Care Approaches for the Person with Dementia

Presenter:

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Great Plains QIN LAN Event

Presentation Objectives

After attending this presentation, participants will be able to:

- Define dementia
- Identify different types of dementia
- Apply non-pharmacological care approaches for the person with dementia
- Utilize antipsychotic medication reduction strategies
- Acquire dementia care resources

Dementia Definition

- Dementia is:
  - An **umbrella term** for a variety of conditions where consciousness is not impaired, but memory, thinking, orientation, comprehension, calculation, learning, language capability and judgment can all be affected
  - A chronic or persistent disorder of mental processes caused by brain disease or injury
  - Classified into ‘reversible’ and ‘irreversible’

Reversible Dementia (sometimes)

- Brain Tumor
- Depression
- Dehydration
- Surgery
- Metabolic disorders (diseases of thyroid, pancreas, liver or kidneys)
- Side effects of medications
- Infections
- Circulatory disorders
- Nutritional deficiencies/ malnutrition
- Substance abuse
- Head trauma
- Lyme disease
- Sleep disorders
- Brain fog
- Simple and normal pressure hydrocephalus
- Toxic factors, such as carbon monoxide

Irreversible Dementia

- **Alzheimer's disease-** *(most common, gradual memory loss)*
- **Vascular disease-** *(impaired blood flow to brain)*
- **Lewy Body disease** – *(2nd most common, visual / auditory hallucinations)*
- **Frontotemporal dementia** *–frontal and temporal lobes atrophy. Dramatic changes in personalities, socially inappropriate, language issues. Often begins 40 – 65 years.*
- **Mixed dementia** (*usually Alzheimer's disease and vascular*)
- **Huntington disease-** *(genetic, movement, cognitive, psychiatric s/s)*
- **Parkinson's** – *(affects nervous system)*
- **Creutzfeldt-Jacob disease** – *(very rare – prion protein)*
- **Wernicke –Korsakoff** *(lack of thiamine)*

How Dementia Impacts Human Behavior

Moderate Dementia

- Difficulty w/ short and long – term memory. Struggles to learn new things
- Difficulties w/ understanding and being understood
- Knows comfort and discomfort
- Can't self regulate emotions
- Often easily upset or frustrated
- Can become fearful
- May misinterpret actions of others

Advanced Dementia

- Limited/no short and long-term memory-often lives in the moment
- Can't learn new information or pick up new routines
- Unable to carry on meaningful conversation
- May appear withdrawn and can have difficulty interacting or responding to surroundings

Behavior Key Facts

1. Every behavior has a trigger, a cause
2. Most behaviors are attempts to communicate something to us – **behaviors are generally a result of an unmet need**
3. When dealing with a person with mid-stage dementia Alzheimer's disease, we cannot expect that person to change . . . we need to adapt!
4. Want to get them in positive emotion right away in morning and maintain throughout the course of day –proven to reduce challenging behaviors . Negativity has a cumulative effect.

Internal Behavior Triggers

- Usually deals w/mind or body
- More often sudden changes
- Pain
- Infection
- Hallucinations /Delusions
- Constipation
- High or Low Blood Glucose
- Irregular heartbeats
- Medication side effects
- Dehydration
- Sleep Depravation
- Depression
- Low B12 levels?
- Abnormal lab values?
- Are they hungry?

Attempt to resolve as quickly as you can

External Behavior Triggers

Environment

- Noisy/ Overstimulation
- Under stimulation
- Inadequate light and increase glare
- Are there barriers causing frustrations?
- Boredom – nothing for them to do that has meaning for them
- What is climate? Cold? Hot? Stuffy?

Caregivers/ Communication

- How did we approach?
- Did we rush resident?
- What was body language, tone of our voice?
- Did we use negative words *(No, Don't, Stop, I told you)?*
- Are we asking them to do something they no longer can cognitively do?

Our Behavior Creates Consequences – So Always:

- Approach from the front – get into their visual range (about 6 feet away before starting the interaction)
- Use touch, but be respectful of personal space. Don't touch until you get a clue that he/she is receptive
- Always treat with love and respect. ***Listen with your heart and soul***
- Slow down.. . Use short sentences. . . Calm tone
- May have to repeat yourself exactly *(some people with dementia have a 2 minute response time)*
- Try again later. Never force
- Sometimes another co-worker is better
- Know their former lifestyle, share what works with each other
- Understand it is not personal, they can't help their behavior

Establishing the Connection

- **Greet** – introduce yourself and their preferred name. *"Hi Claire, my name is Lori Hintz and I will be your nurse today"*
- **Compliment** – indicate something about them of value. *"You are looking very colorful today." "I love your nail polish color."*
- **Share** – share something about yourself and then ask them something. *" Summer is my favorite season. What is your favorite time of the year?*
- **Notice** – point out something in the environment. *"This plant is beautiful. It looks like you take good care of it"*
- **Seek** – Explore a possible unmet like, want or need. *"It's a bit chilly in here, a hot drink would be nice. Do you prefer coffee or tea?"*

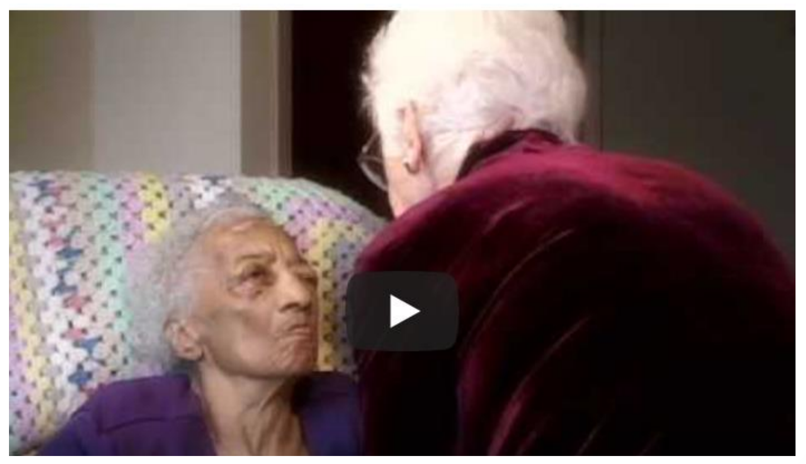
Approaches for Positive Actions

- **Help** – Be sure to compliment his /her skill in this area, then ask for help with something. *"You are so good at __________, would you please help me?"*
- **Try** – Hold up or point to the item you would like to use, possibly sharing in the dislike of the item or task. *"Could we try this?"*
- ***Choice*** – Try using visual clues to offer two possibilities or one choice with something else as the other option. *"This or that?"*
- ***Short and Simple*** – Give only the first piece of information, maybe offer a time frame of 1-5 minutes. *"It's about time to (first task)"*
- **Step by Step** – Only give a small part of the task at first. *"Lean forward."*

What we label as "behavior" in dementia is really a method of communication by the person affected

Our job is to figure that out and respond appropriately

Gladys Wilson Naomi Feil : https://www.youtube.com/watch?v=CrZXz10FcVM



When Faced With a Behavior you Don't Understand . . .

- Start a behavioral log
- Charting on just that one behavior for a week – even 72 hours would be good
- Write everything about that behavior , the surroundings, who was present, were they sitting or standing, were the lights on or off, what happened earlier in day. . . **EVERYTHING!**
- Then you need to look at the log!
- Look for patterns, trends. It may be the most tiniest of det[ails] that is the trigger . Be Sherlock Holmes!
- Involve CNA's, family members, maybe housekeeping, dietary, activities, therapies, Dr's . . . TEAM MEETINGS
- Sometimes intervention found to help can be easily identified and sometimes it is not . . . **BE PATIENT,** but keep trying

Approach to Problematic Behavior: “ABC” Framework

“A-B-C” concept

- **A**: What are the **a**ntecedents to the behavior?
- **B**: What is the **b**ehavior?
- **C**: what are the **c**onsequences of the behavior?

I’ve had ENOUGH!

- Walter has always been a “quiet man”. Worried he is withdrawn, the staff bring him to the dayroom that has a piano, a bird, a TV and other loud activities.
- Walter begins to get restless – and when an aide walks by, he strikes out at her.
- Walter is then put in his room for “time out” and he seems much calmer.
- The next day the same thing happens.

How long before Walter figures out the best way to get out of the noisy setting is to hit someone?

KNOW THEIR STORY!

- Assess how people lived their life.
- What did they enjoy? What do they still enjoy doing?
- What their occupation?
- What is their daily schedule now and in earlier days?
- Find out things that they were proud of? Accomplishments and honors
- What things frustrated them?

What is your story? If the tables were turned, what would someone need to know about you to take care of you?

Non-Pharmacological Approaches to Dementia Care

- Starts with a culture of *comfort* and *person-centeredness*
- Using consistent staff assignments helps with behaviors and also helps to reduce FALLS
- Increasing exercise and time outdoors
- Managing pain
- Planning individualized activities that have meaning!
- Reduce and/or eliminate triggers
- Refocus and redirect
- Always accept the person's emotion as real – enter their reality, not bring them back to our reality. Ok to use "therapeutic fiblettes"

Non-Pharmacological Approaches to Dementia care (continued)

- Always indicate your name and say their name as well
- Always say something positive like *"I love your hat"* or *"That is a beautiful dress"* with each interaction
- Be at same level. If resident is sitting down, so should we
- Never position a resident so that a light source (window or lamp) is behind you as you face them . . . They will not see your face details
- "Chunk " information into short explicit communications. For example, avoid saying, "Please set the table" but rather use series of short commands such as *"come with me", "take a dish from the shelf", "put the dish on the table"*

Non-Medication Treatment Category & Strategies

Sensory	Music, aroma, pet therapy, massage, light therapy, food or snack, physical touch (with caution in some), eliminating physical discomfort, games on ipads, tablets, art
Environmental	Increase in personal space, reduction in disruptive stimuli, increased or decreased lighting, availability of personal effects/mementos
Behavioral	Reinforcement of alternative behaviors, positive reinforcement, validation therapy, redirection, psychotherapy (with mild dementia)
Communication	Awareness of caregiver's nonverbal, verbal & written communication skills: keeping communication simple, supportive, & positive; use foreshadowing (e.g. tell patient bath time will be in 10 minutes, remind again in 5 minutes, remind again on the way to the shower, etc.)
Family support and education	Offer caregiving classes or lectures, provide written materials, refer families and caregivers to local support groups

Wandering

Possible Antecedents	Possible Interventions
Stress: noise, clutter, crowding	Reduce excess stimulation, remove resident from stressful situation
Restlessness, boredom	Provide personally meaningful activity, according to patient's abilities
Reacting to environmental stimuli	Remove or camouflage exit signs, people leaving; Use ID or alarm bracelets, black carpets, do not enter signs

Walking . . . A Good Thing

Studies have shown that walking is the most prevalent type of physical activity among older adults and the most preferred physical activity among cognitively impaired older adults

Mindful walking and cognition in older adults: A proof of concept study using in-lab and ambulatory cognitive measures - PMC (nih.gov)

Maybe wandering is just a way that the body self medicates itself?

Resisting Bathing, Dressing, Grooming

Possible Antecedents	Possible Interventions
Task to difficult or overwhelming	Break task into small steps, give fewer choices, foreshadowing
Caregiver impatience, rushed	Allow ample time or try again later. *Spend 5 minutes and save 20 minutes rule*
Can't understand or follow instructions	Simplify request; give instructions and allow performance one step at a time
Resident modesty causes embarrassment	Respect resident request for privacy
Fear of task, doesn't understand need for task	Reassure, add comfort measure, distract with music or conversation

Other Bathing Interventions

- Schedule bathing when person is in best frame of mind, alert and cooperative
- Showering is best done starting at feet and working up, stopping at the neck, rather than the standard practice of working from head down
- Use hand held shower nozzles
- May want to wash face and hair at a different time
- Avoid letting water pour over face and eyes as this may frighten
- Many times better if only one caregiver assists with the bath/shower rather than two or three
- Could give a back rub prior to shower to help relax resident

Bathing and Dementia with Teepa Snow

- Teepa Snow has many You Tube videos that you can access that help caregivers work with those with dementia
- Bathing and Dementia - Positive Approach to Care (PAC) - Bing video (4:49 minutes)
- Positive Approach to Care (teepasnow.com)

Screaming – 3 types/3 meanings

Rhythmic Sound "help me, help me, help me, help me, help me"	Caused by minimal brain stimulation from the senses–creates form of auto stimulation. Doesn't usually stop when one approaches	Replace stimulation & rhythm w/more acceptable form, such as sitting resident in rocking chair /glider, give a lollipop. If Catholic, could give rosary recorded on audiotape creates a rhythmic mantra, music therapy
Low Pitched & Constant Sound	Often caused by pain. Doesn't usually stop when one approaches	Assess for pain and address pain source
Loud, Shrill, Continuous	Stops when one approaches resident	Often sign of panic or boredom. Interventions: make resident feel safe & secure (more 1 to 1 care, backrubs, more stimulation)

Incontinence

Possible Antecedents	Possible Interventions
Difficulty in finding a toilet, clothing difficulty	Appropriate signs, picture on door, adequate lighting, colored toilet seat, easy on/off clothing
Lack of privacy	Provide privacy
Dependency created by socialized reinforcement	Provide increased attention for continence rather than incontinence; allow independence whenever possible, even if time-consuming
Can't express need or forgets	Schedule toileting
Decreased judgment and lack of social awareness	Do not overreact or confront, calmly redirect

Inappropriate/impulsive sexual behavior

Possible Antecedents	Interventions
Misinterpreting caregiver's interaction	Avoid mixed/nonverbal sexual messages, even in jest. Distract during personal care use simple words
Decreased judgment and lack of social awareness	Do not overreact or confront, respond calmly & firmly, distract & redirect
Uncomfortable—too warm, clothing to tight, need to void, genital irritation	Check temperature, assist with weather appropriate clothing, ensure elimination needs are met, examine for skin problems
Need for attention, affection, intimacy	Increase or meet basic need for touch & warmth, model appropriate touch, offer soothing objects (dolls, stuffed animals)
Self stimulating, reacting to what feels good	Offer privacy, remove from inappropriate place

Suspiciousness or Paranoia

Possible Antecedents	Possible Interventions
Forgot where objects were placed	Offer to help find, have more than one of the same object, learn favorite hiding places
Misinterpreting actions or words	Do not argue or try to reason with resident, distract and do not take personally
Misinterpreting who people are and their actions	Introduce self and role routinely, draw on old memory, connections; do not argue or quiz
Misinterpreting environment	Assess vision, hearing; modify environment, provide simple explanation, distract

Suspiciousness Intervention Example

If person experiencing suspiciousness symptoms and accuses caregiver of taking her purse (wallet), the caregiver could say something like:

- ***"I know how you feel. When I lose my purse (or wallet), I feel panicky. Let me help you find it."*** OR
- ***"I know you must be very upset. I get panicky when I lose my wallet because all my important stuff is in there. Let's go look for it together."***

Once the offer of assistance is communicated, outcome likely to be a change in the person's emotional state. Telling the resident that you did not take it, will go nowhere! Need to get into their world and acknowledge the basic emotion (panicky, upset). If these emotions are ignored, they fester and lead to catastrophic behavior

Catastrophic Reactions

Possible Antecedents	Possible Interventions
Fatigue	Schedule adequate rest, monitor activity schedule (too much, too little?)
Mirroring of caregiver affect w/ lower tone & slow rate	Control affect with resident, model calm
Too much noise, clutter, crowding	Reduce excessive stimulation, remove resident from stressful situation
Resident being stopped from desired activity	Redirect energy to similar activity, ask person to "help" with personally meaningful activity
Unfamiliar people or environment, fear	Be consistent, make changes gradually; reassurance
Restlessness/boredom	Calming music, massage, or personally meaningful activity, assign tasks that provide exercise

Let the person with dementia always come out as the winner of any situation . . .

Caregivers . . take the *"You were right and I was wrong approach"*

Teepa Snow's Positive Approaches to Care

Five Apologies

Intent

I'm sorry. I was trying to help

Change

I'm sorry, this is hard. I hate this for you.

Emotion

I'm sorry I made you angry

Intellectual Capacity

I'm sorry, I had no right to make you feel that way

Experience

I'm sorry, that should NOT have happened to you

Antipsychotic Agents Should NOT be Used for Persons With Dementia for:

- wandering
- poor self-care
- restlessness
- impaired memory
- mild anxiety
- insomnia
- inattention or indifference to surroundings
- sadness or crying alone; not related to depression or other psychiatric disorders
- fidgeting
- nervousness
- uncooperativeness

Either DON'T Work or Better Alternatives

When is it Appropriate to Use Antipsychotics?

- Behavioral symptoms present a danger to the resident or others
- Expressions or indications of distress that are significant distress to resident
- Multiple nonpharm approaches have been attempted, but did not relieve symptoms which are presenting a danger or significant distress and/or
- Gradual Dose Reduction (GDR) was attempted, but clinical symptoms returned

DOCUMENTATION must clearly show indication for the medication, multiple nonpharm approaches and ongoing evaluations of interventions effectiveness

State Operations Manual - Appendix PP -Guidance to Surveyors for LTC – page 580

Antipsychotic Medications have Limited Use and Effectiveness in Residents with Dementia

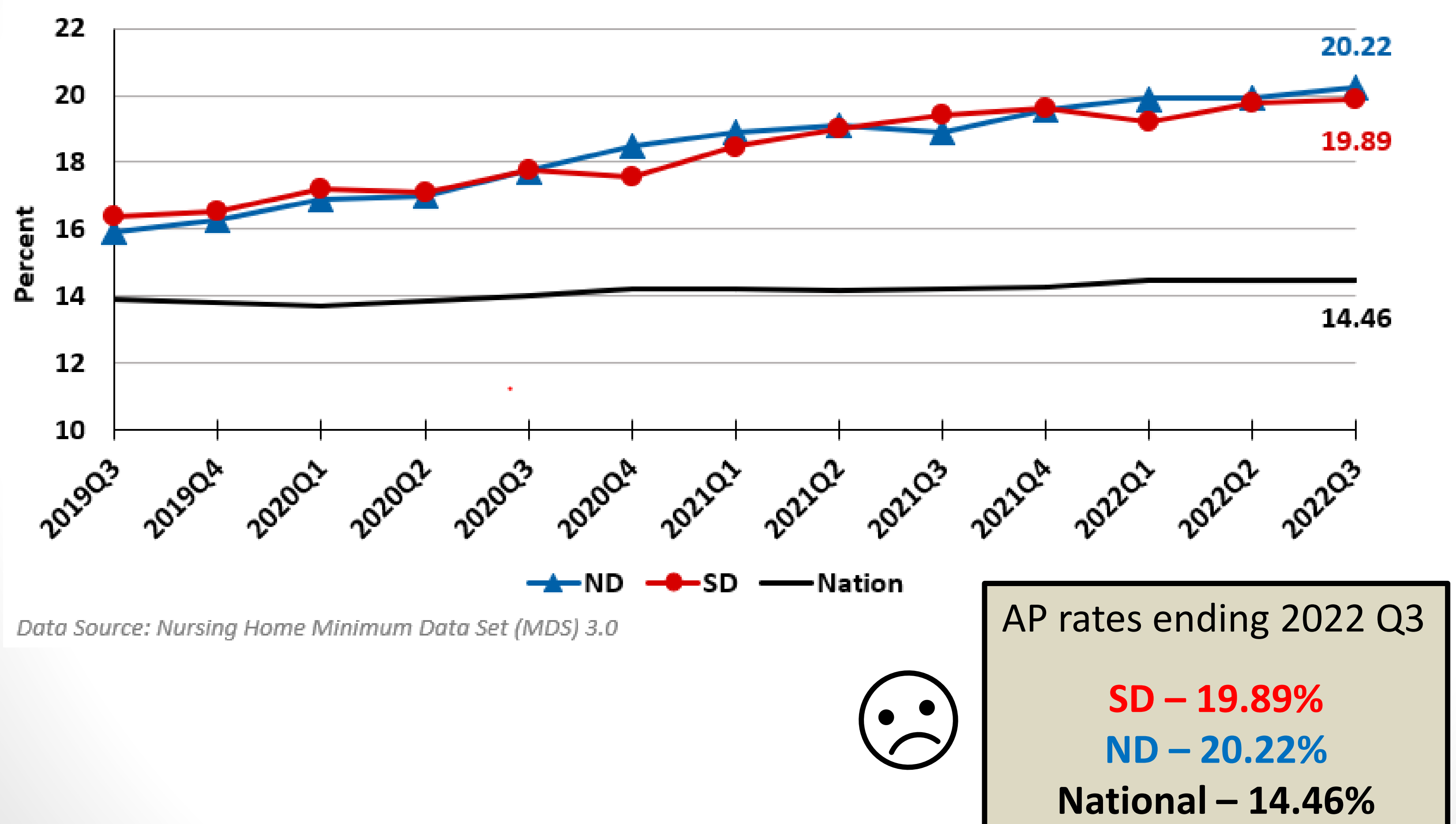
Often causes severe side effects

- Low blood pressure
- Over sedation
- Increased risk of stroke, diabetes, heart disease
- Falls and fractures
- Increased mortality

Polypharmacy issues: especially w/ anticholinergics

https://khn.org/news/common-medications-can-masquerade-as-dementia-in-seniors/

Antipsychotic Medication Data Trends



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AP rates ending 2022 Q3

SD – 19.89%

ND – 20.22%

National – 14.46%

What are Psychotropic Drugs?

483.45(c) (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Those drugs include, but are not limited to, drugs in the following categories:

- **Antipsychotics**
- **Antidepressants**
- **Antianxiety**
- **Hypnotics**

Use of these medications or any other medications should NOT increase when efforts to decrease Antipsychotic medications are being implemented – pg. 576 of Appendix PP

Gradual Dose Reduction Requirements – F758

- Within 1st year: must attempt a GDR in 2 separate quarters (with greater than 1 month between the attempts, unless contraindicated
- After 1st year: must attempt a GDR annually unless contraindicated

Ongoing GDR assessment/documentation

- At admission or within 2 weeks, at time of initial MDS
- During quarterly care plan meeting
- When possible, side effects/ adverse consequences noted or change in condition
- Dose reductions should be done incrementally – slow

Antipsychotic Medicaton Reduction Tips

- Review resources / Establish a PIP team/ Make it a priority
  - National Partnership to Improve Dementia Care in Nursing Homes | CMS
  - Lake Superior AP Medication Reduction Toolkit
- Don't know where to start? Use GPQIN's tool
  - Antipsychotic Reduction Resident Prioritization Tool
  - AP Resident Prioritization Reduction Video Tutorial
- Go slow – select 1 or 2 residents at a time for GDR's. Once resident is stabilized, choose one or two more to focus on

Reduction Tips continued

- Designate a nurse leader champion as the "gatekeeper" for all AP medications
  - Structure it so nurses must first check in with the *"champion"* leader before contacting the physician for a new order/dose change. The nurse leader should model how to use non-pharm interventions
- Do not allow a 'knee- jerk reaction' of ordering an AP med after an isolated behavior
- Conduct a huddle on the unit after a new distressed behavior. Involve CNA's and family in problem solving.
- Care plan specific interventions for EACH distressed behavior
- Make a policy that all new AP orders have an automatic stop after 72 hours and cannot be resumed without care team recommendations

Reduction Tips continued

- Use a spreadsheet/monitoring tool to track all behaviors, AP's, GDR's and the results…And then review and study!
- Observe and assess a resident over 48 hours; look for patterns, triggers and unmet needs
  - Some people also use simple behavior monitoring tool for the staff on the floor per resident. Be specific to the behavior elicited, time, who was there, precipitating factors and any successful nonpharm approaches
- Exchange info at weekly IDT team meetings. Review behavior and meds. Have access to the PDR (medication drug book) during your meetings. *Polypharmacy consequences are real!*

Reduction tips continued

- Track your facility Antipsychotic Medication QM rate
  - Review CASPER QM report monthly
  - Review the QM trending report provided by GPQIN
  - Select your baseline rate and track progress thereafter
- Share progress with staff, physicians, other departments – consider doing a storyboard that highlights projects and milestones accomplished
- STAY FOCUSED!

Take Home Messages

- There are different types of dementia
- Every behavior has a trigger, a cause – most behaviors are attempts to communicate an unmet need
- When working with a person who has mid stage dementia Alzheimer's disease, we can **not** expect the person to change … we need to adapt
- Provide patient centered individualize care – know the patient's story
- Implement and attempt nonpharm approaches first before medications – keep trying
- Potentially there are multiple side effects and consequences of psychotropics – does the risk outweigh the benefit?
- ND and SD are among the highest in the nation for antipsychotic meds in nh's
- Available resources to assist in efforts to improve dementia care and reduce unnecessary antipsychotic medication usage

Resources

Dementia Training / Education Resources

- "Positive Approaches to Caring " Teepa Snow dementia training Homepage - Positive Approach to Care (teepasnow.com)
- National Council of Certified Dementia Practitioners: https://www.nccdp.org/
- Nat'l Partnership to Improve Dementia Care: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes
- Great Plains QIN Nursing Home Section: Look under Antipsychotic Medications and Dementia sections: https://greatplainsqin.org/initiatives/nursing-home-quality/
- Lake Superior Antipsychotic Reduction Toolkit**:** http://docs.wixstatic.com/ugd/50392a_7e66e620e315420c8c6205887c60c97b.pdf
- Alzheimer's Association Family Care Guide: https://alz.org/media/manh/documents/Alzheimer_s-Family-Care-Guide-(FCG).pdf
- Dementia Cue Cards: Dementia Cue Cards: https://files.constantcontact.com/a41ebce2701/c5606a04-3d77-4157-828f-306f47e27e12.pdf

Impactful Videos to share with staff

- Henry and Music: https://www.youtube.com/watch?v=SKO1ODNgbxs
- Gladys Wilson Naomi Feil : https://www.youtube.com/watch?v=CrZXz10FcVM
- Raymond- Brett Eldredge: https://youtu.be/txCUwSKo1kg

Data/ Regulation Resources

- AP Data Rates: https:///www.cms.gov/filesdocument/antipsychotic-medication-use-data-report-2021q2-updated-01142022.pdf
- DOH HH LTC Trends of Psychotropic Drug Use in NHs Nov 22: https://oig.hhs.gov/oei/reports/OEI-07-20-00500.pdf
- Appendix PP, Critical Element Pathways, Survey Resources: https://www.cms.gov/files/zip/survey-resources-02/17/2023.zip
- Alsheimer's Facts and Figures Document: https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf

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