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# THE INTERNATIONAL ALZHEIMER'S DISEASE CONFERENCE

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Emergency Nurse Educator
February 22, 2012

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# Wednesday, February 22, 2012

| | |
|---|---|
| **1300-1330** | ✸ **Introduction to Program Agenda/Review** |
| **1330-1500** | ✸ CARES™ Program *(Part II)* |
| | • Eating Well |
| | • Recognizing Pain |
| | • Minimizing Falls |
| | • Wondering about Wandering |
| **1500-1600** | ✸ Switching Places Simulation |
| **1600-1630** | ✸ Post-Activity |
| **1630-1700** | ✸ Conclusion for the day |
| | • Resources |

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# Day 1

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# Memory

- Dementia attacks the short-term memory first
  - Difficulty recalling things that were just said
- Caregivers will need to repeat things multiple times to residents
  - Simplify things and make statements and tasks concrete using short sentences
- Respect them while facilitating memory
  - Limit options by giving 2 choices
- Preserve memories are those from a long time ago (childhood, family, school and friends).
- As dementia progresses the memories are stolen & eventually never found.
  - Recall memories by talking to the resident to connect and revive their identity

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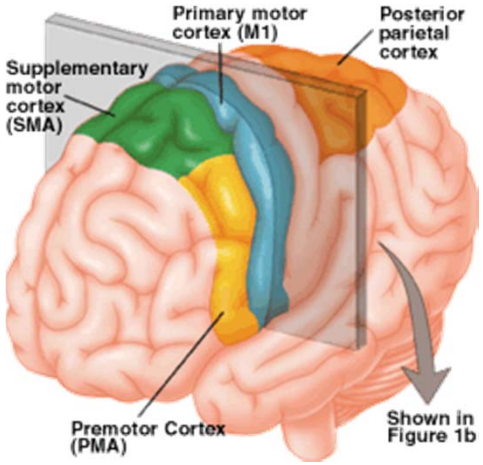
# Motor

- Differs depending on the resident's phase in dementia
- Generally will lack coordination & balance in day-to-day movements
- Fine motor (in fingers) and gross motor (in walking) will all be affected
  - Increased risk of falls
- As dementia progresses, chewing and swallowing difficulties will occur.
  - Motor response for the mouth and tongue decline



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# Language


- First impacted!
- It is difficult for the resident to express themselves
  - Word finding (tip of the tongue) becomes more frequent
  - Sentences will be broken down and difficulty to understand by others
    - Loss of the ability to use the correct word (thingy for telephone)
    - Content will become general or vague
- Emotional experience of what they communicate is well preserved.
  - Focus **less** on what they are saying and more on the emotion they project
    - Are they crying, in pain, insecure, tone of voice, posture
    - Give them an object of comfort
    - Pay attention to your feelings (annoyed, anger, body language, tone).
      - The resident lives in the moment & will identify the behavior

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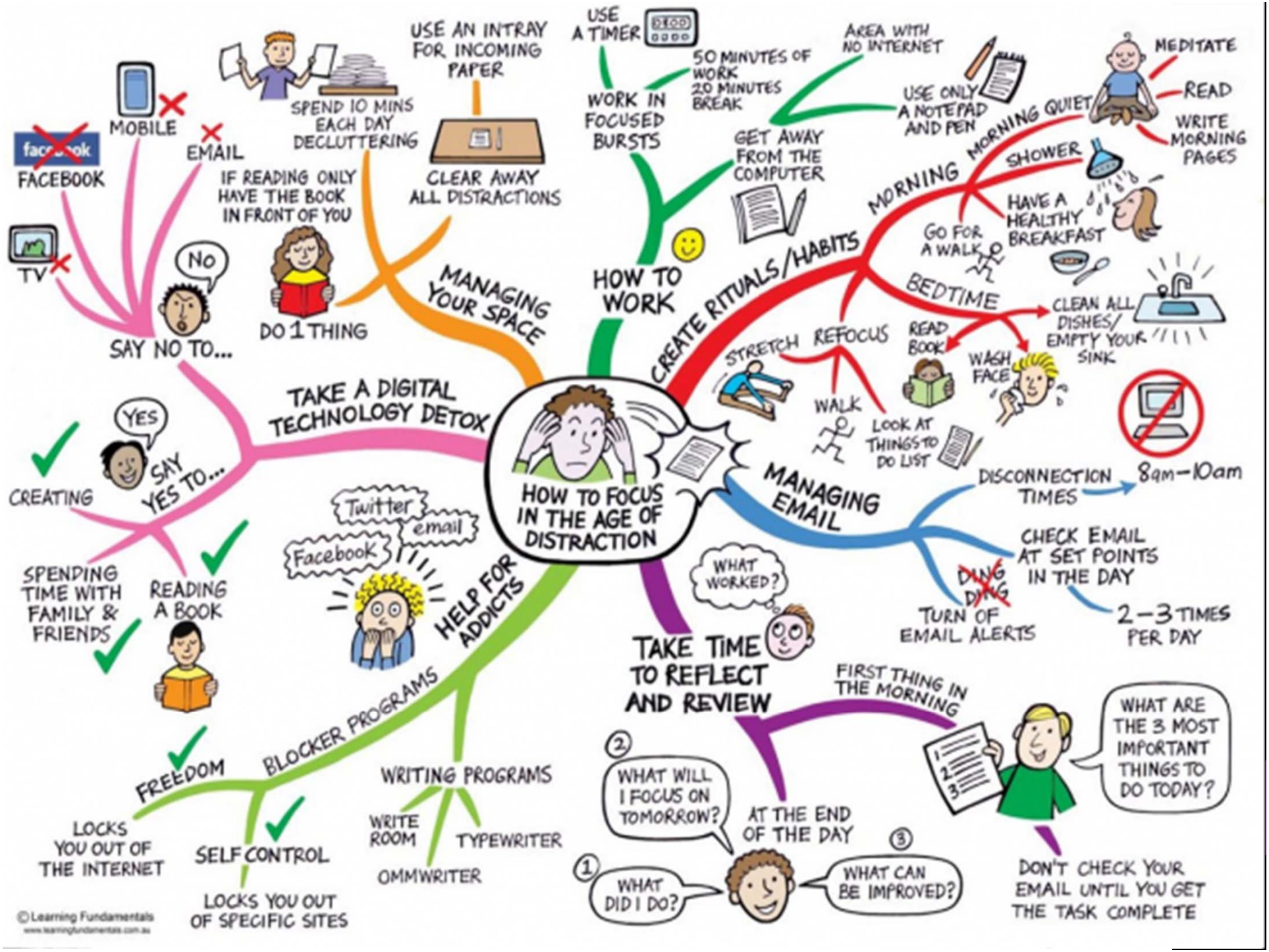
# Attention

- The fundamental areas in dementia that are affected are attention and concentration.
  - Progression of the disease will increase distraction and decrease their ability to concentrate.
    - Sounds, lights and color may be distractors
  - Tunnel vision- they will focus one thing at a time and if something else distracts them they forget the latter task/conversation


HOW TO FOCUS IN THE AGE OF DISTRACTION
MANAGING YOUR SPACE
USE AN INTRAY FOR INCOMING PAPER
SPEND 10 MINS EACH DAY DECLUTTERING
CLEAR AWAY ALL DISTRACTIONS
IF READING ONLY HAVE THE BOOK IN FRONT OF YOU
DO 1 THING
MOBILE
EMAIL
FACEBOOK
TV
NO
SAY NO TO...
TAKE A DIGITAL TECHNOLOGY DETOX
YES
SAY YES TO...
CREATING
SPENDING TIME WITH FAMILY & FRIENDS
READING A BOOK
HELP FOR ADDICTS
Twitter
email
Facebook
BLOCKER PROGRAMS
FREEDOM
LOCKS YOU OUT OF THE INTERNET
SELF CONTROL
LOCKS YOU OUT OF SPECIFIC SITES
WRITING PROGRAMS
WRITE ROOM
TYPEWRITER
OMMWRITER
HOW TO WORK
USE A TIMER
50 MINUTES OF WORK 20 MINUTES BREAK
WORK IN FOCUSED BURSTS
AREA WITH NO INTERNET
USE ONLY A NOTEPAD AND PEN
GET AWAY FROM THE COMPUTER
CREATE RITUALS/HABITS
MORNING
MORNING QUIET
MEDITATE
READ
WRITE MORNING PAGES
SHOWER
HAVE A HEALTHY BREAKFAST
GO FOR A WALK
BEDTIME
CLEAN ALL DISHES/ EMPTY YOUR SINK
READ BOOK
WASH FACE
STRETCH
REFOCUS
WALK
LOOK AT THINGS TO DO LIST
MANAGING EMAIL
DISCONNECTION TIMES
8am–10am
CHECK EMAIL AT SET POINTS IN THE DAY
2–3 TIMES PER DAY
DING
DING
TURN OF EMAIL ALERTS
TAKE TIME TO REFLECT AND REVIEW
WHAT WORKED?
FIRST THING IN THE MORNING
WHAT ARE THE 3 MOST IMPORTANT THINGS TO DO TODAY?
DON'T CHECK YOUR EMAIL UNTIL YOU GET THE TASK COMPLETE
AT THE END OF THE DAY
1
WHAT DID I DO?
2
WHAT WILL I FOCUS ON TOMORROW?
3
WHAT CAN BE IMPROVED?
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# Perception

- Defined as the difficulty in recognizing familiar objects in their environment
  - The brain that interprets what is being seen (Not a visual problem)
- Examples
  - Drove home from the grocery store, but did not know how to get out of the car
    - Saw the car door, the lock, the outside of the car, but did not understand how to get out and became anxious.
- Spatial interpretation is impaired
  - A black spot on the carpet may appear as a hole making the resident walk around
  - A glossy floor may look like water
- Waive finding is difficult because of not perceiving the meaning of common landmarks
- Always attempt to name objects with the client

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# Abstraction

- For a person with dementia to think abstracting they have to use their thought to get to another meaning.
- Avoid the following
  - Time is not tangible- I'll be back in a minute
  - Sarcasm- saying one thing and meaning another
  - Proverbs- too many cooks in the kitchen
- Say exactly what you mean and mean exactly what you say

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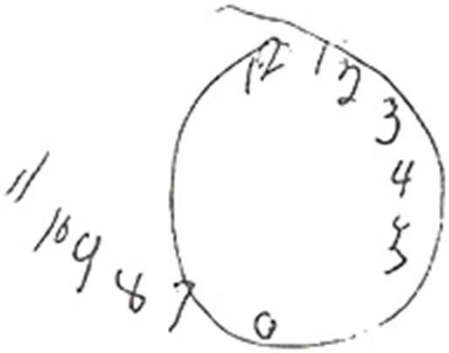
# Judgment

- Ultimately, judgment is impaired
- An accumulation of memory, language and reasoning are also impaired.
- Spur of the moment actions occur with residents because all information is not available.
- Attempt to identify the options that are available & simplify them.
- Avoid open/ended question
  - Never say “what would you like to do today”?
  - Instead say “today we will …..”

## Examples of Clock Drawing Test

### Early Alzheimer's Disease

### Moderate Alzheimer's Disease



### Severe Alzheimer's Disease

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# Phases in Dementia

- Normal phase
  - A person without dementia; typical behavior
- The 1st signs
  - Careful observation and skillful details.
  - Carries on with a routine conversation.
  - May need occasional reminders and cues
- Increasing problems
  - Cannot figure out all tasks that need to be performed
    - Be careful as not to make the resident uncomfortable or dependent
- Minimal self-care abilities
  - Unable to perform task even with cues
  - Misunderstanding of words and confusion with task
    - Comfort and participation in
- Required complete assistance
  - Unable to maintain independence or any activity without caregiver

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***RESIDENTS WITH DEMENTIA ARE DOING THE BEST THE CAN.***

***BE COMPASSIONATE, PATIENT, AND REASSURING.***

***THIS IS THE MOST IMPORTANT FIRST STEP IN CARING FOR INDIVIDUALS WITH DEMENTIA***

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# CARES Approach- Review

**C-Connect with the resident**

- Use the resident's name or favorite nickname
- Introduce yourself before entering
- Discuss or do something meaningful with the resident
- Learn about the resident's interest

**A-Assess the behavior**

- Observe the resident carefully
- Think about the residents point of view
- Consider the resident's needs
- Get input from family & others on the care team

**S- Share with othe staff**

- Tell the care team & family about approached that did/did not work for the resident
- Use written and verbal communication

**R- Responding appropriately**

- Respond based on your assessment of the resident
- Respond to the resident's emotional as well as physical needs
- Continue to adjust your response based on the resident

**E- Evaluate what you have done and what works**

- Pay attention to the approaches that work well with a particular resident
- Pay attention to the approached that don't work so well for each resident

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# Positive Approach-Review

Approach from the front of the resident

Walk slowly

Move to the side

Get down to level of the resident

Offer your hand to the resident

Call them by their name

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# EVERYONE GET UP
# &
# TRY

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# Eating Well

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# Importance of Eating

- The ability for a resident to feed him or herself varies.
  - Some resident may need verbal cues now and then.
    - “Drink some juice”
  - Other may need hands-on assistance
    - Opening items, handed a spoon, or even being fed
- Let them do as much as possible
  - It can be very tempting to do everything because its quicker or easier
    - But, it is NOT the best action for the resident
- Residents can lose their abilities more quickly if they have not practiced certain skills.

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# Eating Stages

- **Normal**
  - Someone who does not have dementia
  - Eating habits are typical
- **First signs (early dementia)**
  - Early dementia should have very little impact on ability to eat
  - Difficulty focusing and completing the task of meal preparation (maybe even skipping meals)
- **Increasing problem**
  - Difficulty remaining focused on the task of meal preparations
  - Likely to skip meals without verbal reminders
  - Lack of awareness of time and/or hunger sensation may result in skipped meals
  - Able to prepare only simple meals without assistance

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# Eating Stages *Continued*

- **Significant confusion**
  - May not chew or swallow carefully; beginning to have trouble swallowing
  - Will forget to eat without help and reminders from others
  - Might ask for food shortly after eating a complete meal, forgetting they just ate.
  - Might attempt to get up before finishing a meal
  - Need assistance cutting food
  - Needs prompting, but can use a fork and spoon
    - Guide their hand to their mouth to remind them of the action
  - Difficulty getting food to their mouth
  - Might not recognize food or utensils;
    - Throws food;
    - Puts food in pockets or purse
  - Strong preference for sweets
  - Difficulty knowing how much food to put in mouth

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# Eating Stages *Continued*

- **Minimal Self Care Abilities**
  - Willingness to eat and appetite vary from day to day
  - Might use utensils, but often does better with finger foods
  - Will need constant cueing- verbal and visual- to continue with task of eating
  - Forgets to chew and swallowing- remind them to chew and swallow
  - Needs help with swallowing such as stroking the throat
  - May leave food in mouth pockets
  - Has trouble sitting up; must position and reposition
  - Strong preference for sweets

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# Eating Stages *Continued*

- **<u>Requires Complete Assistance</u>**
  - May have difficulty holding their head up
  - Comfort is the focus of care at this point.
    - Comfort care may include assisted oral feedings
  - Using a straw may make drinking from a cup easier by encouraging a sucking response
  - At some point, most residents lost the ability to chew or swallow.
    - Staff should monitor the safety of continued feeding
    - Choking, coughing, or refusal to eat (clamping teeth shut) or signs of difficulty with eating <u>should always be reported and communicated with the team</u>
  - Oral care is always important, but it is especially important at the end of life.
    - Focus on keeping the mouth clean and the lips moist
  - Artificial nutrition and hydration is a personal decision between the treating physician and the family or main decision maker.
    - Some may have to choose to have tube feedings and some may not.

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# Things that Affect Eating

## Most Common

- Resident is losing the ability to swallow
- Poor oral care and resulting pain in the mouth, gums, or teeth.
- Distractions in the environment
- Too many food choices
- Need for individual physical assistance (caregivers need to provide resident their full attention.

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# Things that Affect Eating

- Changes in the Resident's Health and Comfort
  - Physical skill and balance
  - Loss of sense of smell, taste, and texture
  - Ability to sit up
- Environmental Causes
  - Background noise, such as television or loud rooms that echo
  - Too much or too little space
  - Plate color blends with the table
  - Plate color blends with the food
- Problems with the Task
  - Does not know what the food is
  - Can not remember how to use the fork or spoon
  - Has trouble getting started
- Communication Difficulty
  - Untreated visual or hearing loss
  - Has trouble finding the right words
  - Too many steps to follow
    - May respond better to one step at a time

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# Warning Signs

## Alert the Clinician or Supervisor Immediately


- Resident complains that swallowing is difficulty
- Leakage of food and saliva from mouth
- Coughing before, during, or after swallowing foods or liquids
- Choking while eating or drinking
- Increased congestion or runny nose after a meal
- Change in voice (wet, gurgling, or hoarseness)
- Retaining food in mouth or throat
- Resistance to being fed too quickly
- Refusal to open mouth or accept large bites of food
- Unexplained weight loss

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# Techniques with Eating

## Maintain the Resident's Dignity

- Hand over hand assistance
- Be creative and remove utensils
- Levels 2-3 with noise is a distractor
- Bright color plates to the food
- Caregiver is a calm and talking slow
- Never scrape resident's lips with a spoon.
- Tactile cueing

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# Contrasting Colors

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# Bingo Research & Dementia

| B | I | N | G | O |
|---|---|---|---|---|
| 46 | 57 | 45 | 39 | 56 |
| 1 | 12 | 10 | 71 | 15 |
| 27 | 48 | Free Space | 13 | 21 |
| 51 | 6 | 4 | 63 | 18 |
| 49 | 24 | 74 | 34 | 2 |




**BINGO ACTIVITY!!**

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# CARES™ Approach- Eating

**C-Connect with the resident**

- Mealtime provides a way to connect in an individualized way
- Know something about the resident & choose and approach that fits the situation

**A-Assess the behavior**

- Understand the behavior (verbal & non-verbal)
- When, where, and with whom did a particular behavior happen?
- Are there patterns
- You should be able to identify reasons for behaviors with eating.

**S- Share with othe staff**

- Tell the care team & family about approached that did/did not work for the resident
- Use written and verbal communication

**R- Responding appropriately**

- Use what you know about each resident & what you have observed in assessing their behavior
- Adjust your plan accordingly

**E- Evaluate what you have done and what works**

- How well is the connection?
- What strategies are used?
- Does the resident respond to change?
- Does the caregiver adjust plan?

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# Environment & Eating

- Make sure eating area is not noisy or distracting
- Make the table setting more appealing
- Invite residents to join each other in the dining area
- Aromatherapy
- Engage residents in a physical activity right before the meal to stimulate their appetite
- Have residents assist in setting the table or meal preparation
- Host a tea party & have residents dress up

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# Conversations & Eating

- Talk about the resident's clothing (colorful)
- Ask the resident about their interesting piece of clothing
- Find out what kind of food are they eating
- What is their favorite food
- Talk about cooking.

# 10 MINUTE BREAK

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# Recognizing Pain

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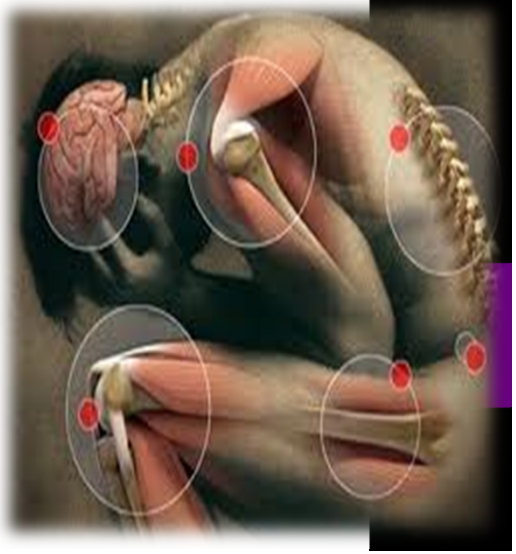
# Pain

- How to tell if someone is in pain?
  - Subjective-opinion, belief, varies person to person, sometimes completely false; S/he thought, feels, thinks, needs
  - Objective-observable, able to be counted, able to be described, helpful in decision making; This is what s/he did/said, s/he made an action that looked like
- Difficult to identify in persons without cognitive disorders.
- Residents with dementia may have difficulty telling a caregiver about pain.
  - Important to identify signs of pain for residents
  - Right kind of care and comfort is essential
- Importance in knowing each resident independently
  - Health history, medications, activity level
  - Common signs of pain



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# True or False

**Half of all nursing home residents have pain, and residents in early stages of dementia are just as likely to have pain as residents with no dementia.**

TRUE

Because of the difficulty of measuring pain in the late stages of dementia, caregivers cannot be sure how many of the residents have pain and how elevated the pain is.

Won, A. B., Lapane, K. L., Vallow, S., Scheim, J., Morris, J. N., & Lipsitz, L. A. (2004). Persistent nonmalignant pain and analgesic prescribing patterns in elderly nursing home residents. Journal of the American Geriatrics Society, 52(6), 867-874. doi: 10.1111/j.1532-5415.2004.52251

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# True or False

**In a study published in 1998, it was found that nurses tend not to value residents' reports of pain and do not provide the most appropriate treatments**

TRUE

It is important for all staff who have contact with a resident to take any report of pain seriously and to respond appropriately

Coyne, M. L., Smith, J. F. H., Stein, D., Hieser, M. J., & Hoover, L. (1998). Describing pain management documentation. Medical-Surgical Nursing Journal, 7, 45-51

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# True or False

**Residents with Alzheimer's disease experience as much pain as those without the disease.**

## FALSE

However, these individuals are less likely to report pain and to be treated for their pain. Staff need to pay close attention to the resident's behavior and any changes from their normal routine.


1. Horgas, A. L., & Tsai, P-F. (1998). Analgesic drug prescription and use in cognitively impaired nursing home residents. Nursing Research, 47(4), 235-242.

2. Parmelee, P. A., Smith, B., & Katz, I. R. (1993). Pain complaints and cognitive status among elderly institution residents. Journal of the American Geriatrics Society, 41, 517-522.

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# True or False

**Residents with pain that is not well treated often have higher levels of depression, anxiety, agitation, and problems with sleep.**

## TRUE

Especially for residents with dementia, pain decreases the ability to move and function. Pain can make bathing and dressing more difficult.


1. Ferrell, B. A. (1995). Pain evaluation and management in the nursing home. Annals of Internal Medicine, 123(9), 681-687.

2. Horgas, A. L., & Dunn, K. (2001). Pain in nursing home residents: Comparison of residents' self-report and nursing assistants' perceptions. Journal of Gerontological Nursing, 27(3), 44-53.

3. Parmelee, P. A., Smith, B., & Katz, I. R. (1993). Pain complaints and cognitive status among elderly institution residents. Journal of the American Geriatrics Society, 41, 517-522.

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# True or False

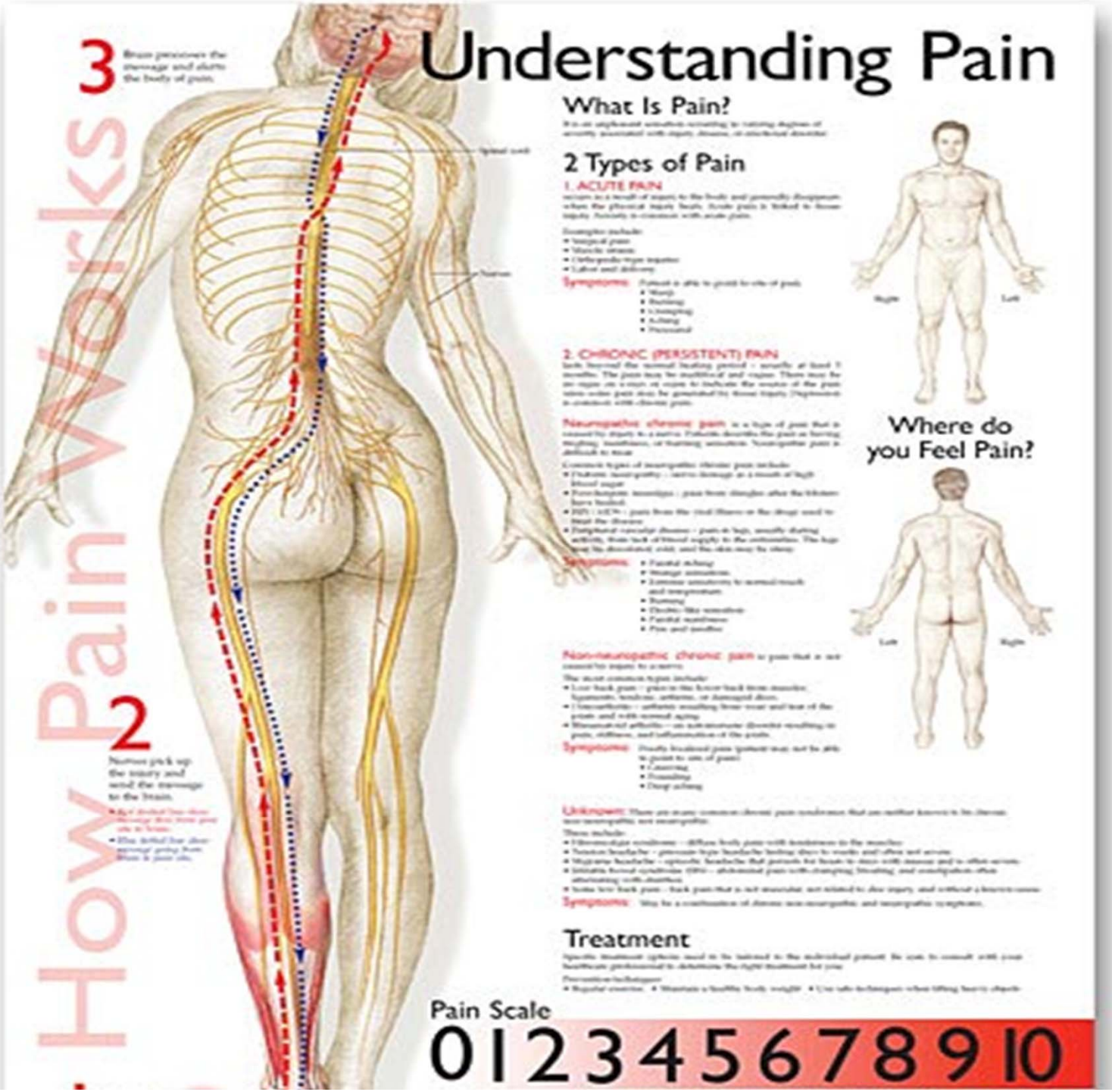
**It is difficult to assess pain when a person cannot report pain.**

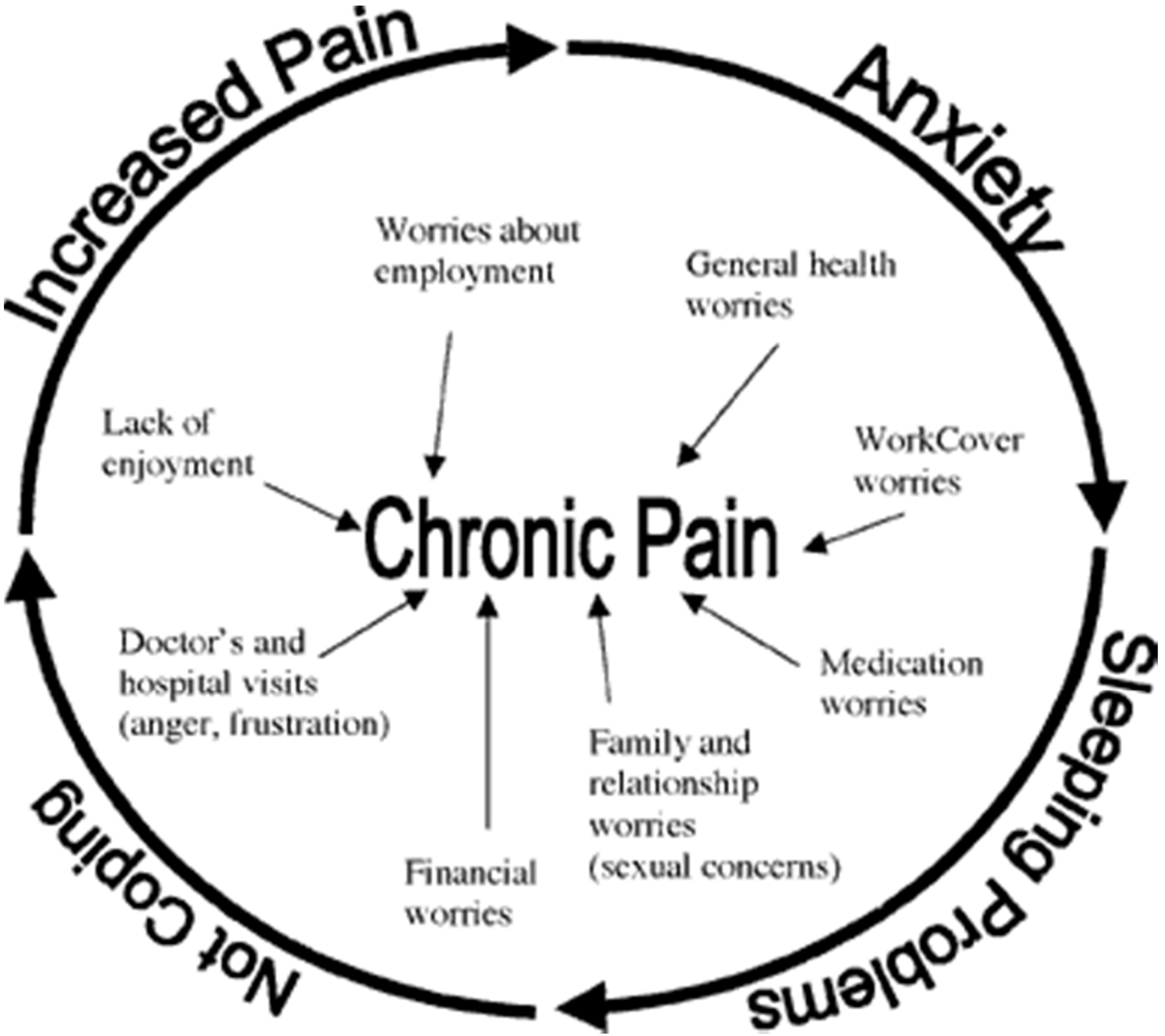
## FALSE

However, pain can be noticed in other ways. Knowing the person and looking for signs is important.

1. Buffum, J. D., Miaskowski, C., Sands, L., & Brod, M. (2001). A pilot study of the relationship between discomfort and agitation in patients with dementia. Geriatric Nursing, 22(2), 80-85.

2. Horgas, A. L., & Dunn, K. (2001). Pain in nursing home residents: Comparison of residents' self-report and nursing assistants' perceptions. Journal of Gerontological Nursing, 27(3), 44-53.


Understanding Pain
How Pain Works
3
2
What Is Pain?
2 Types of Pain
1. ACUTE PAIN
2. CHRONIC (PERSISTENT) PAIN
Where do you Feel Pain?
Treatment
Pain Scale
0 1 2 3 4 5 6 7 8 9 10


Increased Pain
Anxiety
Sleeping Problems
Not Coping
Chronic Pain
Worries about employment
General health worries
Lack of enjoyment
WorkCover worries
Doctor's and hospital visits (anger, frustration)
Medication worries
Financial worries
Family and relationship worries (sexual concerns)

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# Signs of Pain

- Agitation and noticeable discomfort
  - Kicking, screaming, cursing, unkind sayings
- Sadness
- Noisy breath
- Crying
- Being less active
- Favoring one side over the other
- Rubbing the area where the pain is strongest
- Facial expression
  - Grimacing, frowning
  - Social withdrawal

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# Pain Stages

- **Normal**
  - Someone who does not have dementia
  - Communication about experienced pain is adequate
- **First signs (early dementia)**
  - The resident can tell a caregiver about pain with no difficulty
  - Because of mild forgetfulness, they may have trouble describing the origin of the pain.
    - Onset
    - Length of pain
    - Better/worse
- **Increasing problem**
  - Resident can express their needs and report pain
  - Caregiver will need to ask questions to gather enough information
  - Residents may have difficulty finding words to express feelings

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# Pain Stages *Continued*

- **Significant confusion**
  - Residents will have trouble with finding the correct words to express their needs.
  - The care giver will need to figure out how they feel and what they need
    - Asking questions
    - Verbal and nonverbal communication
  - Resident's expression of pain may be more physical
    - Fidgeting, rocking, facial expressions, and talking a lot or making lots of verbal noises

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# Pain Stages *Continued*

- **<u>Minimal Self Care Abilities & Required Complete Assistance</u>**
  - Residents are not speaking very often at this stage
    - When they do it will make little sense
  - Pain is likely to be expressed through
    - Restlessness or agitation
    - Shouting or moaning
      - All moaning is not necessarily related to pain

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# Pain & Family/Friends

- Gather information from family and friends
  - Identifying pain
  - Residents cues for pain
  - Helpful ways to manage pain

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# Things that Affect Pain

## Most Common

- Arthritic pain- musculoskeletal pain
- 70-80% of residents have some joint pain

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# Things that Affect Pain

- Changes in the Resident's Health and Comfort
  - Constipation
  - Bed sores
  - Pain from dental problems
  - Dry or sticky mouth
  - Incomplete emptying of the bladder
  - Sore feet
  - Shortness of breath
  - Cancer
  - Chest pain
  - Heartburn or ulcer pain
  - Other medical problems
  - Anxiety, worry, depression
- Environmental Causes
  - Noise
  - Temperature of the room (too cold or cold)
  - Bed or chair surfaces that are hard and uncomfortable
- Problems with the Task
  - Physical tasks can cause pain (buttoning can be difficulty with arthritis)
- Communication Difficulty
  - Cannot describe the pain or source of pain
  - Body part may be different that what the resident is communicating

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# CARES™ Approach- Pain

## C-Connect with the resident

- Recognizing pain in people
- Learning about the resident's health
- Paying attention to typical behaviors and watching for changes

## A-Assess the behavior

- Understand the behavior (verbal & non-verbal)
- When, where, and with whom did a particular behavior happen?
- Are there patterns
- You should be able to identify reasons for behaviors with pain.

## S- Share with othe staff

- Tell the care team & family about approached that did/did not work for the resident
- Use written and verbal communication

## R- Responding appropriately

- Use what you know about each resident & what you have observed in assessing their behavior
- Adjust your plan accordingly

## E- Evaluate what you have done and what works

- How well is the connection?
- What strategies are used?
- Does the resident respond to change?
- Does the caregiver adjust plan?

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# Management of Pain

- It is extremely important to keep good records.
  - Assist in assessing why a resident's behavior has changed
    - Recording a resident's bowel movements is helpful in determining if a resident is suffering from constipation or diarrhea.
    - Checking the skin daily is important to discover skin problems such as yeast infections to itchy dry sking
- Always make the nurse, manager or supervisor aware of any new and concerning findings.

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# Verbal and Physical Symptoms

Trouble sleeping

Agitation/Increased activity and movement

Clenched teeth

Increased confusion

Sighing

Depression

Changes in Vital Signs

Grimacing
(Frown or painful look)

Withdrawal

Resistance to care

Wandering

Cursing

Mood changes/Irritability

Crying

Changes in weight

Slow movement

Combativeness

Rigid posture

Guarding a body part

Increased sweating

Noisy breathing

Yelling

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# Easing Pain

Offer a cup of tea

Sing with them

Comb their hair

Hand massage

Read with them

*Play soft music*

Move them to their bed

Guided imagery

**Calm with touch**

Distract with lotions/oils

Comfort them

Warm blankets

Encourage exercise

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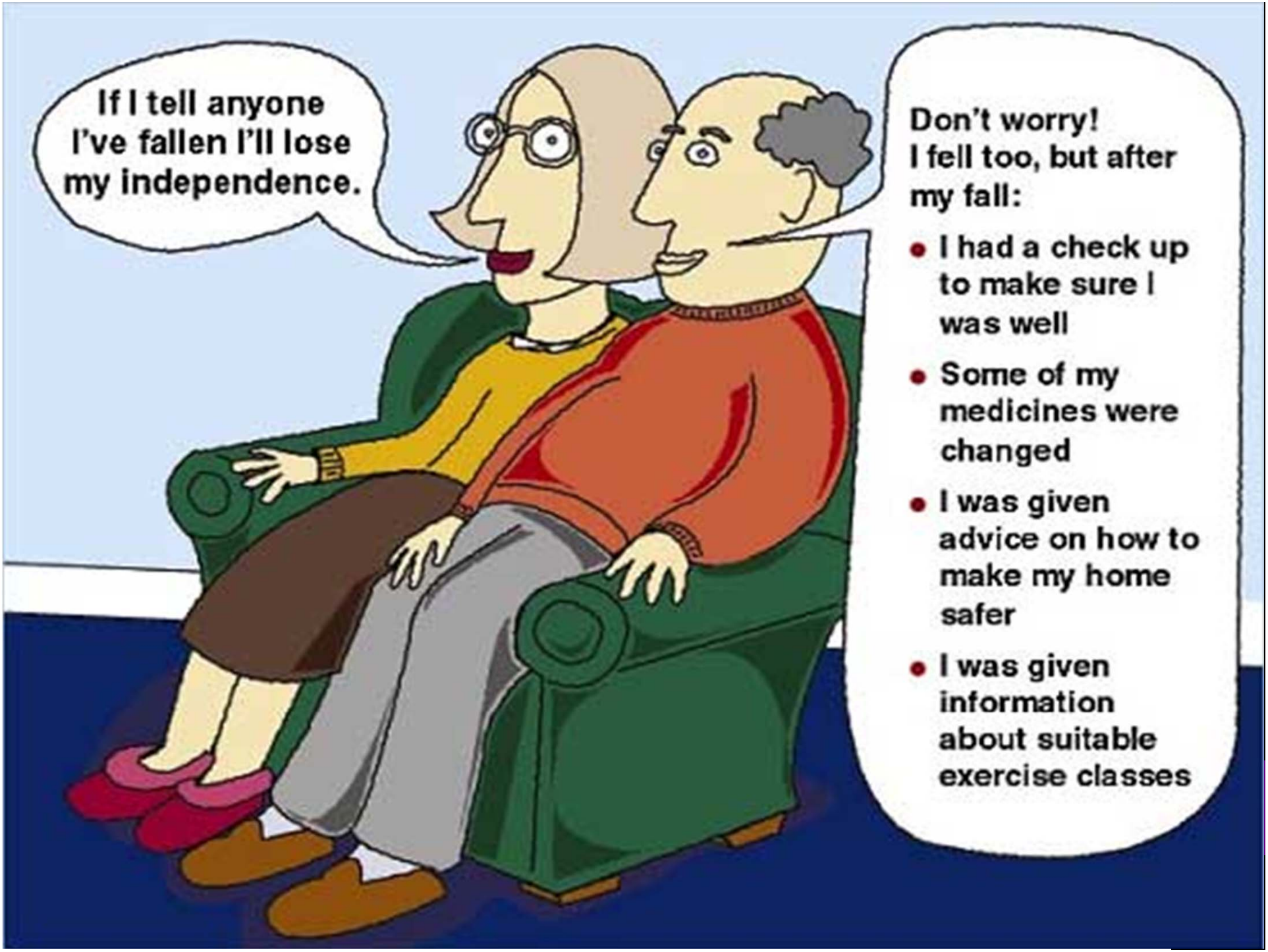
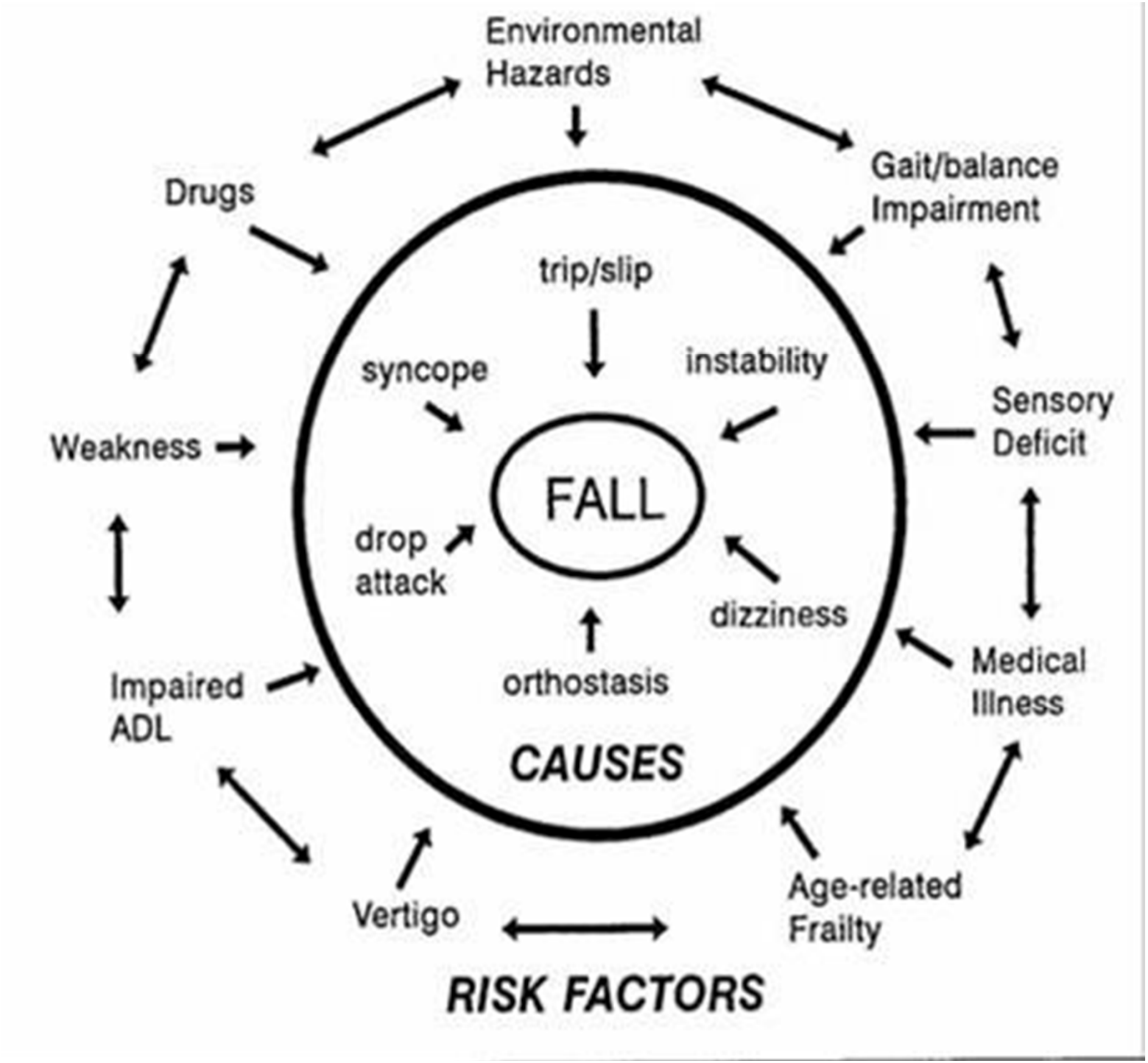
# Minimizing Falls


If I tell anyone I've fallen I'll lose my independence.
Don't worry! I fell too, but after my fall:
• I had a check up to make sure I was well
• Some of my medicines were changed
• I was given advice on how to make my home safer
• I was given information about suitable exercise classes


Environmental Hazards
Drugs
Gait/balance Impairment
trip/slip
syncope
instability
Weakness
Sensory Deficit
FALL
drop attack
dizziness
orthostasis
Impaired ADL
Medical Illness
CAUSES
Vertigo
Age-related Frailty
RISK FACTORS

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# Falling

- Accidently coming in contact with the ground, another low level such as a chair or bed, or accidentally changing position
  - Most obvious fall
  - Least obvious fall
- Consequences of falls
  - Cuts and skin tears
  - Bruises
  - Broken bones
  - Concussions
  - Head injury
  - Fears of falling
  - Death
- It is absolutely essential to recognize and investigate when a person has fallen.
  - Prevention is an important step.

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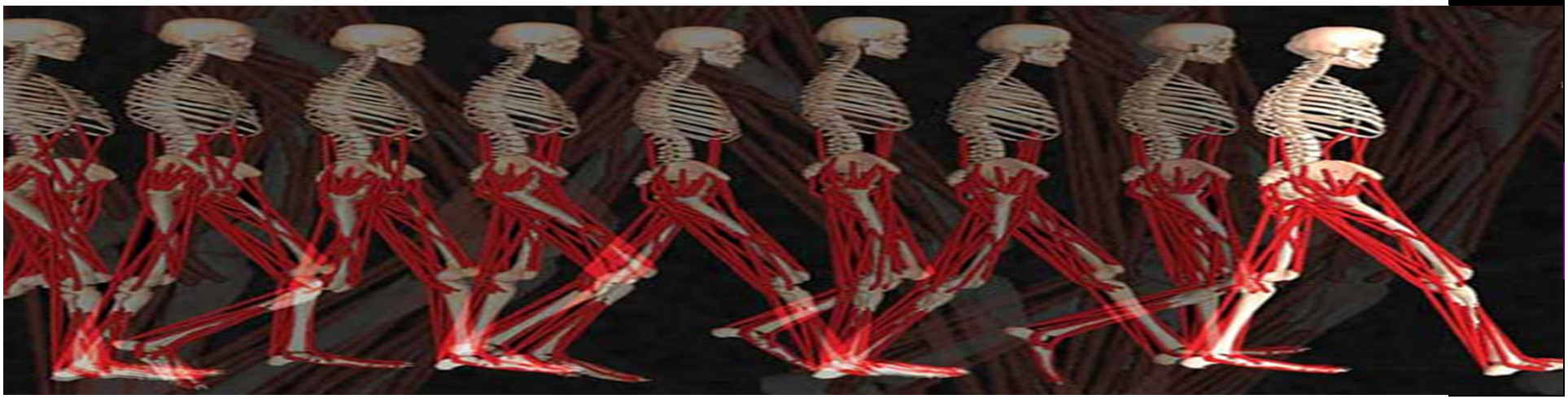
# Falling

- We are not born with the ability to walk
  - Coordination of muscles
  - Sensory and motor involvement for muscles to respond to incoming signals and outgoing messages
  - A breakdown in the process will produce loss of balance or a fall
- As our body changes the risk for a breakdown in internal communication increases
  - Increase risk of falls



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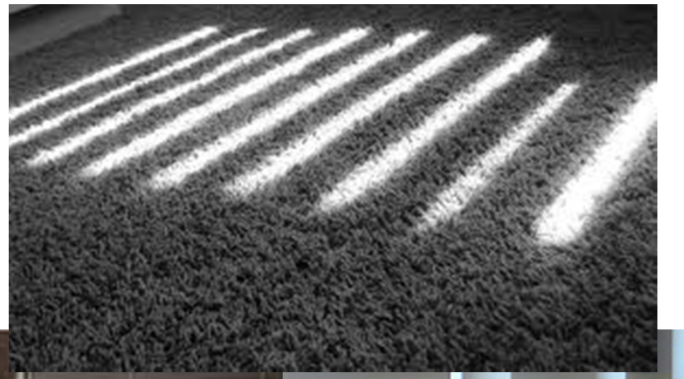
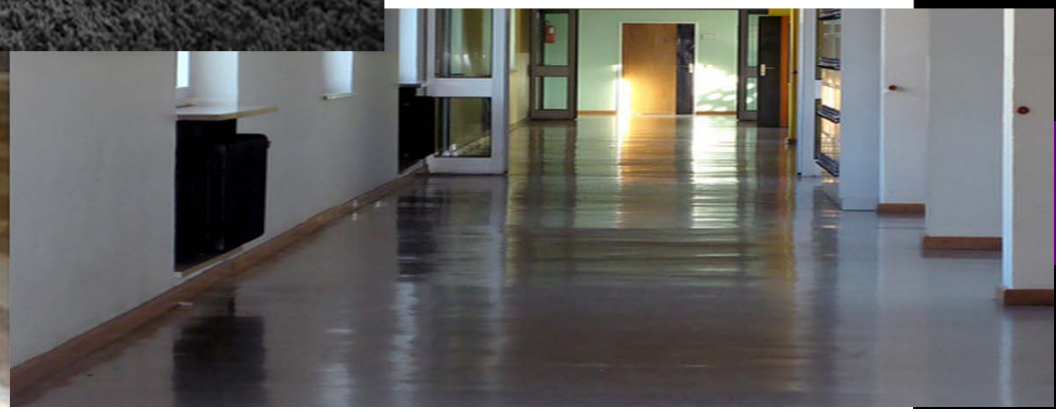
# Falling

- Eyes
  - Aging eyes do not adjust when we are going from light to dark areas as readily
    - Increasing the risk of falls
  - More sensitive to glare
  - Areas seen become smaller and perception is changes
    - A pattern on the floor is something to step over, so a resident v





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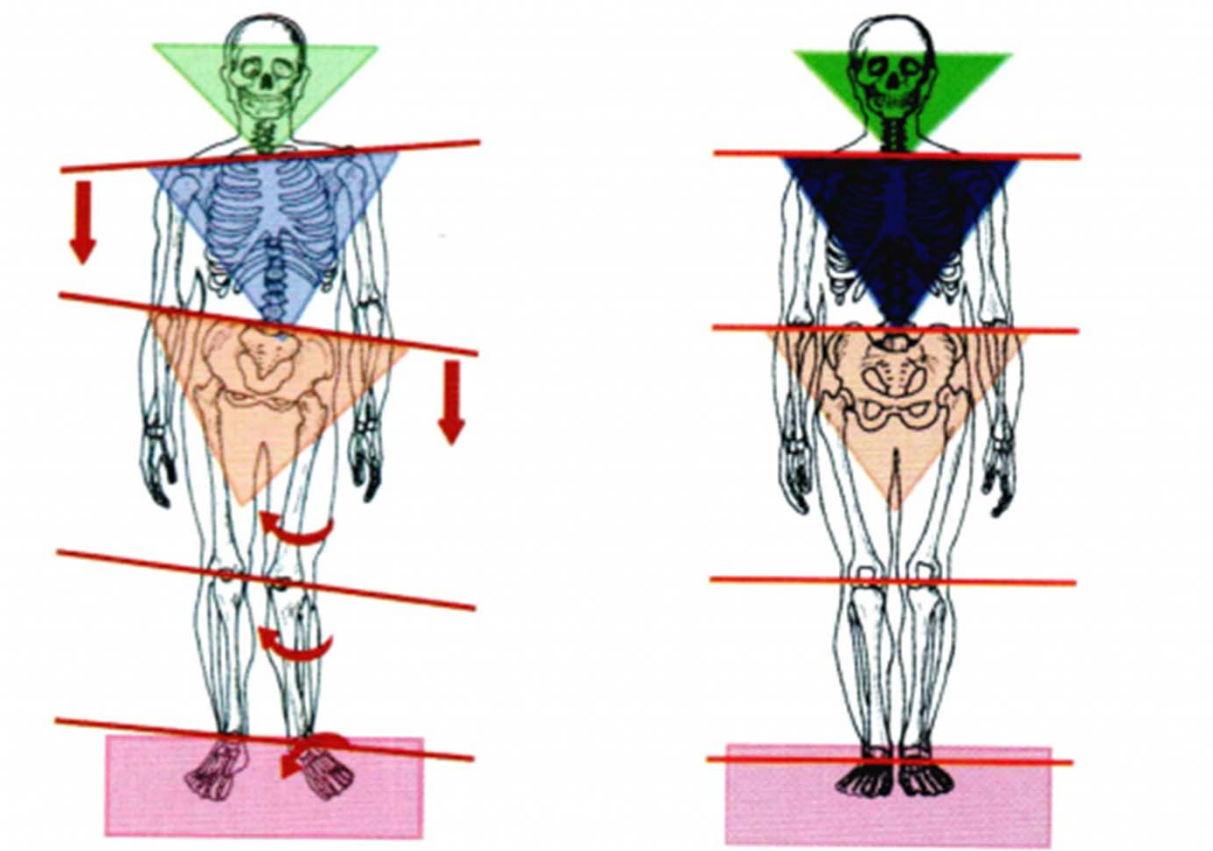
# Falling

- Arthritis or joint pain affects the way someone walks or moves
- Reflexes (the ability to move or respond quickly to a situation) slows down with age.
- Muscle strength decreases with age



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# Contributing Factors to Falling

- Loose rugs or carpet
- Floor mats
- Clutter in hallways
- Poor fitting shoes
- Slippers or no tracking on slippers
- Exposed cords
- Uneven or slippery floors
- Poor lighting
- Low tables that can be tripped over
- No grab bars

**You can not change the person's thinking abilities,**

**But you can change the environment!**

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# Falling

- Each resident is different and should have an individual falls risk assessment
  - If a resident's condition changes (physical health, functional ability, or cognitive ability)
  - After hospitalization and return to the residence
  - With a change in mobility
  - With a change in continence, toileting, or eliminating
- It is important to understand what you need to look for
  - History of falling
  - Physical condition (vision, blood pressure, gait, balance, joint function, lower body function, muscle strength, etc)
  - Brain function (muscle coordination, reflexes, body's ability to detect where it is in space, and mental function)
  - Current medications
  - Continence or ability to use the toilet

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# Fall Stages

- **Normal**
  - Someone who does not have dementia
  - But, changes in the body as it ages can place anyone at risk of falling
- **First signs (early dementia)**
  - Cognitive abilities are still quite intact
  - The risk of falls is not much greater than for a person of similar age without dementia
- **Increasing problem**
  - The risk for falling increases, but the risk is still relatively low for most.
    - The resident is having more thinking problems such as challenges with perception and judgment.
      - Difficulty in knowing how high to lift your foot
      - Whether a blue rug on the floor is a hole
  - When level of thinking skills decline, residents may move impulsively as they do not have the ability to adjust their physical performance to what is occurring around them.
    - Moving too fast or moving too slow

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# Fall Stages *Continued*

- **Significant confusion**
  - The risk for falls increases significantly.
  - Perception and judgment problems are getting much worse.
  - Residents have trouble with motor control
    - The brain does not seem to connect to parts of the body
  - Motor coordination is also becoming an issue
    - Residents may begin to walk fine, but will lose their balance and fall
  - Residents are also less likely to notice obstacles or clutter in the way.
    - Keeping walkways and hallways clear can help decrease their risk of falls

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# Fall Stages *Continued*

- **Minimal Self Care Abilities**
  - Residents are not as mobile, but there is still a chance in falls
  - There is less risk of falls because residents cannot get up or walk on their own as easily.
    - When a resident does attempt to try to get up, it can result in a fall
- **Required Complete Assistance**
    - Residents are not mobile at this stage
    - Falls are not considered a risk

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# Things that Affect Falls

## Most Common

- Recent illness and resulting weakness in muscles
- New Medication(s)
- Vision problems
- Clutter
- History of falls

- Residents Have a Greater Chance of Falling if They
  - Are new to the care setting
  - Wander
  - Wear poor-fitting clothing or footwear
  - Have a drop in blood pressure with change in position
  - Have poor balance
  - Have medications that affect gait/positioning

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# Things that Affect Falls

- Environmental Causes
  - Bedside rails
  - Restraints (including chair to bed alarms)
  - Lack of stable furniture or handrails
  - Uneven, slippery or glaring floors
  - Poor lighting
  - Weather (heat exhaustion, snow)
  - Poorly equipped bath and shower areas
- Nighttime Fall Risks
  - Sleepiness or disoriented
  - Poor lighting
  - Needing to toilet quickly
  - Bare feet or stocking feet
  - Not wearing glasses hearing aids, or other assistive devices

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# Family Questions for Falls

- What is or was your loved one's daily routine?
- What medications is s/he taking?
- What is his/her toileting routine?
- How does s/he sleep? (time the arise/sleep, use to sleeping with someone)
- What are your family member's bathing preference?
- What is his/her vision? (corrective lenses)
- What is their mobility? (gait, assistive devices)
- Will your family member remember to call for assistance? Use a walker? Sit up and wait before walking? Recall where the bathroom is?
- What does your loved one like to wear?
- What is upsetting to him/her?
- What calms them down?
- Has your family member fallen before?
- How was his/her room set up at home (or the previous facility)?

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# CARES™ Approach- Pain

**C-Connect with the resident**

- Recognizing the risk for falls in people
- Learning about the resident's health
- Paying attention to typical behaviors and watching for changes

**A-Assess the behavior**

- Understand the behavior (verbal & non-verbal)
- When, where, and with whom did a particular behavior happen?
- Are there patterns to falls
- You should be able to identify the risk for a fall

**S- Share with othe staff**

- Tell the care team & family about approached that did/did not work for the resident
- Use written and verbal communication

**R- Responding appropriately**

- Use what you know about each resident & what you have observed in assessing their behavior
- Adjust your plan accordingly and make changes to the environment

**E- Evaluate what you have done and what works**

- How well is the connection?
- What strategies are used?
- Does the resident respond to change?
- Does the caregiver adjust plan?

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# Wondering about Wandering

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# Wandering

- A form of communication
  - Always ask yourself what a resident's behavior means
    - Is s/he searching for a relative, a friend?
    - Are they searching for a way out?
    - Are they restless or bored?
    - Are they searching to something to eat or drink?
    - Are they searching for the toilet?
- Promotes mobility and release of energy

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# Wandering Concerns

- Unsafe wandering
  - Leaving the healthcare facility
    - Elopement
  - Invading another's space

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# Wandering Stages

- **Normal**
  - Someone who does not have dementia
  - Walking or pacing with a purpose (not considered wandering)
- **First signs (early dementia)**
  - Wandering can begin to occur
    - Will get lost until they see a familiar marker to get them on track
    - Confusion
    - Keep an eye on new residents
      - Establish routines and way-finding
      - Personalize their door to identify their room
- **Increasing problem**
  - Residents will appear unsure of himself
  - Signs of wandering become more apparent
    - Moving about and going in/out of other residents' rooms
    - Taking objects from others
    - Having trouble finding familiar objects
    - Pacing back and forth (may be delusional thinking, reliving past events)
  - More at risk of unsafe wandering because of their abilities

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# Wandering Stages *Continued*

- **Significant confusion**
  - Very common
    - They are able to get around, but are easily confused about where they are.
    - Much of what is done is without purpose
    - Can't explain by words
  - Unsafe wandering is a big concern because of the poor judgment and problem-solving skills.
  - Actions may be driven by delusional thinking.
    - Emotionally painful or unpleasant

Imagine believing that you need to get in the kitchen to prepare dinner.

You can't find the kitchen and begin to get anxious.

You look around furiously for the kitchen and start to wander away further.

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# Wandering Stages *Continued*

- **Minimal Self Care Abilities**
  - Most residents can not move about alone
  - They will typically need assistance with walking
- **Required Complete Assistance**
    - Residents are not mobile at this stage
    - Wandering is not considered a risk

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# Things that Affect Wandering

## Most Common

- Physical need such as hunger, thirst, or need to toilet
- Following old routines or habits
- Searching for someone or something

- Residents Have a Greater Chance of Wandering with
  - Changes in resident's health and comfort
  - Pain or discomfort
  - Boredom
  - Delusions
  - Restlessness
  - Desire for fresh air, sunlight- to just change their environment
  - Medication side effects

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# Things that Affect Wandering

- Environmental Causes
  - Busy, confusing, or irritating environment
  - Uncomfortable temperature
  - Lighting changes
  - Transition from days to evening (sun-downing)
- Problems with Tasks
  - Task is too complicated; easily frustrated
- Communication Difficulty
  - Unable to express needs

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# CARES™ Approach- Wandering

## C-Connect with the resident

- Recognizing the risk for wandering in people
- Learning about the resident's health
- Paying attention to typical behaviors and watching for changes

## A-Assess the behavior

- Understand the behavior by watching patterns.
- When and where are they more prone to wander to
- Are there patterns to wandering
- Is it safe vs unsafe wandering

## S- Share with othe staff

- Tell the care team & family about approached that did/did not work for the resident
- Use written and verbal communication

## R- Responding appropriately

- Use what you know about each resident & what you have observed in assessing their behavior
- Adjust your plan accordingly and make changes to the environment
- Remember that safe wandering is healthy

## E- Evaluate what you have done and what works

- How well is the connection?
- What strategies are used?
- Does the resident respond to change?
- Does the caregiver adjust plan?

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# Safe Wandering

- Action plan if the resident leaves the care setting
- Help the resident explore and use activity areas
- Encourage outdoor walking paths (may need supervision)
- Give extra attention to new residents (24-48 hours are critical)
- Communicate with family to understand wandering patterns
- Know toileting patterns
- Provide stimulation, regular exercise, balance and quiet time
- Be aware of those residents at risk for leaving
- Disguise exit doors
- Place familiar items near door or room as markers

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# Causes of Wandering

- Sight of workers leaving and entering the facility
- Confusion about where they are
- Desire to return to a familiar place or time
- Restlessness or lack of stimulation
- Need for socializing, security, or friendship
- Need to toilet
- Need to eat or drink
- A change in routine or pace
- A change in caregivers
- A noisy or busy environment
- Medication
- Pain or infection
- Depression, anxiety, delusions
- Boredom
- Following old habits (cooking dinner)

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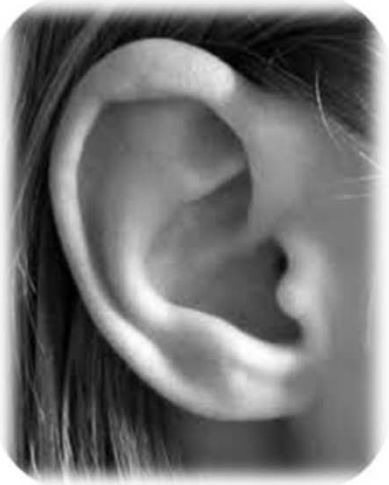
# DEMENTIA SIMULATION ACTIVITY



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# Questions, Comments, Concerns?

# Resources

- Alzheimer's Association –www.alz.org
- National Institute of Aging (NIH)
- Pain and Alzheimer's- http://www.painanddementia.ualberta.ca/index2.html
- Brain Health- http://brainmind.net/BrainLecture1.html
- Brain Line- http://www.brainline.org/index.html
- International Journal of Alzheimer's Disease
- Journal of Alzheimer's Disease
- Journal of Neuro-degeneration and Regeneration
- Surf the web
- Visit the local Neurology Institute or rehabilitation center

# Thank You