- Link with Alzheimer Society for support and knowledge
- Future wishes re living arrangement- discuss with family/ main support person.
- Update or make a Will
- Personal Directive- In Alberta this document appoints someone to make non-financial decisions E.g. health care, living arrangements
- Enduring Power of Attorney- Financial decisions

Examples of common deficits include decreased ability to manage finances, withdrawal from former activities that are too complex E.g. work

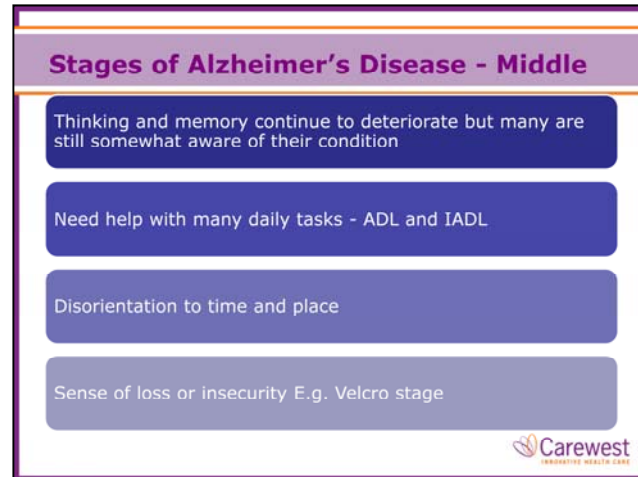


PERSONALITY CHANGES – quotes from clients who have dementia

For some types of dementia personality changes may be the first sign and can be dramatic E.g. Frontotemporal

mood swings

- apathy,
- anxiety,
- depression,
- suspiciousness
- misinterpretation of visual or auditory stimuli
- irritability
- may be a decrease in emotion and a flattening of affect. One person with Alzheimers described it as, "you don't smile like you used to." (Shared Experiences, p. 21).
- personality changes are difficult for family members to deal with. Some family and friends may stop visiting the person as they no longer see them as the same person.
- family members may not understand the disease process and may attribute the person's actions as being deliberate or against them ("She is just trying to make me feel guilty"). Family and caregiver education re the disease process is very important.



Middle Stage

- also called "moderate Alzheimer's disease."
- for families and caregivers, it is the point where they may increasingly need to provide care. Community services often involved.
- disorientation to time and place
- safety issues- wandering, water temperature, guns
- caregiver support needed
- it may include moving the person to a care facility.
- this stage often seems the longest

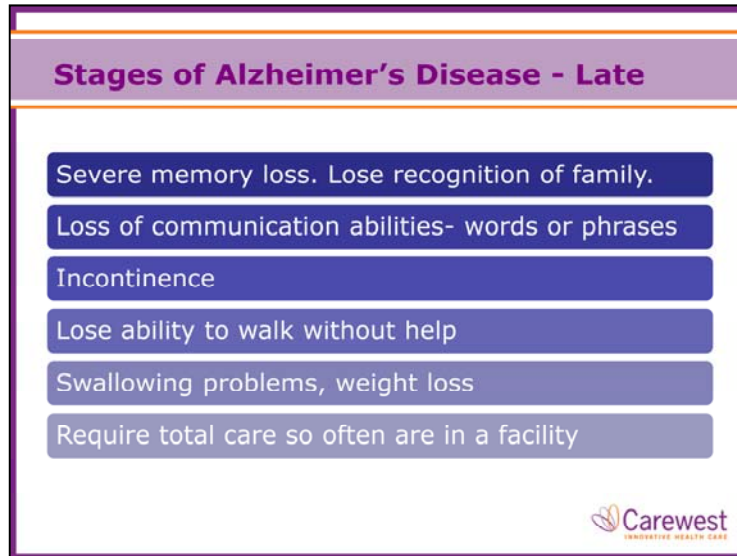
Often people are diagnosed in this stage as their deficits become more apparent. Guardianship and trustee issues may arise.

For some people with little family involvement they will come to the attention of the community during this stage if not earlier (spoiled food, not taking medications, unkempt).

Caregivers may still be managing at home with home care, day care and respite programs.

ADL – activities of daily living e.g personal care like bathing

IADL – instrumental activities of daily living – e.g. shopping, banking




Late Stage-Reinforce that Alzheimer Disease is a terminal disease.

- also called "severe" or "advanced."
- distressed behaviour issues may emerge as communication decreases and brain deterioration increases
- decreased mental ability -severe loss of memory, ability to process information and understanding of time and place
- lose their ability to speak, although they may still say words or phrases. Non-verbal communication will become more important.
- lose the ability to walk without help, then the ability to sit without support, the ability to smile, and the ability to hold their head up. The brain appears to no longer be able to tell the body what to do.
- more frail physically and need 24-hour care. The goal of care at this stage is to continue to support the person to ensure the highest quality of life possible.
- total care so most are living in a facility

FAST (Functional Assessment Scaling Tool)

- Another tool used to describe the progression of **Alzheimer's Disease**
- Developed by Dr. Barry Reisberg in 1982
- Includes Stages 1-7
- Based on the concept that people with Alzheimer's Disease lose their abilities to do things in the opposite order that we gained them
- This awareness helps us understand what types of assistance may be needed



Reisberg has developed a 7-stage tool called Functional Assessment Staging (FAST). This is another approach to describe the progression of **Alzheimer's Disease**.

These stages describe a loss of functional/cognitive ability that seems to occur in a predictable pattern. A client once described what he was experiencing when he said; "I'm not a child going up, I'm a man coming down".

This loss of ability appears to researchers to be opposite to the order in which we gain abilities. For example, we learn to feed ourselves, walk and speak at a young age. These abilities are usually retained until late in the disease process. This concept is referred to as 'Retrogenesis'.

In spite of declining abilities it is important that we do not treat persons with dementia like children. Our goal is to always maintain their dignity. We preserve the person's dignity by changing our approach to meet their changing needs.

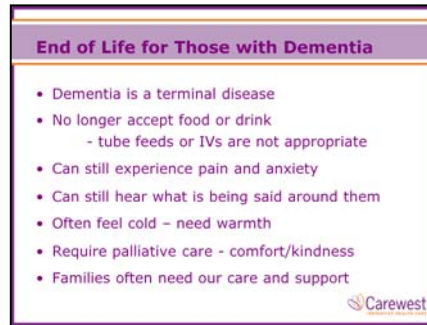
Examples:

- when we are a toddler we can't manage all our foods at once – if we have Alzheimer's disease there may be a time where we need one food item at a time
- one of our last skills to learn may be balancing a check book and it may be one of the first skills lost in Alz Ds so they will need help with this

FAST Stages	
FAST Stage	Description
Stage 1,2,3	Normal Function Stage 1,2. Stage 3 Mild Cognitive Impairment
Stage 4	Mild Alzheimer Disease Decrease in memory apparent. Needs help for complex tasks.
Stage 5	Moderate Alzheimer Disease Remote memory loss starts. Unable to live alone.
Stage 6 (has 5 sub-stages)	Moderately Severe Alzheimer disease Incontinence. Fear of bathing. Increase in behavioural disturbances.
Stage 7 (6 sub stages)	Severe Alzheimer disease Speech limited. Physical rigidity. The client will die in this stage.

Stage 5 has been referred to as the “all dressed and no place to go” stage. This is when the person may be packing their bags to leave often because they think they have to go and take care of something e.g their young children, their job etc

Stage 6 has been referred as the “velco” stage where the person seems to latch onto someone because they fear being alone and unable to find their way



In the terminal stage of AD, food refusal and difficulty with eating and swallowing is the initial sign of the dying process. Intermittent and variable appetite declines to the point the person is unable or unwilling to eat or swallow. Person becomes lethargic, needs more bed rest, total care for ADL's. Behavioural issues subside and many oral meds can be discontinued. The staff provide total care and support the family who need increased emotional support.

Caring for the Client with End Stage Dementia

Loss of ambulation, swallowing difficulties and severe communication deficits characterize the terminal stage of dementia. Although presenting symptoms may vary between dementias there is not much difference clinically in the terminal stage. Our goal for care at this stage is comfort. Reisberg (as cited in Wagner, 2000) states, ***“If we are going to keep people alive, we owe them a life as opposed to suffering. They need not suffer if we understand their condition.”*** Some advocate that clients in end stage dementia be treated with a palliative care approach. The word “palliative” is defined as “to ease without curing”.

INFECTIONS:

An infection is an inevitable consequence of terminal dementia

- impairment of immune function
- incontinence
- inability to ambulate
- aspiration

Pneumonia is the most common cause of death in individuals with dementia. Infections are often recurrent and antibiotics become less effective. There are ethical issues that arise re: treatment or non-treatment of infections. The main question to ask is if the treatment contributes to the comfort of the person – if it would help them be more comfortable, then we would treat their infection.

SWALLOWING DIFFICULTIES/REFUSAL TO EAT

Food refusal may be a result of decreased appetite, dislike of the food, inability to open the mouth or swallow. They may forget to chew and swallow or pouch food in their cheeks. They may eventually be unable to take even a modified diet. This may be a natural consequence of the dying process during which all body functions are gradually terminated.

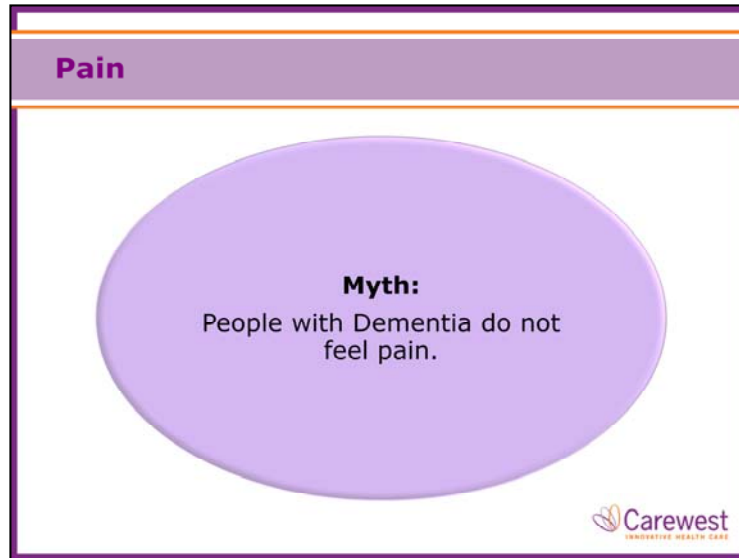
We need to educate the family re the disease progression and prepare them for the time when the client will no longer take food. It is much better to have these issues discussed before a crisis situation. The dying individual does not feel hunger or thirst and the only discomfort is dryness of the mouth (Volicer 2001, p 383). As dementia is a terminal disease, feeding tubes are not appropriate. Research has shown that aspiration pneumonia was found to increase among patients with feeding tubes. Most literature does NOT support the use of tube feedings to prevent malnutrition, improve survival time, prevent or improve pressure ulcers, reduce infections or improve comfort (Head, 2003).

SKIN BREAKDOWN

Immobility, incontinence, weight loss and decreasing nutritional status cause clients in end-stage to be extremely high risk for skin breakdown.

CONTRACTURES

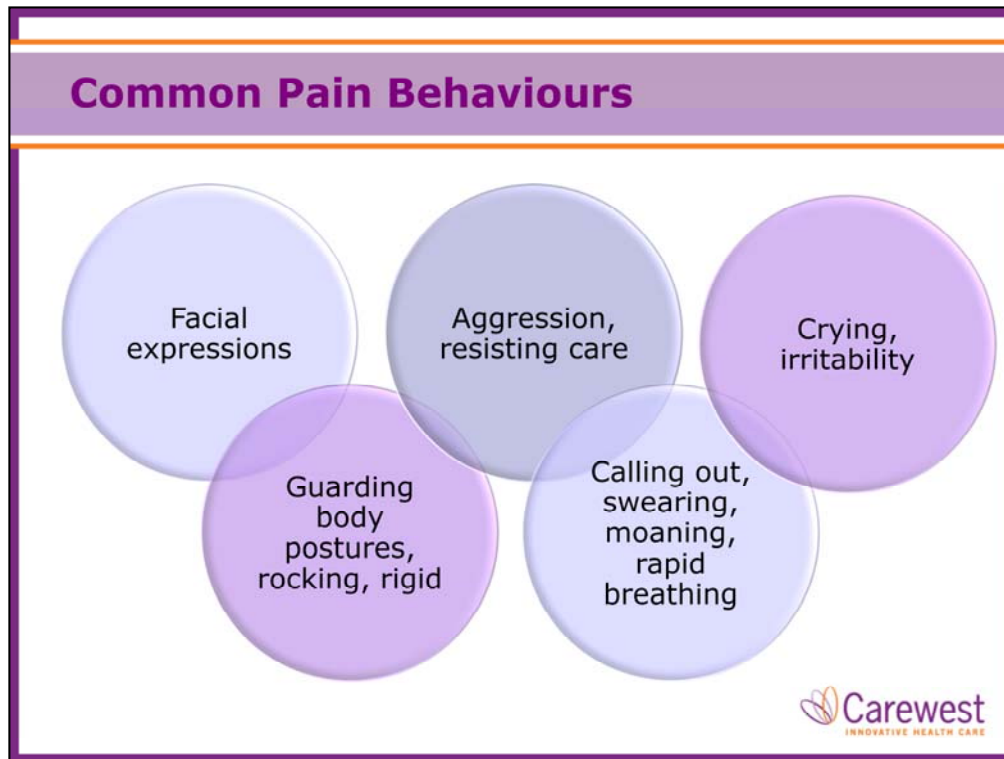
Contractures occur as the client becomes immobile and can be a source of pain. Contractures make it more difficult to provide care. Experience with people who are kept moving, even in the final stages of AD, has shown that contractures can be avoided for many years (Wagner, 2002).



50% community elderly report pain and 80% of LTC report pain.

They have the same reasons for pain as other elderly people-arthritis, shingles, toothache etc. The issue is they may not be able to express pain verbally in late stage dementia.

There may have been an unwitnessed fall causing pain



PAIN

Clients often have severe communication deficits so are unable to verbalize pain. May show as restlessness, repetitive calling out, and irritability that can escalate to aggression during care if the care is causing pain. Caregivers have to watch for non- verbal signs of pain.

Trainer Tip:

Ask: What are signs of pain you would look for? Then click to bring items onto slide.

Restlessness, agitation, facial grimacing, moaning, withdrawal, alteration in respiratory rate.

Involve a Palliative Care team (if one available) to help assess and manage pain.

Dementia

“You wouldn’t ask a person with COPD to ‘just breathe better’ would you?”

Of course not,

but we do catch ourselves expecting someone with dementia to ‘behave better’

– this is a disease of the brain!



Questions?



Please refer to your handouts (references are included)



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