**Title of Course:** Alzheimer’s Disease & Related Disorders (ADRD)

**CE Credit:** 3 Hours (0.3 CEUs)

**Learning Level:** Intermediate

**Author:** Jeanne Christian, MA, SLP-CCC

**Abstract:** This course provides an in-depth discussion of Alzheimer’s disease, including the disease progression and strategies for care and management of individuals with Alzheimer’s Disease or Related Disorders. It considers all aspects of ADRD, including the various stages of the disease, problem behaviors, communication issues, ethical considerations and appropriate activities. In addition, strategies are presented for working with families and caregivers of ADRD patients.

**Learner Objectives:**
1. List 6 ways to create an environment in which AD residents feel secure
2. Identify 5 “Do’s & Don’ts” when communicating with AD residents
3. Describe 3 common behavior problems & solutions for managing them safely & effectively
4. Identify strategies you can employ for promoting independence in all stages of ADRD
5. List 3 skills the caregiver can use to help connect ADRD residents with their families
6. Describe key features required to make activities for memory impaired residents successful
7. List “best practices” for organizing reminiscing activities with memory impaired residents
8. Distinguish among the moral principles involved in ethical practice

*Test questions and directions for submitting are located at the end of this document.*
Alzheimer’s Disease & Related Disorders (ADRD)

By: Jeanne Christian, MA, SLP-CCC

Topic 1: Creating the Right Environment for AD Residents

**Topic Introduction:** Many residents who suffer from dementia may display inappropriate behaviors as a result of the environmental factors that affect them. These factors can prevent residents from enjoying and participating in constructive activities, and deter the attempts of activities staff. After reading through this topic section you will be able to create an environment in which AD residents feel secure.

**Environment**

The attributes of a resident’s environment, such as the noise level from unfamiliar or unpleasant sounds, can affect his or her behavior. In addition to unsettling noises, a lack of sensory or environmental stimulation can also cause a resident to demonstrate upsetting or disruptive behaviors. For example, a lack of appropriate cues for navigating his or her surroundings may cause residents to become disoriented and resort to inappropriate behaviors.

When designing the surroundings for memory impaired residents, it is important to create an environment that is dementia friendly and has a “homey” feeling. The overall goal of the design should be centered on helping residents function at optimal levels. Some suggestions for improving the resident’s environment include:

- Remove any overhead speakers
- Provide a pleasant smell in the environment
- Adjust lighting to limit shadows
- Remove all tripping hazards
- Provide furniture with limited patterns
- Install solid colored or basic carpet

**Staff Interaction/Approach**

Poor communication by staff members can also be the source of a resident's unwanted behavior. For instance, residents can become upset if the tasks they are provided are too complicated or have too many steps. Residents can also have a difficult time understanding directions when staff members are moving and speaking very fast.

**Security**

Residents who have any form of dementia are unable to view their world with a sense of “reality”. Therefore, their world becomes unpredictable and frightening. They begin to express feelings of fear about the future, as well as complaints of disorientation and spatial distortions. Their decreased capabilities also lead to an increased need for assistance. Staff can comfort a resident’s feelings of fear by providing the following:

- Provide a calm and predictable environment
- Design “homey” surroundings and decorations
- Provide an accepting atmosphere
- Create a failure-free environment
- Offer physical and verbal assistance
- Provide reassurance of love and caring
Goals and recommendations to improve the environment for residents with memory impairment:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Criteria</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide common areas with ample space for residents to gather and congregate.</td>
<td>Variability</td>
<td>Activity room, dining room, sitting areas</td>
</tr>
<tr>
<td>Exit control</td>
<td>Safety</td>
<td>Key Pad System, camouflaged doors, black mat at doorway</td>
</tr>
<tr>
<td>Create a home-like atmosphere</td>
<td>Familiarity</td>
<td>Provide a home-like atmosphere; include personal &amp; familiar items</td>
</tr>
<tr>
<td>Outdoor Environment</td>
<td>Availability</td>
<td>Accessible outdoor space (e.g. secured courtyard). Safe interactions with nature (e.g. planter boxes with non-toxic plants and garden with non-toxic plants)</td>
</tr>
<tr>
<td>Stimulation: Limit the amount of distracting stimulus in the environment</td>
<td>Noise Management</td>
<td>Examples: warm colors, subdued patterns, disconnect overhead paging system, limited visual stimulation</td>
</tr>
<tr>
<td>Foster an environment that includes dementia trained staff</td>
<td>Education</td>
<td>Provide dementia training for staff</td>
</tr>
<tr>
<td>Provide wandering paths and other devices to keep residents occupied</td>
<td>Continuing to find a way out</td>
<td>Circular walkway, no dead ends, visual aids (e.g. Bio-boards, pictures, signs)</td>
</tr>
</tbody>
</table>

Learning Scenario:

Angela, the daughter of an Alzheimer's patient wants to make her father feel at home in the new facility. She comes to you for advice as to how to prepare his room. What suggestions might you give her?

Answer to Learning Scenario:

There are a number of things that Angela can do to make her father feel more at home. Items that create a familiar, homey feeling should be placed in his room. This could include framed family pictures, a special blanket or afghan, or stuffed animals. A favorite chair may be brought in if it is solid-colored or has limited patterns. In addition, attention should be given to the noise level, lighting, and smells associated with the room. Naturally, all tripping hazards should be removed.

Topic Summary: In regards to memory-impaired individuals, factors that can lead to problem behaviors include environmental conditions, such as disturbing sounds or improper lighting. There are a number of actions that staff can take to make residents more secure and feel safer in both indoor and outdoor environments.
Topic 2: Communicating Effectively with Patients with ADRD

**Topic Introduction:** Developing communication skills for speaking to a person with ADRD is a vital aspect of providing quality care. In addition, it is important to learn how to “read” an individual’s non-verbal cues.

Just as clinical trials are ongoing to discover better medications to treat ADRD, researchers continue to seek ways to enhance the quality of life for both residents and caregivers dealing with ADRD. Presented in this part of the course are tips and techniques for better communication with ADRD residents, whether or not they are able to say in words what they need, want, and feel. This topic will enable you to describe how ADRD affects communication skills, and apply that knowledge when you work with ADRD patients.

**Effective Communication Techniques**

In the Broadway musical, *Annie*, there is a song called “You’re Never Fully Dressed Without A Smile.” Thinking of that (or anything else that brings a smile to your face) when approaching a resident with ADRD may remind you to be friendly and compassionate, even if it is the end of a hectic shift. A positive greeting is a comforting prelude to whatever comes next. It can help soothe a resident who is fearful or not having one of his better days.

As ADRD stages progress, the resident experiences increasing difficulties with language. Both speaking and understanding what others are saying presents a greater challenge. A person may not be able to keep up with the conversation, especially if the setting is noisy or busy. Frustration, anger, confusion and sadness often result.

One technique that helps is called “Show and Tell.” It means showing with gestures, facial expressions and an open posture while telling in short, simple statements. Residents with ADRD will watch for clues in their efforts to understand what you are saying.

Practicing the tips listed below will help you communicate more effectively:

- Smile!
- Say the person’s name to gain his attention and remind him that he knows you.
- Pay attention to your posture, gestures and facial expressions. Keep them open, positive and kind.
- Maintain eye contact with the resident.
- Identify yourself by name to be friendly, respectful and serve as a reminder. Understand that residents may not remember you from day to day.
- Speak slowly, clearly, and simply: “Let’s go for a walk” may work better than saying, “Would you like to stroll over to the window and look out at the beautiful day and watch the birds build a nest?”
- Use a calm tone and keep a “smile” in your voice.
- If a person is unreceptive, leave him alone for a few minutes before trying again.
- Use names of things and words the resident knows. For example, say “fork” instead of “utensil.”
- Pay attention to nonverbal cues you are giving and receiving from residents.
- Give clear directions, “Mr. Jones, please sit in this chair.”
- Add gestures to match your words whenever possible. Use “show and tell” methods. Remember that ADRD residents watch *and* listen when they are trying to understand you.
- Be patient for responses. Rushing will frustrate both you and the resident.

**Communication Cards May Help**

Print a clear message, using large print, positive words, and simple language. Personalize cards using “I”, “you”, and “my”.


Read the card aloud with the resident and then leave the card with the resident. You should plan for card making by having supplies ready. Include family members in making cards.

The BIG “don’ts:” Things to Avoid When Communication with AD Residents

- Don’t talk in front of residents as if they were not there.
- Don’t speak to a resident using “baby talk.”
- Don’t argue or try to reason with a resident.
- Don’t yell, scold, threaten, or use an angry or condescending tone of voice.
- Don’t “quiz” the resident in efforts to sharpen her memory.

Learning Scenario:

You are supervising young healthcare workers in your facility. You overhear Tim, a CNA, talking to his colleague. Tim is explaining his approach to working with ADRD patients. “I always maintain eye contact with the resident and speak in a soft, clear tone of voice. Only if they don't respond, do I raise my tone and continue to speak until they respond.”

How would you judge Tim's approach? Write down your answer and the reasoning behind it.

Answer to Learning Scenario:

Give Tim 2 out of 3 points. He’s right about the importance of making eye contact and speaking in a soft tone. However, raising his tone of voice is never a good idea even with a non-responsive resident. Also, if a person is unresponsive, Tim should leave him alone for a few minutes before trying again.

Topic Summary: Given that people with ADRD have a diminished capacity to communicate and to understand the world around them, it is vital that caregivers adapt special practices to address the situation. Smiling and speaking in a calm tone is one way to establish a positive rapport. When speaking, give clear, straightforward instructions such as “please sit in this chair.” If an ADRD resident is unresponsive, it may be advisable to leave the person alone for a few minutes. Also, use gestures to supplement your communication and use concrete terms such as “fork” rather than “utensil.” Above all, be patient and kind.
**Topic 3: Behavior Identification & Symptoms Management**

**Topic Introduction:** Alzheimer’s disease or related disorders (ADRD) is a progressive, irreversible disease that destroys a great number of brain cells. These damaging biochemical changes in the brain result in memory loss, thinking and language difficulties, uncontrollable behavior problems, loss of body functions, and eventually, death.

People who suffer from ADRD are prone to problem behaviors. Some behaviors can be puzzling, embarrassing, annoying or dangerous. Caregivers need to be aware of troublesome behaviors and how to prevent or manage them to maintain a safe, secure and calm environment. Reviewing this topic will enable you to respond to the challenging behavior associated with ADRD.

**The Source of Problem Behaviors**

To manage problem behaviors, you must understand their source. Problem behaviors can be triggered by the combined effects of damaged thinking processes resulting from the disease (which cannot be controlled) and certain stress factors (many can be controlled.) Types of stress factors include:

- Medical / Physical
- Emotional
- Environmental
- Psychosocial

**Why is it a problem?**

To determine the scope of a behavior problem, ask yourself if the behavior is:

- Disturbing for the resident, other residents, or caregivers?
- Impinging on other residents’ rights?
- A safety concern for residents or staff?
- Interfering with the resident’s care, safety, or well being?
- Likely to cause the resident to become overtired?

**What is the problem?**

Understanding different stress factors of ADRD and the impact they have on behaviors will help you cope with problems when they occur. This section identifies the source of common behavior problems and offers solutions for managing them safely and effectively.

**Medical / Physical Stress Factors**

**Malnutrition and Dehydration**

Encouraging sufficient intake of nutrients and fluids can be a challenge for caregivers working with individuals who have ADRD. It is essential to address that challenge. Individuals with ADRD may not feel hungry or thirsty or may be unable to ask for food or drink. Residents may forget to eat and drink what is provided, especially when there are noises or distracting activities occurring in the area. Discomfort from ill-fitting dentures is another deterrent.

Monitoring the resident’s fluid intake is vital and must be increased during hot weather. A resident who may be unaware of thirst will often drink liquids if offered. Inadequate intake of food and fluids can hinder elimination. Dehydration can contribute to confusion, disorientation, and other problem behaviors.
**Constipation**

Improper elimination often results in constipation and impacted bowels. This often causes discomfort, irritability, increased confusion, even hallucinations and delusions. Setting up a toileting schedule for residents and monitoring elimination will allow you to identify the problem and take corrective measures.

**Poor Vision and Hearing**

Make sure that residents wear their eyeglasses and hearing aids. Routine vision and hearing tests are critical. Individuals with sensory deficits can misinterpret words or actions, which increases confusion and frustration.

**Pain**

Communication difficulties can result in pain being unreported. The resident may have joint pain, headaches, stomach cramps, and other discomforts, but be incapable of putting the problem into words. Watch for non-verbal cues and signs of pain. Grimacing, wringing hands, moaning, and increased agitation can be indicators of pain. Find the source of the pain and resolve it, if possible. Administer pain medication as prescribed. Relieving pain is a vital quality-of-life issue. It replaces frustration with calmness, and fosters greater enjoyment of all activities, including meals, visits, and other interactions.

**Medication Side Effects**

Polypharmacy, the concurrent use of several drugs, can result in a broad range of cognitive side effects. It is important to review all prescribed medications, including vitamins and herbal supplements. Keeping this information documented and updated enables the care team to evaluate the effectiveness of combined medications and identify possible drug interactions.

**Infections and Injuries**

The presence of undetected infection or unreported injury can cause illness, discomfort, and strained interactions. In the advanced stages of ADRD, the resident is more prone to infections, such as urinary tract and bronchial infections. Simply bumping into a chair can leave a painful bruise or lesion that the resident forgets to report. A system must be in place to check residents for infections and injuries. This will help keep residents feeling well, consequently improving receptivity and cooperation with staff and other residents.

**Insomnia and Fatigue**

Disruptions in sleep patterns are common among individuals with ADRD. Too many daytime naps contribute to restless nights. A lack of sleep at night leads to fatigue and irritability during the day. To support the residents' normal sleep pattern, consider the following:

- Balance stimulants and physical activities with rest periods during the day.
- Reduce foods and drinks that contain sugar and caffeine.
- Develop a set evening routine, starting with quiet time prior to bedtime.
- Play soft music to aid relaxation.
- Encourage the use of sleep comforts, like a soft blanket or stuffed animal.
- Give medications as indicated.

**Emotional Stress Factors**

**Fear about the illness**
Residents with ADRD can become very fearful during all stages of this disease process. Fear is a strong emotion. It can cloud communication and initiate problematic behaviors. Listed below are some reasons a person with ADRD feels fearful:

- Disoriented to time and place – feeling lost and nothing looks familiar
- Inability to recognize loved ones
- Unable to communicate needs or get help
- Forgetting how to do everyday activities; loss of independence
- Sensing that the end of life is near

Caregivers need to offer residents with ADRD constant reassurance that they are safe and well cared for. Therapeutic touch, praise, and hugs (if the resident is comfortable with that) can calm fears and help relax the person. A renewed sense of security often increases the resident’s willingness and ability to communicate.

**Frustration**

At any time, an individual with ADRD may be struggling to understand what is going on or what you are asking him to do. This confusion is magnified by too many competing stimuli in the area. The person feels overwhelmed and frustrated with himself for not being able to understand what is being said and done around him. When this happens, he may give abrupt responses, become uncooperative, anxious, or angry. The resident may feel out-of-control, but not know how to stop the anger and regain composure.

**Loss of Self**

A resident with dementia often feels lost; like a “stranger in a strange land.” Studies indicate that some dementia-related anxiety is caused by not knowing how to recover a sense of self; being the same as the person was before the illness. This loss of identity, sense of self-worth, and purpose in life can bring on diminished self-esteem, despair, and anger.

**Environmental Stress Factors**

The physical environment influences how residents with ADRD feel, think, and interact with each other. Maintaining a balance between stimulation and rest is crucial. A crowded or noisy area tends to increase anxiety and agitation among residents. Likewise, a room that is too quiet, dark, bright, hot or cold may elicit similar reactions. Introducing new equipment into an area also can be upsetting.

**Lost without Labels**

As the disease progresses, people with ADRD have increasing difficulties with directions. They can get lost in a hallway where all the doors look the same and nothing is labeled. They need a supportive environment that makes it easier for them to find their way. Using signs to label the doors to places like bathrooms and dining rooms can be a tremendous help. Signage should display both words and illustrations that clearly depict the room’s purpose. For instance, include a picture of a toilet for the bathroom.

Try placing a photograph of the resident over the door to her room. This helps her find her way with greater confidence. A photograph taken 30 years ago is often more easily recognized by the resident than a recent photograph. Labels posted inside the resident’s room, such as “Dresser” and “Closet”, may help as well. Ask a family member to bring familiar personal items to keep in the resident’s room, such as a blanket, pillow, and family photographs.

You can help pave the way to more positive interactions by adding little touches to the resident’s environment that help her feel connected to her surroundings and more capable of navigating them.
**Privacy**

Residents have a right to privacy. Lack of privacy can be upsetting to them. Caregivers should respect residents' privacy and personal space conventions as much as possible. When assisting a resident with bathing and dressing, doors and curtains should be closed. Towels can be used as drapes while assisting with bathing and personal care needs. Similarly, a resident’s condition, symptoms, medications, or other care needs should not be discussed in the presence of other residents.

**Psychosocial Stress Factors**

**Paranoia**

Residents with ADRD often feel threatened by an impending sense of doom. They fear some real or imagined person or situation. They cannot reason their way out of that fear. They may feel rushed by caregivers, or think that caregivers are angry with them. These feelings can be magnified by changes in the daily routine, or by meeting a different staff member. Residents feel more secure when matched with the same caregivers as consistently as possible and when there is a set schedule for meals, activities, bath, and bedtime.

**Denial**

A resident may be uncooperative because he does not want to admit the need for assistance. He may deny offers for help, even when he needs it badly. You can support the resident’s sense of dignity by monitoring a situation to ensure safety, while allowing him to achieve daily activities (like shaving) with as much independence as possible.

**Agitation**

Agitation is a feeling of non-specific restlessness, frustration, or apprehension that can be very disruptive. Medical, emotional and environmental stress factors contribute to agitation. Physical signs of agitation may include:

- Pacing
- Disrobing
- Trying to go somewhere to find someone or something
- Repetitive actions and intrusive behaviors

Verbal signs of agitation may include:

- Complaining
- Seeking attention
- Repeating questions
- Screaming and negativity

**Aggression**

Aggression is an action, and it is hostile toward others, objects, or oneself. Physical signs of aggression may include:

- Slapping
- Pushing
- Spitting
- Kicking
- Scratching
- Biting
- Throwing objects
Verbal signs of aggression include:

- Name-calling
- Shouting obscenities
- Threatening and accusing

Aggressive behavior typically stems from anger, fear, or extreme frustration. If you identify agitation before it escalates and intervene appropriately, aggressive behavior can often be prevented.

**Wandering**

Wandering is an action. It is walking aimlessly, without purpose or destination, feeling unable to sit or stop walking. A resident may wander around the fringe of a group activity, refusing to participate or settle anywhere. He may wake up at night and wander, trying to leave the facility. Wandering behavior is aggravated by medical, emotional, and environmental stress factors. Residents who wander must be monitored closely to ensure safety of all residents, and to prevent the person who wanders from getting lost or injured.

**Sundowner’s Syndrome**

This is the name given to behavioral problems that increase in the late afternoon or evening. Sundowner’s syndrome is possibly caused by fatigue, over-stimulation during the day, and feeling confused by the changing environment. The symptoms of Sundowner’s syndrome include:

- Pacing
- Wandering
- Increasing anxiety
- Sadness
- Asking to “go home”

**Altered perceptions**

Altered perceptions are mental distortions of reality. The person experiencing this state believes the distortion is real. She may be suspicious and fearful.

**Hallucinations**

Hallucinations can be visual, auditory, tactile or gustatory (perception of a bad taste). Refusal to cooperate with caregivers, sudden mood changes, and physical reactions occur in response to hallucinations. For example, a resident who is experiencing a tactile hallucination may feel the sensation of things crawling on or under his skin. The physical reaction may be rubbing and scratching his arms, trying to brush away what he feels is crawling on him. He also may disrobe in efforts to rid himself of this disturbing feeling.

**Delusions**

Delusions are fixed false beliefs that persist in the face of evidence to the contrary. For example, a resident may believe that people are stealing things or plotting against him. A wife may not recognize her spouse, identifying him as an intruder.

**Catastrophic Reactions**

This occurs when a person with dementia becomes overwhelmed. Excessive stimulation (noise, activity, light) and demanding too much from the resident can be overwhelming for him. Talking too fast, giving multiple-step directions or asking for cognitive reasoning beyond the resident's capabilities can push the resident into sensory overload. Correcting a resident or pointing out his cognitive deficits will serve no constructive purpose and may lead to a catastrophic reaction. Watch for the following signs:
- Sudden change in mood
- Anger, crying, agitation
- Striking out, raising fists, any gestures of physical aggression
- Paranoia and accusations
- Flushed face
- Stubborn refusal to cooperate
- Pacing or wandering, trying to “go home” or “get out.”

**Remember, problem behaviors are part of the disease process and are not done intentionally to annoy others. They indicate the resident’s attempt to send a message, to communicate a physical or emotional need.**

The person with ADRD is incapable of controlling his problem behaviors. However, the behaviors cannot be ignored or allowed to escalate because they can become dangerous to all residents and staff in the area. To ensure the safety and well being of all residents and staff, you must address problem behaviors.

**Solutions for Managing Problem Behavior**

Noise, such as paging systems or calling out to someone down the hall, is distracting and disturbing. It adds to confusion among residents who have ADRD. Keeping the area as quiet and calm as possible should be a shared goal of all staff. Talking to a resident in a quiet area that is free from distractions is more likely to yield satisfactory results. Trying to be heard and understood in bustling surroundings often leads to agitation.

**Tips for Soothing Agitated Behavior**

- Check for any reason the person may be in physical and/or emotional discomfort. If you can relieve the discomfort, do so.
- Redirect the resident with a constructive task, such as folding towels.
- Reduce the noise level in the area.
- Keep your voice low and calm.
- Approach the resident from the front and smile.
- Use the resident’s name and identify yourself. Do not expect the person to remember you.
- Mention the resident’s grandchildren or something she likes to talk about.
- Experiment with diversions, like holding an object or toy that can be manipulated.
- Turn off televisions and radios in the area.
- “Slow and easy” speech and movements help calm an agitated resident. Don’t get as “ruffled” as he is. Modeling a calm demeanor shows the resident appropriate behavior. The “Show and Tell” technique used in everyday communications applies to resolving agitated behavior as well.
- Keep your voice low when speaking to co-workers, as well as when addressing residents. Calling out to each other from down the hall creates a sense of disruption in the environment.
- Ask the resident to go for a walk with you. Talk quietly and walk at the same pace as the resident wants to walk toward a peaceful area. Perhaps, find a chair near a window or point out a beautiful painting or some other soothing object to help redirect the person’s focus.
- Make simple requests, one step at a time.
- Be patient. Wait for the resident to respond before moving on to the next step. For example, say “Mr. Jones, will you walk with me?” Then say, “Will you fold this towel?” Then say, “Thank you for helping, Mr. Jones.”
Tips for Calming Aggressive Behavior

- Approach the resident from the front, modeling a calm attitude.
- Respond to cues. Pulling at clothes may mean the person needs to use the bathroom.
- If a resident becomes aggressive while you are helping him, stop what you are doing and move other residents away to a safe place. Make sure the aggressive individual is safe and not apt to harm himself. Then leave the person alone for a moment and try approaching him again when he begins to calm down.
- Redirect the person’s attention with a change of scene or other distractions, like holding an object. This will keep his hands busy.
- Make a note of residents who do not get along and keep them apart as much as possible.
- Plan a scheduled time each day for exercise programs. Take the time for an unscheduled stroll when needed to calm or redirect a resident.

Tips for Tracking Wanderers

- Keep walkways and hallways clear of obstacles that could cause a fall.
- Alert all staff and let surrounding neighbors know that a resident wanders.
- Maintain a regular exercise program.
- Provide “busy boards” or stations where residents can go to sort scarves, handle fabric or fold towels.
- Place a rocking chair in the corner. Its motion can be soothing.
- Label rooms and objects to help residents who feel lost or disoriented.
- Post pictures and stop signs at exit and entrance doors.
- Use secure monitoring devices, like combination door alarms.

Note: Register residents with Safe Return, a national program assisting in the safe, timely return of individuals with ADRD who get lost when wandering away from home. Safe Return is sponsored by The Alzheimer’s Association. For more information, go to the following website: http://www.alz.org/Services/SafeReturn.asp

Interventions for Sundowner’s Syndrome or “Sundowning”

- Provide daily exercise opportunities
- Reduce caffeine and sugar intake
- Plan more stimulating activities for the patient’s best time of day
- Offer comfort – stuffed animal, favorite music or snack in late afternoons

Remember the 5 “R’s” of Managing Catastrophic Reactions

Remain calm. Never confront, argue or try to reason.
Respond to feelings. Say: “You seem upset” or “You seem worried.”
Reassure the person. Say: “It’s OK, Mr. Green. You are in a safe place.”
Remove yourself for a moment and take a deep breath.
Return when the resident begins to calm down.

The Behavior Profile

There is a strong link between impaired communication skills due to ADRD and the anxiety and agitation that residents sometimes express. Understanding the importance of communication is the foundation for all interactions with people who have ADRD. Problem behaviors are attempts to send a message. If you respond appropriately, you will feel more in control of the situation. When working with an individual who displays anxiety or agitation, consider the verbal and nonverbal clues to his message. Behavior profiling is a tool for better understanding the causes of the behaviors and devising the best approach to resolution.
### Triggered event
- What happened?

### Behavior exhibited
- How is the resident responding?

### Interventions
- What can you do?

When assessing the behavior of someone with ADRD, it is important to ask some basic questions:

- What is the behavior?
- Where is it occurring? (Bathroom, activities area?)
- What is the time of day? (Notice patterns: dinnertime, bath or bedtime)
- Did something create a disruption? (Change of shifts? New activity?)

### Documenting Behaviors

Tracking behavior is essential to:

- Validate its significance, intensity, and potential for recurrence.
- Determine the effect of the resolution strategy on the behavior.
- Learn more about the behavior patterns and potential prevention.

### Creating a Log to Document Problem Behaviors

The purpose of logging problem behaviors is to better understand and have written documentation of the specific circumstances within which the behavior occurs. Gathering all this information in a concise format like a log will aid the care team’s problem-solving efforts. The following are recommended components of a Behavior Log:

- Define the behavior
- Briefly describe surrounding circumstances
- Develop a plan for preventive measures

### Table 3: Sample Behavior Log

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Behavior</th>
<th>Circumstances</th>
<th>Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/14/03</td>
<td>4:30PM</td>
<td>Agitated/Sundowning</td>
<td>Noisy area - TV too loud</td>
<td>Quiet music activity in late afternoons</td>
</tr>
</tbody>
</table>

### Tips for Making the Log Work

- Communicate to all staff the benefits of logging behavioral information and ask that all agree to participate.
- Collect data over a period so patterns become evident.
- Designate a timeframe (24 to 48 hours) within which the care team will evaluate the information logged.
- Recommended intervention plans should be determined following the evaluation.
- Advise all staff of the behavior logged and the intervention plan recommended.
- Include any helpful hints for dealing with a difficult behavior on the service plan.

### Tune-in to Your Residents to Prevent Problem Behaviors

As a caregiver, you can learn to spot the potential for a problem and often stop it before the behavior fully manifests. This ability to tune-in to your residents will help keep challenges from escalating into unsafe situations. Be aware of subtle signs that residents are becoming bored, overtired, frustrated, angry or upset.
Visually scan the area to see if other residents appear upset by something someone is doing or saying. The following five steps will help you evaluate residents’ behavior:

**Restrict:** Stop the behavior. When a behavior looks potentially harmful, step in and stop it. Then, gently redirect the resident’s attention to another area, focal point or activity.

**Reassess:** Double check to see if the resident is bored, experiencing some physical discomfort or reacting to a medication. Make sure that noise and confusion are minimal. Focus your attention on the problem’s cause, not the result.

**Reconsider:** A request that may seem simple to you might actually be much too difficult for a person with dementia. A task that was no problem for a person yesterday may be overwhelming for that same person today. Staff must continually adjust expectations of a resident’s remaining abilities, remembering that the stages of ADRD progress at different rates and in different ways for each resident. Also, a behavior that may seem peculiar to you may in fact serve a purpose to the person with dementia. (Holding a baby doll, for example) The rule of thumb is: if a behavior is comforting to a resident and not harmful or disturbing to anyone else, allow it.

**Redirect:** Presenting an alternative focal point is the key to stopping a behavior with a positive approach. Instead of saying, “Don’t do that” you should say,”Try this.” Offering a favorite snack or enjoyable activity distracts the resident from the problem and guides her attention in a different direction.

**Reassure:** “It’s okay, Mrs. Collins. You’re fine. I’m taking good care of you.” When a person is anxious or fearful, simple reassuring words go a long way towards resolving their anxiety. Repeat reassurances. Tell her she’s okay until she starts to feel okay.

**Steps to Resolving Problem Behaviors**

Assessing and analyzing the possible sources and combinations of factors leading to disruptive behaviors is important. Documentation and analysis will help in developing successful strategies for coping with and modifying problem behaviors.

**Step 1 – Analyze the behavior**

Determine who, what, where, when, and why.

- Who was in the area when the behavior occurred?
- What was happening? Was it noisy or otherwise stressful in that area?
- Where does the disruptive behavior occur?
- When does the disruptive behavior occur?
- Why? Look at triggers such as illness or wet or soiled clothing?

**Step 2 – Identify behavioral strategies.**

Create a treatment plan specifically designed to address that resident’s particular pattern of behavior. For example:

“Mr. Green enjoys folding towels in the afternoon. He looks forward to this activity and sees it as his responsibility. Three days last week, Mr. Green became agitated and upset when there were no towels for him to fold. He began to pace. He became withdrawn, suspicious and accused others of stealing the towels. Presenting him with a handful of towels to fold in a quiet area resolved his symptoms. Having at least three towels on hand for Mr. Green to fold every afternoon before a 3:00 snack has been a successful strategy in modifying this problem behavior.”
**Step 3 – Implement a behavioral intervention.**

It may be necessary to make environmental, staffing, and/or schedule changes to care for specific needs of individuals.

Advise all members of the care team about the behavioral intervention plan. Anyone who has contact with the resident should understand the plan and respond consistently as indicated by the plan. In the case of Mr. Green (above), any staff that comes into contact with Mr. Green needs to know about his pattern of problem behavior and the plan to provide towels for him to fold every afternoon between 2:00pm and 3:00pm. Communicate the plan to family members and support personnel, as well.

Require staff members to use a consistent approach to the resident’s behavior. Monitor and document responses and observations regarding the behavior for the next step.

**Step 4 – Evaluate and modify the plan as required**

Whether a strategy succeeds or fails, it can be used as a learning tool. The process helps caregivers get to know residents better and practice problem-solving skills.

Adjust elements of the plan as needed to keep it working with resident’s shifting needs.

Some strategies seem to work initially, but do not succeed long-term. Revised strategies may need to be developed and implemented.

**De- fuse & De- escalate Potential Danger**

When a resident’s behavior becomes out of control or dangerous, the following techniques for de-escalation are recommended to defuse a tense situation:

- Present a calm, confident appearance. Do not match the resident’s anger and frustration with your own impatience.
- Protect residents and staff in the area by removing sharp objects and other items that could be harmful if thrown or used as weapons.
- Try to redirect the resident’s attention. Distract him by offering a favorite activity or a food treat.
- Gently remove the person who is upset from the stressful environment. Sometimes a simple change of scene will change the mood.
- Keep your voice low and calm.
- Avoid trying to reason with the individual. Don’t ask questions or confront any cognitive deficit. (Don’t ask, for example, “What were you thinking?”)
- Assess the level of danger for yourself, the resident, and others in the area. Ask yourself these questions: “Am I in danger? How much danger? What can I do about it?” Oftentimes, you can avoid harm simply by taking five steps back and standing away from the resident for a few moments.
- If these practices are ineffective, leave the room and get help immediately.

**Set the Stage for Success**

- “Accentuate the Positive”
- Help residents feel confident and capable by focusing on their abilities, not their deficits.
- Modify the environment as needed to prevent distractions and problems.
- Reassure residents to reduce their fear. Most residents need a lot of reassurance.
- Smile and use therapeutic touch when appropriate.
- “Flooding Praise” is a method of communication that is recommended to improve relationships in a variety of settings. Everyone enjoys praise. Residents with ADRD need praise to feel safe, secure and
valued. Try praising every effort, every bite, and every smile. "What a beautiful smile you have, Mrs. Smith!" “I see you tried some of that delicious blueberry muffin. Excellent job!"

- Offer choices rather than commands. “Will you walk over here with me, Mr. Jones?” instead of “Don’t go out that door!” Avoid saying, “don’t”, “can’t” and “have to.” Presenting a direction as a choice shows respect and supports the person’s sense of dignity. It also invites a more cooperative response.
- Respond to feelings, not facts. Here is an example:

**Fact:** Mr. Jones is pulling off his pajamas in the middle of the hallway.

**Responding to fact:** “Stop that! You can’t undress out here.”

**Responding to the underlying feeling:** “Mr. Jones, will you please come with me?” while quickly escorting him to the toilet, which he is in dire need of using.

Managing Communications in Three Stages of ADRD

**Early stage**

**Challenges for ADRD residents:**

- Cannot think of the right words to name things and complete sentences
- Scramble the sequence of events when telling stories
- Speak of past events as if they are happening now
- Cannot remember what was just said
- Have difficulty following directions

**How you can help:**

- Approach resident from the front
- Introduce yourself. Understand that the resident may not remember who you are.
- Smile!
- Discuss important business at the time that is best for the ADRD patient.
- Talk about one topic at a time.
- When the resident mentions past events, chat with him about those events.
- Use names of people and objects that are familiar – not fancy.
- Keep language specific; avoid pronouns and general terms.
- Be patient and encouraging. Praise efforts.

**Middle stage**

**Challenges for ADRD Residents:**

- Confusion if you talk fast
- Frustration if more than one person talks at the same time
- Unable to pay attention
- Less talking and responding
- Mainly “Yes” or “No” answers
- Saying or shouting inappropriate, puzzling, or impolite things
- Repeating the same questions and stories
How you can help:

- Maintain focus with gentle therapeutic touch.
- Offer easy choices ("Do you want to put on the red or blue shirt?")
- Use sensory stimulation, like touch and smell, perhaps during meals and while bathing and grooming.
- Break down instructions into simple steps, one at a time. ("Put on your shirt"). Then, "Put on your pants" rather than, "Get dressed."
- Smile and present a positive attitude, facial expression and stance when you need to redirect a resident: "Come take a walk with me," instead of saying, "Don't go out that door!"
- Repeat instructions as needed, using the same language.
- Avoid gestures or postures that may appear angry or threatening (standing with arms crossed, frowning).
- Watch for non-verbal cues. For example, a resident who needs to go to the bathroom may start pulling at his clothes.
- Continue being patient. Use praise.
- Keep smiling!

Late Stage

Challenges for ADRD Residents

- Speech diminished to about 1 to 6 words a day
- Words spoken may make no sense, or may just be sounds
- Rather than responding to you, the resident may try to repeat what you say
- Very little ability to communicate verbally or non-verbally

How you can help

- Keep talking to the resident, even if he seems unresponsive. It is not clear how much is heard and sensed by people in advanced stage ADRD.
- Say the resident's name often.
- Continue to comfort with therapeutic touch.
- Always use good manners. Say "Good morning." "Thank you." "Good-bye." Residents may hear and be comforted by your voice, even if they do not respond to you.
- Be kind.

Intervention Communication Skills Review

- Approach residents slowly, from the front.
- Speak slowly and clearly in a calm voice.
- Use names – yours and the resident's.
- Use touch to reassure and comfort, not to restrain residents.
- Make direct statements, using familiar – not fancy – language.
- Give the person a moment to hear you and respond.
- Break down tasks into step-by-step requests.
- Repeat request if needed, using the same words.
- Speak on an adult-to-adult level.
- Stay calm and be patient.

Coping with Resistant Behavior

If a resident is mildly resisting your suggestion to eat, drink, or get ready for bed, try gentle coaxing, then try a different approach to gain cooperation. Next, consider asking a different staff person to try. If resistance
grows stronger, redirect the person to an activity she prefers and suggest the resisted activity again later on. It is not a job requirement to force a resident to do something she is not willing to do. It is required that you try options available to you.

If an unexpected catastrophic reaction occurs (an extreme outburst of emotion, anger, or agitation in response to a request or situation), know that the person is overwhelmed. Take immediate action to restore calm; redirect and ask for help from other staff if needed, and then put the activity aside until a later time.

**Restraints and Alternatives**

Restraints can be physical or chemical. The purpose of using any type of restraint is to keep residents safe. However, studies have shown that restraints sometimes create more problems than they correct. The use of restraints is associated with an increased risk of falls, injury, behavioral problems, agitation, and even death in residents. Some communities have successfully implemented a restraint-free policy. The care team needs to address the use of restraints on a case-by-case basis. Family members, and the resident whenever possible, should be part of that discussion with the care team.

**Use of Restraints under OBRA**

The purpose of OBRA, (Omnibus Budget Reconciliation Act) is to provide federal legislation governing a variety of services provided to developmentally disabled adults living in nursing homes. The objective is to provide guidelines to help caregivers improve residents’ quality of life.

**Physical restraints as defined by OBRA**

“Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident’s body that the individual cannot remove easily [and] which restricts freedom of movement or normal access to one’s body. -- (OBRA definition, tag numbers F221 and F222)

Examples of physical restraints include: leg restraints, arm restraints, hand mitts, soft ties, vests, side rails, lap buddies, Geri-chairs, and Merry walkers.

**Chemical restraints as defined by OBRA**

“A psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms.” (OBRA definition, tag numbers F221 and F222)

Drugs prescribed to control mood, mental status, or behavior are chemical restraints.

The use of restraints is typically limited to situations that may be dangerous without them. If the use of restraints is warranted, monitor the restrained resident for increased risk of accidents, decline in functioning, incontinence, loss of muscle tone, increased agitation, symptoms of withdrawal or depression, reduced social contact, or decreased appetite. Use the least restrictive restraint for the shortest timeframe possible.

The facility’s policy on the use of restraints should be fully discussed with residents and family members. More and more facilities are training staff about safe alternatives to using restraints.

**Restraint Alternatives for Residents who Wander**

- Accompany resident outside and walk with him at his chosen pace. Enhance the walk together with therapeutic conversation.
• Assign a staff member to be responsible for a resident who wanders. Each “watch” can last a short time period, depending upon available staffing. Staff members are encouraged to learn the resident’s patterns of movement so they are prepared and able to remain calm and supportive.
• Alert all staff to be aware of individuals who tend to wander.
• Provide a secure, enclosed outside walkway, with shaded benches for rest stops. Keep these walkways clear of obstacles, hoses, water or anything that could cause a fall.
• Wandering is often precipitated by a desire to find a loved one. Provide opportunities for residents to listen to tapes or watch videos of the people they are trying to find. When appropriate, allow them to telephone loved ones.
• Try increasing stimulating activities with residents who wander. Music, singing, conversation, reading aloud and discussion sessions may help channel the energy used to wander. The better you know your residents, the better able you are to create programs they will enjoy. They don’t need something different every day. People who have ADRD often enjoy repeating the same activities, and a set daily routine is comforting.
• Offer opportunities for exercise. Moving to music provides additional stimulation, which residents who wander may need.
• Develop activity programs that match the residents’ interests and attention spans.
• Check “agenda behaviors” to be sure the person who is wandering is not seeking the toilet or trying to find his bed to have a rest.

Learning Activity:

Think about a resident in your department who wanders, or a family caregiver who has shared with you the struggle of keeping the wandering loved one safe. Please take 10 minutes now to learn more about Safe Return, a national program sponsored by The Alzheimer’s Association. Find information that applies to your area and jot it down to share with anyone who needs it. http://www.alz.org/Services/SafeReturn.asp

Restraint Alternatives for Residents who Pace

Pacing differs slightly from wandering. Some residents may pace in a path around a table or around a group of people. People who pace are not necessarily trying to find someone or something. For some, the need to pace is related to changes in the brain. For others, confusion, agitation or boredom may be triggers for pacing. If the cause is modifiable, try to change the stimulus causing the pacing behavior. Factors that may motivate a person to pace include:

- Reactions to environmental changes
- Emotional response to a stimulus
- Boredom
- Need for exercise
- Constipation
- Pain or discomfort
- Too many daytime naps
- Need for toileting
- Hunger or thirst
- Biochemical changes in the brain

Keeping Residents Who Pace Safe

- Check residents’ shoes for appropriate support and non-slip soles. Residents who pace will need to have their shoes checked more frequently.
- Examine the resident’s feet, toes and legs. Note any swelling, blisters or other problems. Notify the nurse of problems that may need treatment or examination by a doctor.
- Set up a secure area that is clear of obstacles, where a person can pace without danger of tripping, falling or getting lost, similar to an area designed to maintain safety for wanderers. One difference in a person who paces may be their choice to pace in a path repeatedly around a smaller area. (A table or chair, for example). Even so, offering to take a walk outside with a resident who paces can be helpful.
- Suggest frequent rest periods on benches or chairs along outside walkways.
Provide treatment for blisters, muscle soreness and nail care.
Offer frequent snacks and fluids. Like other forms of exercise, pacing burns calories.

**Restraint Alternatives for Agitated Residents**

- Stay calm when approaching an agitated resident.
- Lead the agitated person to a "time out" area that is quiet and removed from other residents and stimuli.
- Increase communication with the person. Broach a subject you know the person enjoys talking about (grandchildren, hobbies, hometown)
- Acknowledge and validate their concerns. Avoid reasoning, correcting or explaining anything. For example, say, “Your mother sounds like she was a wonderful person. What was she like?” Do NOT say, “No, you cannot talk to your mother. You know she’s dead.”
- Reminisce with residents. Take an interest in their stories from the past. If you are aware that events are not told in proper sequence, refrain from correcting the person. This will increase, rather than reduce, their agitation. Just go with the flow and enjoy the ride.
- Redirecting the person to an enjoyable activity is also an option that is preferred over using restraints.
- Offer opportunities for residents to listen to relaxation tapes with nature sounds, soothing music, prayers and guided meditations.

**Topic Summary:** Problem behavior in people with ADRD may stem from a variety of causes including medical / physical ailments, emotional distress, environmental triggers, and psychosocial anxiety. Problem behavior can include aggression, agitation, and hallucinations. Tips for soothing the nerves of people with ADRD include reducing noise, smiling, and speaking in a comforting tone. It is recommended that healthcare workers keep a problem behavior log to help track behavior patterns. A four step plan for dealing with problem behavior is described.
**Topic 4: Applying the Principles of Independence & Dignity**

**Topic Introduction:** When working with ADRD patients it is deceptively easy to begin focusing on the problems their illness causes and forget that each person is more than a series of symptoms. Even people whose cognitive ability has been diminished need a sense of control over their own lives, as well as a feeling of being respected by others. Learn to honor the person's values and individuality while assisting with ADLs. At the conclusion of this topic you will be able to employ general strategies for promoting independence in the beginning, middle, and late stages of ADRD.

**Philosophy of Care**

A philosophy of care statement is akin to a healthcare mission statement insofar as it states the ideas and principles that support and direct the practices of a healthcare organization.

Every organization involved in the care of ADRD patients should have their own philosophy of care statement. Below is a list of principles that could be included in the philosophy of care statement for an organization that serves ADRD patients:

1. The staff will strive at all times to preserve and support the well-being and dignity of ADRD residents.
2. The staff will strive to meet the special emotional, psychological, and physical needs of the ADRD residents.
3. The staff will always keep in mind that those who suffer from dementia tend to feel isolated. Consequently, staff will strive to make ADRD residents feel a sense of belonging to our community.
4. The staff will recognize and address the special needs of the families of ADRD residents.
5. The staff will seek opportunities to enlarge their understanding of ADRD residents through continuing education and training.
6. The staff will take whatever opportunities become available to educate the public about adult dementia and enlarge public understanding about the needs of the ADRD community.
7. In order to access the shared knowledge and experience of other organizations that participate in the care of ADRD residents, staff will participate in professional organizations dedicated to the dissemination of knowledge about adult dementia.
8. To best serve the interests of our residents, there shall be weekly staff meetings to facilitate communication and an exchange of ideas so that we can provide the best care possible.

**Modifying Daily Activities**

Each resident must receive a baseline assessment to determine which stage of ADRD he is currently experiencing and what type of assistance is needed to achieve activities of daily living (ADLs). Because every individual’s progression through the stages of dementia is unique, it helps to refer to each resident's history. Knowing the person’s habits, preferences, and behavioral issues can help you better connect with a resident or redirect one who is upset. This understanding of the person’s history can be especially helpful when modifying activities of daily living. A familiarity with language and references to childhood friends, events and places can be a key to interpreting a resident’s behaviors and speech.

Use this history to help you design a care plan that is based on the resident’s remaining abilities and areas of need. Respect established patterns of waking, sleeping, bathing, and eating as much as possible within the framework of the community's policies and schedules. If a resident prefers a morning bath, and it does not disrupt the schedule to accommodate that choice, honor that preference. Avoid situations, foods, and activities the resident dislikes. For example, if a resident says she likes apple juice but dislikes orange juice, honor that preference. Don’t insist that she try the orange juice.

Modifying daily activities is based on the delicate balance between residents’ need for assistance and their need for independence. Again, knowing each resident helps you judge how much assistance to provide without “taking over” the task. It is important to allow as much independence as is safe. As the person’s
symptoms progress, she will need increasingly more assistance with bathing, toileting, grooming, dressing, and eating. There may be a great deal of variance among individuals, but there are some general guidelines regarding appropriate assistance with ADLs in the early, middle and advanced stages of ADRD.

**ADL Assistance in Stages of ADRD**

**The Early Stage** of ADRD is the beginning of the loss of functional brain cells. Residents in this stage exhibit memory loss and confusion that can impair their ability to recognize friends and loved ones, keep appointments and learn new things. Disoriented to time and place, they forget where they are, what they are doing, and what comes next. It is difficult for the person to perform tasks in a sequence. In the early stage, residents require prompting, reminding and monitoring.

For residents in early stage, caregivers should:

- Talk about a single topic at a time
- Name people and objects specifically, not with pronouns or general terms
- Use language that is familiar to the resident
- Broach important topics when the resident is rested and calm

**The Middle Stage** marks advances in damaged brain cells and the resulting confusion and frustration. It is harder for the resident to carry out routine chores and activities, such as choosing apparel suitable for the weather and putting on clothes in the proper order. In the middle stages of ADRD, residents require supervision and, at times, direct assistance.

For residents in middle stage, caregivers should:

- Keep choices simple: “Juice or water?” not “What do you want to drink?”
- Give simple directions
- Redirect problem behavior with a positive option
- Repeat often

**The Advanced Stage** is known for a significant loss in control of body functions, coordination and verbal communication. Swallowing problems often occur in this stage, and the person is typically bedridden. In the advanced stages of ADRD the resident requires full hands-on, direct assistance with all ADLs: eating, fluid intake, bathing, grooming, and voiding.

For residents in late stage, caregivers should:

- Continue verbal (“Hello, Mr. Green”) and non-verbal communications (therapeutic touch) even though the resident’s ability to respond is limited.
- Use the resident’s name. Studies show that residents recognize the sound of their own names late into the disease process.
- Be courteous and observe social conventions. (“Good morning,” “Thank you,” “Good-bye”)
- Watch for non-verbal cues for a need or emotion the resident may be trying to express.
- Honor the person’s values and individuality.

**The Final Stage:** Residents may lose the cough reflex, or the reflex controlling blood pressure and heart rate. Losing the cough reflex can lead to pneumonia, a common direct cause of death in residents suffering with ADRD. In the final stage, residents require total care.

**Communication Skills Review for Modifying Daily Tasks**

- Rather than saying “It’s time to get dressed,” Break the task into small, concrete steps: “Sit here. Put on your socks. Put on these pants. Put on this shirt, etc.”
• Pause between each request to allow time for the information to be understood.
• Repeat instructions using the same language. Remember that it may take several repetitions before the resident can respond.
• Monitor and document declining abilities. Slower responses and increasing resistance or frustration may indicate that the task is too difficult. Documenting these behavioral changes will help all caregivers know to break the task into smaller steps or begin doing some of the steps for the person.
• Praise efforts and help the resident feel successful, not helpless.

**Dressed for Success: Personal Care Strategies**

**Dressing**

• Adjust room temperature and lighting to comfortable levels.
• Ensure the resident’s privacy by closing door and curtains.
• Lay out items of clothing on the bed, placing them in order of use.
• Encourage the resident to select clothing, but simplify the choices. (”Do you want to wear this red shirt or this blue shirt?”)
• Ask the family to bring simple clothing, pull-on pants with elastic waist, sweat suits and shoes with Velcro fasteners.
• Group outfits together on hangers.
• Label dresser drawers.
• Avoid arguing over a change of clothes or about what “goes together.”
• If a resident chooses to wear the same clothes every day, ask the family to buy duplicate sets of the outfit. This way the person can wear what she wants and be dressed in clean clothes.
• Stash rarely worn or out-of-season clothing so it is easier to reach the clothes the person wants to wear on a daily basis.

**Bathing**

• Determine the best time of day and type of bathing, based on the resident’s preference. Be consistent with that schedule and regimen.
• Make sure the bathroom is warm enough and has appropriate lighting.
• Close doors and curtains for privacy.
• Be prepared with bath supplies ahead of time.
• Approach the resident with a calm, quiet, positive tone of voice.
• Do not discuss the need for a bath.
• Support your verbal directions with visual cues.
• Let the resident feel the water before getting wet.
• Keep reassuring the resident with soothing vocal tones.
• Drape a towel over the person’s shoulders to offer privacy. Some residents may be embarrassed about being undressed or needing help with bathing.
• Give the resident a toy or something to hold to redirect his attention during the bath.
• Allow the resident to do as much of the bathing as possible.
• Check the person’s skin for any sign of sores or a rash.
• Towel-dry the resident thoroughly.
• Check the person’s fingernails and toenails. Report any problems that may need medical attention.
• If a person resists a bath, do not argue. Try again a few minutes later.

**Eating**

• Keep it simple at mealtime. Eliminate unnecessary items from the table.
• Plates with colors that contrast with the placemats or tablecloth are easier for the resident to see and use.
• Reduce noise and distractions at meal times.
• Serve meals at a set time and stay on schedule whenever possible.
• A quiet, relaxed atmosphere is best at mealtimes.
• Ask if the person is comfortable and try to resolve any discomfort.
• Remind the resident to eat if she gets distracted, with verbal and nonverbal cues.
• Focus on the person who is eating, but do not rush her or intimidate her.
• Consider the resident’s historical eating habits.
• Make sure the food is not too hot or cold before serving.
• Eliminate unpleasant odors, like cleaning products, from the area when serving a meal.
• Praise the person for eating.
• Extend multiple opportunities to eat. Residents with ADRD tend to prefer small snacks to full meals. By presenting a variety of nutritious snacks every few hours, the resident’s desire to eat less is satisfied without sacrificing the nutrition her body still needs.

**Learning Activity:**

Think about a resident in your department who is rarely interested in eating more than one or two bites of food at a time. Jot down at least three new options you can try to encourage this resident to improve his or her eating habits. Share your ideas with a co-worker.

**Grooming**

• Encourage easy care hairstyles.
• It can be extremely upsetting to some residents to have water poured over their heads and faces. Hair shampooing may need to be separated from the bath for these residents.
• Use a beauty/barber shop for residents whenever possible, especially if this has been a part of their regular routine. Sometimes having a shampoo in a stylist’s chair at a beauty salon is much more comfortable for the resident.
• If the resident enjoys wearing makeup and wants to apply it, allow it, with supervision.
• Let residents continue to shave as long as possible, with supervision.
• Provide electric razors for safe, simple shaving.
• Encourage residents who can to maintain healthy nail care by trimming their fingernails and toenails. If they need assistance, provide it. Advise the nurse if you notice any problems that may need medical attention.
• Residents who need to have their nails cleaned and trimmed for them may be more relaxed and cooperative if it is done while they are watching TV or listening to music.
• Document the need for a podiatrist to address any foot problems, including thickened toenails that are very difficult to trim.
• Help residents brush their teeth twice a day and check for ill-fitting dentures, thrush, broken teeth or sores. Mouth and denture problems can cause pain and affect eating habits.
• Use adaptive devices as needed to assist with oral hygiene.
• When tooth brushing is very difficult, consider Peridex® mouthwash if the resident is able rinse and spit.

**Toileting**

• Causes of incontinence include: inability to remove clothing in time, inability to feel or recognize the need to toilet, dehydration, constipation, medications, stress or urge incontinence, disoriented and unable to find the bathroom, and the perception of a lack of privacy.
• Know the resident’s non-verbal toileting cues, like pulling at clothes. Quickly respond by taking the individual to the bathroom.
• Maintain adequate lighting in the bathroom. Make it easy for the resident to distinguish the toilet from other bathroom fixtures.
• Learn techniques to help residents who have trouble urinating. (For some, it helps to let warm water from the sink’s faucet run gently over their hand while they are seated on the toilet.)
• Try to help an anxious resident relax and calm down before toileting.
• Implement a schedule for toileting before and after meals.
• Reassure residents who have had an accident. Help her get her clothes changed quickly and quietly, maintaining respect, privacy and dignity.
• Use protective garments on residents who have incontinence problems. Dress the resident in loose clothing that conceals the protective garments.
• Clean skin thoroughly after toileting or an accident. Use protective ointments when needed to soothe irritated skin.
• Remind or assist the resident with maintaining healthy skin care.

Strategies for handling nighttime incontinence:

• Use protective pads as needed.
• If the resident’s intake of fluid is adequate, try decreasing fluids near bedtime.
• Just before bedtime, encourage residents to use the toilet, and check to be sure that they actually urinate before leaving the toilet.

Topic Summary: Healthcare workers who assist people with ADRD must be mindful of the stage of the disease their resident is in so as to offer the correct type and level of assistance. Since every person is unique, it is important to review the resident’s personal history. Balance the resident’s need for assistance with their need for independence.
**Topic 5: Developing strategies and skills for working with families and caregivers**

**Topic Introduction:** “No man is an island,” observed the poet John Dunne. In other words, each individual exists in a web of relationships with others. The successful healthcare provider understands that in order to work successfully with a patient, one must also work successfully with the patient’s family. This dynamic becomes more complicated when working with ADRD patients who may no longer be able to recognize and respond to their friends and family. This inability to connect creates a sense of isolation for both the patient and the family. Thus, it is crucial for clinicians working with ADRD patients to identify issues and concerns of family members and patients during the early, middle, and late stages. This topic will help you accomplish that.

**Family Support Groups**

Family members need an opportunity to express their feelings and connect with others who share those feelings. It is important to find a support group that is specific to families of residents with ADRD. If support group meetings are not yet offered in your facility, consider coordinating monthly meetings that are led by a care team social worker, counselor or the facility’s director of social services.

Designate a lead person as a contact for questions regarding the family support group. Invite a member of the clergy to attend family council meetings as well. This connection can help families cope with the grieving process, which begins prior to the actual death of the person with ADRD.

Additional support for family members includes:

- Educational programs focused on the stages of ADRD.
- Handouts showing what to expect as the disease progresses.
- Telephone support among other families.
- Grief sessions facilitated by a licensed psychotherapist and clergy member.
- Emphasizing importance of attending care plan meetings.

**Costs of Care: Time, Dollars, Feelings**

The national Alzheimer’s Association conducted a survey documenting that the average caregiver living with a relative who has ADRD spends about 100 hours per week providing care. Among caregivers employed outside the home, an average of 40 hours weekly is dedicated to providing care. Half of the caregivers surveyed reported feeling like they did not have enough self-care time. Other costs to spouses include the psychological loss of an intimate relationship and companion, and the burden of taking on duties the spouse once handled.

Adult children trying to care for a parent with ADRD note their discomfort with role reversals, as their mother or father gradually became more like their child. Research findings show that caregivers are at great risk of becoming ill and suffering emotional distress. Depression and fatigue also were cited as byproducts of long-term caregiving. The financial burden is enormous due to the duration of the illness.

**Family Members: Part of the Care Team**

A sense of unity among residents, staff and family caregivers will contribute to meaningful and individualized care. Families bring vital historical information about the resident to the staff’s attention. These factors will help you build a better care plan, including stimulating activities and food preferences. When interacting with family members, you are on the same team with the same goal of providing optimal care to their loved one. Include the family in care team decisions and seek their advice, ideas and assistance.
Let family members know how important their visits are to the resident. Remind them that some days the person with ADRD will recognize them and some days they will not. Either way, the visit is important and meaningful. Connecting with another person always has great value.

**Tips for Visiting Family Members**

Here are some tips you can give family members about what to do when they come to visit their loved one who is now in your care.

- Try to plan the visit at the resident’s best time of day, if possible considering their work schedules and other family obligations.
- Encourage family members to share some kind of activity, such as something uplifting to read or photo albums to look at together, but be prepared to drop the idea if it doesn’t work out that day. Try again during another visit.
- Share with family members your communication skills, especially establishing eye contact, speaking in a calm, soothing tone of voice and using names to help the person remember and recognize visitors.
- Mention the need to respect the person’s personal space. Their desire to be hugged may vary from day to day.
- Emphasize the wisdom of responding to feelings and not behaviors, accepting the person’s confusion without arguing or “setting him straight.”
- Remind the family not to take personally anything unkind, untrue or puzzling the person may say, as that is part of the disease process.

**Helpful Strategies for Healthcare Workers Collaborating with Family**

- Know that, initially, it may seem like you actually have to care for both the resident and the family members who have been his caregivers up to now.
- Keep lines of communication open with family members so there are no surprises.
- Listen and absorb feelings expressed by family members. Help them feel safe sharing their concerns with you.
- Educate family members about the process of ADRD and the aspects of the resident's behavior that are part of that disease process.
- Encourage family caregivers; let them know that both staff and the resident greatly value their presence.
- Point out the strengths in people with ADRD, even in the end stages of the disease. Help family members see positive traits.
- Converse with family members who visit about their other interests, besides the illness and the resident.
- Advise family members about the importance of non-verbal communications, like comforting touch, handholding, eye contact, and non-threatening posture and soothing vocal sounds to express acceptance and love to people with ADRD.
- Remind family members to take time for their own needs, interests and health.

**Keep the Family Involved**

Family members begin to feel at a loss when visiting with a relative who has advanced memory impairment. The following suggestions may help.

- Reminisce with the resident, sharing stories and photo albums.
- Go outside for a walk, or sit on a bench, enjoying the wind and trees.
- Listen to music together.
- Bring in a favorite food or order a meal to share from the facility.
- Help the person decorate by posting seasonal décor around the room.
- Rub lotion over the person’s back, legs, feet or hands.
- Therapeutic touch shows love – holding hands, hugs, pats on the back.
• Frequent brief visits may be better than fewer extended visits.
• If other residents interfere with visitation, rely on staff to intervene.
• Respond to the underlying emotional message in the resident’s pleas to go home. Offer reassurance and do not argue about going home.

**Learning Activity:**

Consider a resident in your department with a family member who is visiting less frequently and seems at a loss for how to interact with their loved one. Think of a tip you could give that family member. Jot it down and share the information with a co-worker.

**Grief, Bereavement, and Mourning**

The effects of dementia extend outward from the afflicted to their friends and family. Alzheimer’s can seem like a “death in life” because its victims lose the sense of self built over a lifetime. The memory loss that often accompanies dementia can create a chasm between the victims of the disease and their loved ones. Consequently, family and friends can experience emotions that are normally only felt after a loved one has died.

Grief, mourning, and bereavement are terms that cannot be used interchangeably. Yet, each term describes a vital component of preparing for and coping with serious illness and eventually death on an emotional, physical and spiritual level. To confuse them is to cheat ourselves and deny the importance of what we feel and do.

**Grief** is the physical, emotional, intellectual and spiritual reaction to loss. The nature of the loss is not the determining factor in the extent of grief. Instead, it is the intensity or depth touched in our being by the loss. It will manifest itself in many ways such as tightness in the chest, numbness, anxiety, insomnia, loss of appetite, isolation from others, or a search for the meaning of life and death. It will appear and stay for days, months, or even years. The signs of grief and its impact on professional caregivers will be examined further in a later section.

**Bereavement** refers to the state of suffering loss. Three elements comprise bereavement as defined by Charles A. Corr, Clyde M Nabe and Donna M. Corr. These are:

1. A relationship with some person or thing that is valued;
2. The loss – ending, termination, separation – of that relationship;
3. A survivor deprived of the valued person or thing by the loss

Everyone who suffers loss may be considered bereaved, but the intensity of the former relationship shapes the intensity of the bereavement.

**Mourning** refers to the ways and means by which we cope with death or loss. It includes the use of counseling and support groups for emotional stability, as well as the use of rituals and rites such as burial traditions, the use of sacraments or other ways in which public support is sought by the bereaved. Mourning rites may be as basic as sorting through the deceased individual’s clothing or possessions, or as complicated as prayers and ceremonies lasting 100 days.

**Share Support Resources with Family Members**

In addition to family support groups, family members should contact The Alzheimer’s Association and Area Agency on Aging for more information and support. On-line support groups exist for family members who cannot attend meetings. (See references.)
Stress Management for Professional Caregivers

Helping individuals who suffer with ADRD can be a rewarding and deeply satisfying profession. But when caregivers neglect self-care, they are vulnerable to a specific type of stress called “compassion fatigue.” Today, resources are stretched to the limit. Care providers face mounting case loads, and compassion fatigue has becomes a real problem requiring real solutions.

Causes of Compassion Fatigue

Compassion fatigue is a wearing away of energy, a unique type of exhaustion associated with excessive demands that can be self-imposed or externally motivated. This condition drains energy, coping mechanisms, and all internal resources. Eventually, compassion fatigue depletes a professional caregiver's motivation, attitude, perspective and behavior. The impact is often documented as an inability to deliver quality patient care.

Self-care is an essential ingredient to providing optimal care for others. Due to the long-term nature of ADRD and the prolonged journey to a known incurable outcome, caregivers who feel a need to change and improve outcomes are particularly frustrated by working in this field of healthcare.

Symptoms of Stress

Working with residents who have lost memory and communication skills is challenging. Residents may be aware of the caregiver's feelings though they do not understand everything the caregiver is saying or doing. Over a prolonged period, exposure to the stresses of caring for ADRD residents can lead to physical, emotional and behavioral symptoms that have an adverse impact on the caregiver's ability to provide quality care. The first step to managing stress is recognizing the symptoms.

Physical symptoms may present as exhaustion, fatigue, sleeplessness, gastrointestinal disturbances, headaches, weight loss or gain, and feeling physically run down. Global signs of physical stress include increased rate of breathing, blood pressure, muscle tension, and nervous system activity.

Emotional symptoms include a negative self-image, feeling powerless and hopeless, and feeling a loss of interest in job activities.

Behavioral symptoms manifest as altered work patterns, (absenteeism and arriving late), staff conflict (initiating gossip, rivalry, or power struggles), and negative attitudes (hostility, aggression, or scapegoating)

Stress Busters

- Physical exercise – a walk, bike ride, or aerobics class
- Relaxation techniques like deep breathing and meditation
- Spiritual activities, such as prayer or spiritual readings
- Laughter and humor
- Support groups
- Professional counseling
- Behavior management
- Problem-solving techniques
- Environmental and staffing adaptations
- Supervised staff development and training
- Ask for a few days off to recharge
Overwhelmed or balanced?

To maintain your highest and best emotional, physical and mental health, you need to maintain balance in all aspects of your life, including your work. When you consider all the demands for your time and energy, you may feel overwhelmed. It is important to bring that feeling into balance so that you feel enriched, not consumed, by the variety in your life.

Why Do You Feel Overwhelmed?

- Demanding job requirements
- Not enough quality time with children
- Chest pains associated with “To Do” list
- Feeling behind, never able to catch up
- Victim of “sandwich” generation, squished between children, parents and job
- Lose ability to manage work, home life, and keep up with world events

Finding Balance

In what areas do you feel overwhelmed? How can you release that stress so that it is not projected onto other people and situations, particularly at work?

To keep balanced and healthy, both emotionally and physically, consider the following recommendations:

- Stay involved and active with the care team. Offer suggestions. Try new ideas.
- Deal with your feelings by talking to someone you trust, a clergy member at your church, a counselor or support group. Ask a supervisor at work for guidance to such a person if you do not have a support system in place.
- Relax. Take a deep breath. Give yourself credit for doing the best you can and just focus on one day at a time.
- Maintain healthy habits: Exercise consistently, eat a nutritious diet, get enough sleep. Limit or eliminate caffeine, as it can disrupt your sleep. Remember that alcohol is a depressant.
- Laughter is the best medicine, so keep a sense of humor. Take a break. Be flexible and don’t take yourself too seriously.

Topic Summary: It is important to remember that the families of residents with ADRD are a part of the care team. Assist them by connecting them with support groups for people with family members suffering from ADRD. Also, remember the special strain that family members labor under. Make certain that they feel welcome as active members of the care team.
Topic 6: Key Features of Activities for Memory-Impaired Residents

**Topic Introduction:** When organizing activities for memory-impaired residents, you should try to include as many opportunities for interaction and stimulus as possible. You can provide these opportunities for your residents by making sure you incorporate specific features into each activity. At the end of this topic section you will be able to describe key features required to make activities for memory-impaired residents successful.

**Normalization**

Normalization refers to activities that make the resident feel that they are participating in the normal routines of daily living. This includes such common household chores such as food preparation, dusting, raking, washing tables, stacking, sorting items, gardening, folding clothing, etc.

In addition to participating in household chores, normalization can also be achieved through self-care activities, such as bathing, dressing, and grooming. The benefits of Self-Care activities include:

- Adding purpose to the resident’s daily routine
- Improving the resident’s overall quality of life
- Offering the resident an opportunity for pleasure
- Providing comfort and a good feeling
- Improving self-image and self-esteem

**NOTE:** Some residents may have difficulty accomplishing these tasks and may need assistance.

**Social Interaction**

Social interaction refers to activities that provide residents with the opportunity to socialize with other residents and staff members. The interaction can be provided through one-on-one and small group programs. Specific activities that offer social interaction include parties, music, or a sing-along.

**Spiritual Awareness**

Adding spiritual awareness aspects to activities provide opportunities for residents to enhance their own personal spiritual and religious background. Specific ideas that you can provide for your residents may include: inviting a minister to visit with your residents, singing hymns, or reading the Bible.

**Cognition**

Cognition-related tasks provide opportunities for residents to apply their intellectual abilities. Examples of activities that require cognition include: word games, poetry reading, art appreciation, familiar music, etc.

**Physicality**

Physicality aspects require the resident to move his or her body and limbs. These types of movement are commonly referred to as gross motor activities.

**Goal Orientation**

Goal orientation provides meaning to activities by assigning them a specific purpose. By accomplishing the goal, residents are instilled with feelings of pleasure and self-gratification.
Sensory Awareness

Sensory considerations for activities should address all five senses (sight, hearing, smell, taste, and touch). Specific items that appeal to the senses include: massage, hand washing, aromatherapy, listening to music, taste/cooking, touching various textures, etc.

Learning Activity:

Now it is your chance to participate in an activity. Try to brainstorm some ideas for items that you can include in your activity program that appeal to the residents’ five senses. For each sense, list as many items as you can in a two-minute time period. After you have finished, compare your list with the following list of suggested items.

Answers to Learning Activity:

Appeal to sense of smell:
- Essential oils
- Portable oven to bake cookies
- Popping pop popcorn
- Lotions
- Perfumes/cologne
- Fresh baked bread (bread maker)
- Herbs
- Pungent food (onion, garlic)
- Fragrant foods (cinnamon sticks, vanilla, coffee, peppermint)

Appeal to sense of taste:
- Special treats
- Freshly baked bread
- Fresh baked cookies
- Ethnic foods
- Items from cooking class
- Favorite treats
- Beverages
- Favorite foods/finger foods
- Sweet foods
- Salty foods (broth, pretzels)
- Sour foods (lemon, lime)
- Pungent foods (garlic,)

Appeal to sense of touch:
- Variety of materials, fabrics & textures
- Pillows
- Items to squeeze
- Different textures
- Sandpaper
- Cotton, soft blankets
- Dolls, stuffed animals
- Familiar items
- Massage
- Pet therapy
- Rubber items
- Plastic items
- Bubble wrap
- Wood blocks
- Brushes

Appeal to sense of hearing:
- Television
- Radio/CD Player with resident's choice of music
- Music videos
- Use of musical instruments
- Reminiscing discussions
- Environmental sounds
- Recorded familiar voices
- Singing
- Hymns
- Karaoke
- Hand bells
- Percussion instruments

Appeal to the sense of sight:
- Mobiles
- Memory books
- Decorated bulletin boards
- Window decorations
- Pictures of family members
- Familiar/personal objects
- Posters
- Artwork
- Afghan
- Pillows
- Nick knacks
- Fish tank
- Photos of famous people
- Nature videos
- Pictures of animals
- Pictures of children
- Music videos of appropriate music
- Flashlight
- Colored cards
- Slides & slide projector
- Colored shapes
- Paintings
Guidelines for Successful Activities

Below are some guidelines to follow when organizing activities:

- Provide uplifting music for active games to increase alertness and resident participation
- Offer activities that are compatible to the resident’s abilities and increase their confidence
- Provide activities that include rhythm: music, dancing, drama, etc.
- Provide immediate feedback: throwing, catching, etc.
- Directly engage the resident in group or independent activities
- Utilize volunteers to assist with activities
- Address the resident by his/her name of choice

Mini Quiz:

Review the list of activities below and decide which features (Physicality, Sensory, Cognition, Spiritual Awareness, Social Interaction, Normalization, or Goal Orientation) apply. Some of the activities indicated have one feature, and some may have several features. Some suggested answers are provided on the following page. This activity should take you approximately 10 minutes.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Feature(s)</th>
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<tbody>
<tr>
<td>Bring photographs of family and friends and create a photo album with pictures from the family</td>
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<tr>
<td>Bring a map and discuss traveling</td>
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<tr>
<td>Read the newspaper to the resident</td>
<td></td>
</tr>
<tr>
<td>Read religious/spiritual books to the resident</td>
<td></td>
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<tr>
<td>Wash their hands and face with a warm washcloth.</td>
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<tr>
<td>Provide books on tape to the resident</td>
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<tr>
<td>Do simple hand exercises with the resident</td>
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<tr>
<td>Have the resident do arm and leg exercises</td>
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<tr>
<td>Read the resident’s mail to him/her</td>
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<tr>
<td>Play jacks together</td>
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<tr>
<td>Put on make-up</td>
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<tr>
<td>Do arts &amp; crafts with the resident</td>
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<tr>
<td>File the resident's fingernails</td>
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<tr>
<td>Make cards together for other residents, family or friends</td>
<td></td>
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<tr>
<td>Listen to music or play “name that tune” with the resident</td>
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<tr>
<td>Sing hymns to the resident</td>
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<tr>
<td>Bake cookies with the resident</td>
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</tbody>
</table>
Answers to Mini Quiz:

Suggested Responses:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Feature(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bring photographs of family and friends and create a photo album with pictures from the family</td>
<td>Social Interaction</td>
</tr>
<tr>
<td>Bring a map and discuss traveling</td>
<td>Social Interaction, Cognition</td>
</tr>
<tr>
<td>Read the newspaper to the resident</td>
<td>Cognition</td>
</tr>
<tr>
<td>Read religious/spiritual books to the resident</td>
<td>Spiritual Awareness</td>
</tr>
<tr>
<td>Wash their hands and face with a warm washcloth.</td>
<td>Sensory</td>
</tr>
<tr>
<td>Provide books on tape to the resident</td>
<td>Cognition</td>
</tr>
<tr>
<td>Do simple hand exercises with the resident</td>
<td>Physicality</td>
</tr>
<tr>
<td>Have the resident do arm and leg exercises</td>
<td>Physicality</td>
</tr>
<tr>
<td>Read the resident's mail to him/her</td>
<td>Normalization, Cognition, Social Interaction</td>
</tr>
<tr>
<td>Play jacks together</td>
<td>Social Interaction</td>
</tr>
<tr>
<td>Put on make-up</td>
<td>Normalization</td>
</tr>
<tr>
<td>Do arts &amp; crafts with the resident</td>
<td>Goal Orientation, Social Interaction</td>
</tr>
<tr>
<td>File the resident's fingernails</td>
<td>Normalization, Sensory</td>
</tr>
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<td>Make cards together for other residents, family or friends</td>
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</tr>
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<td>Sensory, Social Interaction</td>
</tr>
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<td>Spiritual Awareness</td>
</tr>
<tr>
<td>Bake cookies with the resident</td>
<td>Sensory</td>
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</tbody>
</table>

Music Related Activities

Listening to and/or participating in the following musical opportunities can provide many benefits to residents including:

- Self-gratification
- Happiness
- Creativity
- Independence
- Sensory stimulation
- Reminiscing
- Socialization

When organizing musical activities for residents with memory impairment, it is essential to follow some important guidelines:

- Music should not be competing with other sounds such as: televisions, radios, people talking, gardeners, vacuum, machinery, etc.
- Familiar music should be used. Pick music from the resident’s young adult years, which can evoke memories and increase the resident’s level or participation. (Big band era, Bing Crosby, Mitch Miller, Glen Miller, Sammy Davis Jr., etc.)
- Avoid using the radio as a form of musical entertainment. There are too many news bulletins and commercial interruptions. News stories can be disturbing, depressing and sad to the resident, which can cause increased anxiety, agitation or behavior outbursts.
- Use appropriate music at the appropriate times. Invigorating/upbeat music should be used in the morning, when the resident’s energy levels are higher. Soft/easy listening music should be played during mealtimes. This can decrease agitation and anxiety and can increase the resident’s appetite. Using upbeat music during exercise can also increase the resident’s activity participation level.
- Use of sing-a-long videos can be implemented if the music is appropriate to the resident’s generation.
• Using culturally and ethically appropriate music is important. Residents from different ethnic backgrounds enjoy music that has a familiar sound.
• Using a Karaoke machine is a great way to increase the resident’s participation through singing of familiar songs with visual cuing.

Creating Seasonal Activities

Because it can be difficult to keep resident activities “fresh”, you may find it easier to introduce activities based on the time of year. Below are some suggested activities that you can provide for memory-impaired residents throughout the year.

<table>
<thead>
<tr>
<th>Month</th>
<th>PROGRAM THEME</th>
<th>PROGRAM DESCRIPTION</th>
</tr>
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</table>
| January| A Little Bit of Italy      | **Food:** Italian food like pasta, pizza, bread, salad with Italian dressing, non-alcoholic wine, plastic oval baskets on the tables with bread, cheese cubes with Italy flag picks, chocolate chip pastry for dessert  
**Decorations:** Italian music, pictures and posters of Italy (Travel Agent), candles in wine bottles as centerpieces, red gingham tablecloths, Italian placemats and napkins, grape clusters, flag/pennant garland, Viva Italy balloons, red gingham aprons for servers; hang a large flag of Italy  
**Activity:** Italian music CD or entertainer, discuss the history of Italy, invite a guest from Italy, show Italian film/travelogue |
| February| Mardi Gras                | **Food:** Southern dishes, king crab cakes, beverages  
**Decorations:** Mardi Gras decorations, beads, large masks to hang, small masks to decorate, green, gold and purple balloon clusters, Mardi Gras confetti, banners, fringed table skirt, door curtain, festive hats & crowns, gold coins, printed horns & blowers  
**Activity:** Have a parade with handmade “floats”, costume/mask contest, Mardi Gras music |
| March  | Safari Party             | **Food:** Participants choose meal & beverage  
**Decorations:** Safari hats & helmets, inflatable safari animals to display or hang, animal print balloons, jungle music, animal print tablecloths, safari centerpieces  
**Activity:** Jungle movie, safari games, hunt for items |
| April  | Baseball Opening Day     | **Food:** Hot dogs, popcorn in popcorn boxes, cotton candy, bags of roasted peanuts, apple pie & ice cream, soda  
**Decorations:** Participants can wear their favorite team’s hat/shirt, baseball decorations, team pennants, baseball banner, baseball balloons, “grand slam” mobiles to hang, baseball plates & napkins, baseball cards on the tables, real bats & balls  
**Activity:** Conduct a baseball pool, play the National Anthem, watch the opening game, do baseball trivia during commercials, have a sing-a-long during half time. After the game, show a movie: “Field of Dreams”, “A League of Their Own”, “Angels in the Outfield”, “Baseball Bloopers”, sports funniest videos, etc. |
<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
<th>Food</th>
<th>Decorations</th>
<th>Activity</th>
<th>Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>Fashion Show Presentation</td>
<td>Finger sandwiches, a variety of beverages (hot &amp; cold), fresh fruit and vegetable tray served on platters with doilies, decorated dessert trays</td>
<td>A red carpet to walk down, pastel colored balloons, create a stage area, flowers (to decorate pillars, walkways, stage, and tables)</td>
<td>Residents, staff and their children can participate; include a variety of fashions (old, new, pant outfits, suits, children’s, summer wear, long dresses, evening gowns, etc. Items can be donated, borrowed or purchased at thrift shops. Assign a host who will describe the model when they down the walkway</td>
<td>Microphone, music, pillars, printed program of the model and item being modeled</td>
</tr>
<tr>
<td>June</td>
<td>Let the Games Begin</td>
<td>Picnic lunches in USA celebration box (one box per resident available from M &amp; N catalog), sandwiches, chips, piece of fruit, cookies, beverage</td>
<td>Red, white and blue balloons, &amp; streamers, Liberty torch (to start off the games)</td>
<td>Participate in a variety of adaptive games: bowling, t-ball, Frisbee toss, horse shoes, wheelchair races, hoop shots, shot puck with rubber ball, score cards to use for tracking each resident</td>
<td>Equipment for the games, gold, silver and bronze medals for the winners, certificates of participation for all residents</td>
</tr>
<tr>
<td>July</td>
<td>The All American, Talent Show</td>
<td>Buffet style: cocktail hot dogs in sauce, deli meat and cheese platter, vegetable platter, patriotic desserts on plastic platter, chips/nuts in star shaped snack trays, fruit cubes with USA flag picks</td>
<td>Red, white and blue balloons, streamers, and top hats, patriotic vests, American flag, patriotic confetti, stars &amp; stripes banners, posters, dancing canes, star centerpieces, solid color tablecloths</td>
<td>Use All-American patriotic music; have the participants perform patriotic songs, marches, routines, and dance programs</td>
<td>Patriotic balloon canopy for the stage area, microphone, printed music, pre-recorded music, instruments, printed program with the participants names and performance</td>
</tr>
<tr>
<td>August</td>
<td>Summertime Party</td>
<td>BBQ chicken, hot dogs hamburgers, fruit salad, potato salad, chips, lemon aide, cookies, corn</td>
<td>Beach theme, sunglasses for all participants, large sun decorations, summertime banner, posters of beaches (travel agents), beach umbrellas, beach/sun hats, beach balls,</td>
<td>Beach related music; can show a movie (old beach movie), sing-a-long summertime melodies, summertime trivia</td>
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<tr>
<td>Month</td>
<td>Event</td>
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| September | 50's Party                   | **Food:** Serve food (hamburgers & French fries and milk shakes), in small cardboard Pink Cadillac boxes (Available from catalog companies)  
**Decorations:** Decorate with a lighted juke box, hanging plastic records, various types of musical notes, black & white checkered tablecloths and napkins, old cars, fuzzy dice, fabulous fifties poster, rock & roll garland, colored rock & roll balloons, soda centerpieces  
**Activity:** Hire an Elvis impersonator to sing; create a soda fountain manned by staff members; have a staff & resident dance contest with fuzzy dice key chains as prizes, 50's attire for the participants, invite staff and families, have a car club bring their classic cars to display in the parking lot at the facility |
| October   | Costume Party                | **Food:** Variety of finger foods, chips, cookies and punch  
**Decorations:** Haunted house door cover, spider webs, party canopy, bright colored balloons & streamers, large plastic skeleton, lights  
**Activity:** Residents & staff wear costumes, conduct a costume contest for: funniest, scariest, most original, cutest, most creative, traditional, and prettiest. Use black lights; play spooky music; apple-bobbing contest. Show a movie: “Adams Family”, “Dracula”, “Frankenstein” |
| November  | Facility Awards Ceremony     | **Food:** Candlelight sit-down dinner (residents’ choice), sparkling cider served in plastic champagne glasses  
**Decorations:** Decorate with silver and gold balloons & streamers, a red carpet walkway, make/order a gold & silver balloon arch for the stage, gold tablecloths, candle centerpieces, color accented place settings  
**Activity:** A few weeks prior to the event conduct an “election day” for categories: funniest, most energetic, most helpful, best sense of humor, best at trivia, best laugh, best artist, most active, most athletic, most knowledgeable, best dancer, most congenial  
**Supplies:** Microphone and host (administrator, volunteer, family member, staff member, mayor, etc), mini trophies for the winners, certificates of nomination, printed program |
| December  | Casino Night                 | **Food:** Cheese and fruit cubes served with poker card food picks, sparkling cider in plastic champagne glasses, finger sandwiches, and fancy finger desserts  
**Decorations:** Casino mural, casino banner, card cutouts, gold $$$ confetti, dealer shades, red & white striped vests, black bowties, black pants/skirts with white shirts, 11” casino decorated balloons  
**Activity:** Residents play casino style games: Roulette set, Black Jack layout, Craps layout, Poker layout, Bingo, (for fake money). Residents turn in their money for prizes (donated or purchased)  
**Supplies:** Colored poker chips, fake money, cash register, playing cards, card holder/shuffler, dice, concession caddy tray (walk around the room with drinks & snacks), donated prizes  
**Staff:** Department supervisors and staff members will act as dealers, waiters, cocktail hosts, pit boss (banker) |
#24-Hour Calendar for a Memory-Impaired Unit

Below is a sample 24-hour calendar for a memory-impaired unit. This sample calendar offers four separate groups at a given time, to help decrease unwanted behavior and limit “idle” time. In addition, this calendar includes all staff on the unit (activity staff and caregivers).

**NOTE:** For the time period between 11:00pm to 6:00am, provide a quiet activity for the residents who are wandering, can’t sleep or refuse to sleep. Examples include: listening to classical music or nature sounds, playing cards or dominoes, looking at memory books/albums, use reminiscing theme kits, folding clothes, hand massage, etc.

<table>
<thead>
<tr>
<th>TIME</th>
<th>HOMEMAKING</th>
<th>COMMUNITY</th>
<th>WORK</th>
<th>GENERAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00-7:30 am</td>
<td>Cleaning the room, setting the tables</td>
<td>Grooming</td>
<td>Read the paper</td>
<td>ADLS</td>
</tr>
<tr>
<td>7:30-8:30 am</td>
<td>Breakfast with music</td>
<td>Breakfast with music</td>
<td>Breakfast with music</td>
<td>Breakfast with music</td>
</tr>
<tr>
<td>8:30-9:00 am</td>
<td>Clean the tables</td>
<td>Nature walk</td>
<td>Walk</td>
<td>Walk</td>
</tr>
<tr>
<td>9:00-9:30 am</td>
<td>Walking</td>
<td>Exercise</td>
<td>Exercise</td>
<td>Exercise</td>
</tr>
<tr>
<td>9:30-10:00 am</td>
<td>Gardening</td>
<td>Discussion</td>
<td>Office work</td>
<td>Bowling</td>
</tr>
<tr>
<td>10:00-10:30 am</td>
<td>Reminiscing</td>
<td>Music</td>
<td>Work project</td>
<td>Music time</td>
</tr>
<tr>
<td>10:00-10:45 am</td>
<td>Juice and snack</td>
<td>Juice and snack</td>
<td>Juice and snack</td>
<td>Juice and snack</td>
</tr>
<tr>
<td>10:45-11:30 am</td>
<td>Folding laundry</td>
<td>Trivia</td>
<td>Stuff envelopes</td>
<td>Story time</td>
</tr>
<tr>
<td>11:30-12:00 pm</td>
<td>Set the tables</td>
<td>Arts &amp; crafts</td>
<td>Music</td>
<td>Trivia</td>
</tr>
<tr>
<td>12:00-1:00 pm</td>
<td>Lunch w/music</td>
<td>Lunch w/music</td>
<td>Lunch w/music</td>
<td>Lunch w/music</td>
</tr>
<tr>
<td>1:00-1:30 pm</td>
<td>Clean the tables</td>
<td>Sorting: cards</td>
<td>Wooden blocks</td>
<td>Sorting: chips</td>
</tr>
<tr>
<td>1:30-2:00 pm</td>
<td>Social activity</td>
<td>Reminiscing</td>
<td>Discussion</td>
<td>Reminiscing</td>
</tr>
<tr>
<td>2:00-2:30 pm</td>
<td>Personal needs</td>
<td>Personal needs</td>
<td>Personal needs</td>
<td>Personal needs</td>
</tr>
<tr>
<td>2:30-3:00 pm</td>
<td>Sing-a-long</td>
<td>Sing-a-long</td>
<td>Sing-a-long</td>
<td>Sing-a-long</td>
</tr>
<tr>
<td>3:00-3:30 pm</td>
<td>Refreshments</td>
<td>Refreshments</td>
<td>Refreshments</td>
<td>Refreshments</td>
</tr>
<tr>
<td>3:30-4:00 pm</td>
<td>Pet Therapy</td>
<td>Pet Therapy</td>
<td>Pet Therapy</td>
<td>Pet Therapy</td>
</tr>
<tr>
<td>4:00-4:30 pm</td>
<td>Patio games</td>
<td>Walk</td>
<td>Golfing</td>
<td>Shuffle board</td>
</tr>
<tr>
<td>4:30-5:00 pm</td>
<td>Set the table</td>
<td>Relaxation</td>
<td>Relaxation</td>
<td>Relaxation</td>
</tr>
<tr>
<td>5:00-6:00 pm</td>
<td>Dinner w/music</td>
<td>Dinner w/music</td>
<td>Dinner w/music</td>
<td>Dinner w/music</td>
</tr>
<tr>
<td>6:00-6:30 pm</td>
<td>Clean up</td>
<td>Leisure time</td>
<td>Sorting papers</td>
<td>Unit walk</td>
</tr>
<tr>
<td>6:30-7:00 pm</td>
<td>Personal needs</td>
<td>Personal needs</td>
<td>Personal needs</td>
<td>Personal needs</td>
</tr>
<tr>
<td>7:00-8:00 pm</td>
<td>Music/singing</td>
<td>Music/singing</td>
<td>Music/singing</td>
<td>Music/singing</td>
</tr>
<tr>
<td>8:00-9:00 pm</td>
<td>Reminiscing</td>
<td>Reminiscing</td>
<td>Reminiscing</td>
<td>Reminiscing</td>
</tr>
<tr>
<td>9:00-10:00 pm</td>
<td>Watching an old film or video</td>
<td>Watching an old film or video</td>
<td>Watching an old film or video</td>
<td>Watching an old film or video</td>
</tr>
<tr>
<td>10:00-11:00 pm</td>
<td>Evening snack</td>
<td>Evening snack</td>
<td>Evening snack</td>
<td>Evening snack</td>
</tr>
</tbody>
</table>
Points to Remember

Below are seven points to remember when providing activities to memory-impaired residents:

1. **Focus on the resident's abilities**: Do not underestimate the resident's abilities. Never focus on limitations. Focus on activities that will enhance their strengths.

2. **Adaptation of activities**: Activities should be similar to the activities a resident would engage in if they did not have memory impairment. Adapt tasks/programs from the resident’s past.

3. **Success**: Success is measured by how the individual responds to the activity, not by completion of the activity. Remember, it is not your perception of what is successful.

4. **Support positive behaviors**: Involving the residents in activities throughout the day is a way to reduce unwanted behaviors. If a resident has too much “idle” time, he or she can become depressed, agitated, bored, exhibit increased anxiety and wander more often. Involving them in purposeful activities will enhance their quality of life.

5. **Foster creativity**: Be creative when planning and implementing activities. Be imaginative, flexible, and not afraid to try alternative activities.

6. **Implementing activities**: Remember that activities occur throughout the facility/unit. Activities should be shorter than traditional activities, simpler, repetitive in nature. A routine and consistency is the better choice when implementing activities.

7. **Validation techniques**: Use Validation verses Reality orientation. Memory-impaired residents will not remember the reality-oriented information that was given to them, thus using validation is a more successful technique.

**Topic Summary**: Involving residents in activities throughout the day is a way to reduce unwanted behaviors and increase their quality of life. When deciding which activities to provide to memory-impaired residents, you should examine each activity in terms of the features they provide. Features that memory-impaired residents benefit the most from include: normalization, social interaction, spiritual awareness, cognition, physicality, goal orientation, and sensory awareness. Activities that address many of these factors will provide the best results for your residents.
**Topic 7: Reminiscing Activities with the Memory Impaired**

**Topic Introduction:** Reviewing the past is a universal process that occurs frequently in later life. People with memory loss often enjoy reminiscing about their life to anyone who will listen. When you have completed reading this topic, you will be able to list some “best practices” advice for organizing reminiscing activities with memory-impaired residents.

**Benefits of Reminiscing Activities**

Families sometimes have difficulty understanding how a relative affected with Alzheimer’s disease and related dementias cannot remember his own age or what his last meal was. This is due to the nature of memory loss. Loss of memory for recent events is usually profound. Individuals may have difficulty remembering a previous sentence or a television show. But long-term memory, that is memory of events in the distant past, may remain relatively intact.

Reminiscing can have profound value. By focusing on reminiscing and using suitable cues and prompts, you can enhance the individual’s feelings of self-worth. Talking about the person’s past interests can validate his contributions, and feelings.

**Reminiscing in Groups**

Group reminiscing discussions are used in many nursing homes, assisted-living facilities and adult day care centers. Groups provide residents with an opportunity to relive some of their past experiences. To evoke a resident’s memories during reminiscing discussions, use items such as old books, pictures, personal items, old diaries, music, poems, records, etc. A list of helpful items that can be utilized during reminiscing activities is displayed below:

- Jewelry can stir up memories because most people have a ring or necklace with special significance. Allow the resident to try on the jewelry and reminisce about the type of jewelry they used to wear.
- Pictures of families, vacations, and military service can spark memories.
- Pictures of movie stars, entertainers, and politicians from the “old” days can be a memory trigger.
- Old books are excellent reminiscing tools.
- History books with pictures can provide an evocative browsing source.
- Trigger items should stimulate the senses: various smells, photos, music, etc.

**Guidelines for Reminiscing with Residents**

Below are some guidelines that you should follow when conducting reminiscing activities with residents:

- Determine whether reminiscing is more appropriate as a group program or on a one-to-one basis.
- Always use a focus for the discussion.
- A memory prop will assist the residents with focusing.
- Always speak slowly. Allow the resident time to absorb questions or materials used to stimulate memory.
- Remember to focus on the resident and what he has to say. Let him be the teller and you the listener.
- Be willing to share your memories too. This is known as “paired reminiscing”.
- Remain sensitive to the resident’s changing abilities and response to the materials and activities being presented.
- Provide stimuli to promote silent reminiscing. Examples: wall posters, old photos, and old-time music. All of these are good sources of stimuli.
Reminiscing Questions

The following are some suggested questions that can be used when conducting a reminiscing program with memory-impaired residents. Questions should be stated in a manner that the resident easily understands. In other words, use “do” instead of “did” when appropriate. Remember, residents with memory impairment have limited or no short-term memory.

- Can you tell me about your parents?
- Where do/did you work?
- How many children do you have?
- What are your children’s names?
- Where do/did you live?
- How did you meet your husband/wife?
- What is your husband’s/wife’s name?
- How long have you been married?
- What did/does your husband do for a living?
- Do you have a favorite holiday?
- What do/did you cook for the holidays?
- Do you like animals?
- Tell me about your wedding day?
- Do/did you garden?
- Do/did you fix things in the house?
- What is/was your ranking in the military?
- What state were you born in?

Reminiscing “Theme Kits”

Activity and Program staff members can use a reminiscing theme kit to enhance a resident’s reminiscing during one-on-one interventions and small group programs. These “theme kits” stimulate the resident’s long-term memory by helping them reminisce on their past. Each kit focuses on a specific “theme” and includes items geared to enhance their memories.

Divisional Baskets for Memory Impairment Resident’s might include the following:

**Jewelry:** Collect various pieces of costume jewelry; necklaces, beads, clip on earrings, etc. Have a handheld and/or free standing mirror available for residents to use.

**Greeting Cards:** Use various greeting cards for residents to sort and look through.

**Sport Cards:** Use baseball, basketball, football, and hockey cards for residents to sort and group together

**Picture Cards:** A variety of pictures cut from magazine/calendars can be glued to 3X5 cards and sorted into different themes or categories.

**Beads:** Provide different colors and sizes of beads for sorting

**Silk/Plastic Flowers:** Use different varieties, colors, and sizes of silk/plastic flowers. Use some florist foam or Styrofoam and baskets to create flower arrangements.

**Nuts & Bolts:** Present a variety of plastic, large-sized nuts and bolts to sort and screw together

**Sensory Items:** Suggestions: fiber optic lights, lava lamp, pin sculpture, light brite game, scented lotions, scented sprays, scented bubbles, stuffed animals, sound machine/tapes, material samples, rug samples, sandpaper, foam items to squeeze, perfume, coffee grounds, vanilla, etc.
**Task Oriented Items:** Connect Four game, puzzles with large pieces, Lincoln Logs, wooden blocks, plastic pipes, latches & locks, yarn to roll, poker chips to sort, etc.

**Picture Books:** Create picture books from calendars, put in a plastic sleeve and then in a binder. Binders can be created for different themes.

**School Days:** Use props like a school lunch box, coloring book, crayons, ruler, markers, and handwriting books, textbooks, pencils, notebook paper, etc.

**Old Days:** Use lace dollies, silver dishes, flowers, and old pictures

**Tool Box:** Use a plastic or metal hand-carry toolbox and fill it with old and new tools (no sharp tools)

**Learning Activity:**

From the list below, chose five kits that you are interested in creating. Then spend approximately ten minutes trying to brainstorm some ideas for items you would include in those kits. After you have finished, compare your ideas with those provided after this activity.

- Famous People Kit
- Card Player Kit
- Baseball Kit
- Baby Kit
- Sewing Kit
- Music Kit
- Spiritual Kit

- Cleaning Kit
- Kitchen Kit
- Laundry Kit
- Reading Kit
- Farmer’s Kit
- Sorting Kit
- Office Kit

**Answers to Learning Activity:**

**Famous People Kit:** Items within this kit could include:
- Photos of movie stars
- Movie Ads (old & new)
- Ticket stubs

- Newspaper/magazine articles
- Movie Magazines

**Card Player Kit:** Items within this kit could include:
- Decks of cards
- Dice
- Poker chips

- Rules to games
- Books on card playing

**Baseball Kit:** Items within this kit could include:
- Baseball
- Batting glove
- Baseball Mitt
- A Base
- Baseball trading cards

- Miniature bat/full-size bat
- Pictures of different playing fields
- Baseball videos/movies
- Trophies
- Replicas of baseball figures

**Baby Kit:** Items within this kit could include:
- Baby doll
- Cloth diapers
- Bottle & bottle brush
- Pacifier, powder, lotion

- Baby blanket
- Variety of rattles
- Tape of lullaby music
- Pictures of babies
Sewing Kit: Items within this kit could include:
- Sewing box
- Tape measure
- Bobbins
- Plastic needles
- Fabric (various textures)
- Spools of thread
- Scissors (safety)

Music Kit: Items within this kit could include:
- Sheets of music
- Audio Tapes
- Instruments
- Radio
- Rhythm sticks
- 8-Tracks
- Old record player

Spiritual Kit: Items within this kit could include:
- Rosaries
- Hymn book
- Tapes of spiritual music
- Prayer books
- Bibles
- Pictures of sacred figures
- Inspirational verses

Cleaning Kit: Items within this kit could include:
- Broom
- Dust pan
- Feather duster
- Paper towels
- Apron
- Spray bottle
- Sponges

Kitchen Kit: Items within this kit could include:
- Placemats
- Rolling pin
- Plastic utensils
- Plastic utensil holder
- Cloth napkins
- Tablecloth
- Cookbooks (old & new)
- Cutting board
- Spices

Laundry Kit: Items within this kit could include:
- Laundry basket
- Socks
- Colored dish towels
- Empty bottle of soap
- Dryer sheets
- Empty bleach bottle
- Clothing
- Sheets

Reading Kit: Items within this kit could include:
- Poems
- Books (variety)
- Bookmarkers
- Library cards
- Reading glasses
- Book club catalogs
- Newspapers (old & new)

Farmer’s Kit: Items within this kit could include:
- Cow bell
- Farming magazines
- Farmer’s Almanac
- Model tractor
- Replicas of farm animals
- Pictures of farms
- Country Magazine
- Books on farming

Sorting Kit: Items within this kit could include:
- Playing cards (2 sets)
- Containers of beads or buttons
- Empty containers for sorting
- Socks (matching sets)
- Holiday cards
- Plastic colored utensils (3 colors)
**Office Kit:** Items within this kit could include:
- File folders
- Envelopes (various sizes)
- Papers to stuff
- Desk
- Stamp & ink pad
- Phonebook
- Labels (various sizes)
- Accounting forms

**Garden Kit:** Items within the kit could include:
- Watering can
- Bird feeder
- Garden tools (plastic)
- Packs of seeds
- Plastic pots
- Gardening gloves
- Pictures of gardens
- Silk flowers

### Monthly Theme Reminiscing Baskets

You can use “monthly theme” baskets with residents to promote reminiscing opportunities through visual aids related to the holidays and the seasons. The following table displays some suggestions for monthly themes.

<table>
<thead>
<tr>
<th>MONTH</th>
<th>ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>Decorate the basket with silver and blue ribbons and snowflakes. Include items to represent New Years Eve, New Years Day, Martin Luther King Jr., winter, snow, mittens, etc.</td>
</tr>
<tr>
<td>February</td>
<td>Decorate the basket with red, white and pink ribbons and hearts. Include items to represent St. Valentine’s Day, Black History month, President’s Day, Leap Year, Groundhog Day</td>
</tr>
<tr>
<td>March</td>
<td>Decorate the basket with green and white ribbons, paper shamrocks and rainbows. Include items to represent St. Patrick’s Day, Easter, Purim, Passover, Springtime, etc.</td>
</tr>
<tr>
<td>April</td>
<td>Decorate the basket with pastel colored ribbons. Include items that represent Easter, Passover, April showers, flowers, baby animals, start of baseball season etc.</td>
</tr>
<tr>
<td>May</td>
<td>Decorate the basket with pink and white ribbons and flowers. Include items that represent Mother’s Day, May Day, Memorial Day, etc.</td>
</tr>
<tr>
<td>June</td>
<td>Decorate the basket with white ribbons or a variety of colors. Include items that represent Graduation Day, Father’s Day, weddings, Flag Day, etc.</td>
</tr>
<tr>
<td>July</td>
<td>Decorate the basket with red, white and blue ribbons. Include items that represent Independence Day, summer, water sports, flags, etc.</td>
</tr>
<tr>
<td>August</td>
<td>Decorate the basket with yellow and white ribbons. Include items that represent summer, the beach, traveling, picnics, etc.</td>
</tr>
<tr>
<td>September</td>
<td>Decorate the basket with red ribbons. Include items that represent school days, Labor Day, Grandparents Day, football season, etc...</td>
</tr>
<tr>
<td>October</td>
<td>Decorate the basket with orange and black ribbons. Include items that represent Halloween, Harvest time, Yom Kippur, Rosh Hashanah, Columbus Day, etc.</td>
</tr>
<tr>
<td>November</td>
<td>Decorate the basket with brown and yellow ribbons. Include items that represent autumn, Thanksgiving, harvest, etc.</td>
</tr>
<tr>
<td>December</td>
<td>Decorate the basket with red and green and/or blue and yellow ribbons. Include items that represent Christmas, Hanukkah, Kwanzaa, Advent, etc.</td>
</tr>
</tbody>
</table>

**Topic Summary:** Sometimes, the best activities for memory-impaired residents are those that provide an opportunity for the resident to make a connection with the past. Reminiscing activities, such as theme kits, can provide residents with a feeling of self-worth as they recall past experiences and achievements. There are many possible topics for theme kits, such as baseball, sewing, or reading. These kits, when combined with carefully structured questions, can enhance a resident’s ability to recall events from their past in both one-on-one interventions and group settings.
**Topic 8: Aspects of ethics and related concepts**

**Topic Introduction:** Ethical reasoning is an essential tool for healthcare professionals. Consequently, it is important for those who work with AD patients to have a good grounding in the basic principles of ethics. When you have completed this topic, you will be able to apply clear ethical principles to the decision-making process.

**Ethics Defined**

The concept of ethics dates back to Aristotle and ancient Greece. The word *ethics* is derived from the Greek word *ethos*, meaning character or customs. Ethics refers to principles that define behavior as right, good and proper. These principles do not necessarily dictate a single course of action, but involve evaluating and deciding among competing options.

Ethics may be normative or descriptive. The *normative* approach attempts to bind a professional’s behavior and actions within certain parameters that are good and right for clients and patients, healthcare professionals, and professional organizations. From this normative approach evolve codes of ethics, organizational rules of conduct, and so on.

The *descriptive* approach attempts to describe or report on what people believe and the behaviors that follow those beliefs.

Therefore, when we focus on what a professional should be doing, we are talking about normative ethics. Conversely, when we simply describe how people behave and/or describe the moral standards they claim to follow, we are referring to descriptive ethics.

**What Ethics Isn't**

To understand the aspects involved with ethics, it is helpful to recognize factors that are not specific to ethics. The following factors should not be confused with ethics:

- **Our feelings:** A person may not do what is right because of feelings to the contrary. Feelings can frequently deviate from what is ethical.
- **Religion:** Although religions promote ethical standards, if ethics were restricted to religion, then ethics would only apply to religious people.
- **Law:** Laws set forth ethical standards for people to follow, but laws can deviate from what is ethical. Two examples are the Pre-Civil War slavery laws and women legally prevented from voting prior to 1919.
- **Whatever our society accepts:** This concept requires social consensus on many different issues. One would have to take a survey on each issue involved and then settle ethical dilemmas based on consensus. As you might guess, there will likely never be consensus on all ethical issues.

**Moral Principles**

The term “moral” implies conformity with the generally accepted standards of goodness or rightness in conduct or character. Ethics is concerned with how a moral person should behave. Therefore, ethics are viewed as standards of conduct that prescribe how one should act or behave based on moral obligations. A list of moral principles is displayed below:

1. **Morality** involves traditional beliefs about right and wrong conduct.
2. **Autonomy** involves the right of self-determination (i.e., that the patient or client has a right to choose). In other words, patients and clients have the right to be fully informed about everything involved in their care. They have the right to make decisions about such matters based on accurate information.
3. **Justice** involves fairness to everyone, sound reason, rightfulness of decisions and actions. It insures, for example, that all people have the same access to healthcare services regardless of their ability to pay, gender, ethnicity or race, physical or mental ability, age, or any other factors, such as behavior or lifestyle. In other words, justice demands equitable and appropriate distribution of resources.

4. **Beneficence** is the duty of ‘doing good’. The duty of the healthcare practitioner is to benefit and promote the well-being of the patient or client.

5. **Non-malfeasance** is the duty to ‘do no harm’.

6. **Advocacy or Loyalty** involves standing up for a patient or client.

7. **Veracity** is simply telling the truth.

8. **Confidentiality** requires keeping confidences – knowing when, and what must remain confidential.

9. **Ethic of Care** gives rise to compassion, equity, fairness, and dignity and provides a framework for relationships.

10. **Reciprocity** involves respect for the client’s goals and values.

11. **Fidelity** is the duty to be true to others, as well as to keep promises.

12. **Integrity** speaks to moral steadfastness and wholeness of beliefs.

13. **Concern for community as a whole** considers costs to the community, as well as the values of the community.

14. **Sanctity of Life** refers to maintaining life rather than the intent to end life.

**Universality**

Most people base their convictions about what is right and wrong on religious beliefs, cultural roots, family background, personal experiences, laws, organizational values, professional norms and political perspectives. However, these are not the best ethical values upon which to make ethical decisions — not because they are unimportant, but because they are not universal.

In contrast to consensus ethical values — such as trustworthiness, respect, responsibility, fairness, and caring — personal and professional beliefs vary over time, among cultures and among members of the same society.

**Values & Beliefs**

Values represent the inner judgments that determine how a person actually behaves. Values pertain to ethics when they concern beliefs about what is right and wrong. The values one holds affects one’s ethical position, which in turn affects how one responds in situations in which ethics come into play.

One definition of values states that values are: **Core beliefs or desires that guide or motivate attitudes and actions**. Not all beliefs are core beliefs or desires. Core beliefs play a large part in determining what attitudes we hold and how we respond to people and situational events in our lives.

For the most part, values cannot be readily seen in everyday, ongoing interactions. Cottone and Tarvydas (1998) observe, "Values are not directly observable, but are expressed verbally or in how they guide human choice and action through the value preferences expressed in human choices and goals" (p. 123).

Cottone and Tarvydas (1998) discuss the way in which counselor and client values affect the counseling process. In this context, the counselor’s values steer the course of the counseling process, while the client’s values determine the content of the counseling process.

On the issue of whether a healthcare provider’s values should visibly come into play during interactions with clients, many are of the opinion that the healthcare provider’s values should not be imposed upon clients. However, through the process of disclosure, a healthcare provider’s values can legitimately come into play in the context of ongoing issues in counseling.
Values are indicators of what one holds in esteem. Values act as standards that guide actions and judgments. Typically, values are organized by priority into what is known as a value system, resulting in a continuum along which judgments are made regarding behaviors and actions.

Values and resulting value systems operate at the individual or personal level, institutional or professional level, and societal or national level. Personal values, for example, are values that do not necessarily involve interaction with others. Personal values are expressed by an individual's behavior that generally brings about the value satisfaction, e.g., someone who works diligently because he or she values a strong work ethic.

Institutional or professional values, alternatively, may be described as a specified prioritization or constellation of values that express and encourage the identification and advancement of the group's values. In this sense, professional values serve as a group's standards and have the propensity to set the direction toward which an organization works. This occurs whether values are clarified by the group and stated up front, or whether they are ambiguous because they have not been formally identified.

When values are not articulated, assumptions are made about what is considered to be of value. Unspoken values and assumptions about what is of value to the group, however, will continue to influence and shape the behaviors and actions of the group.

*Learning Scenarios:*

The following scenarios focus on privacy and confidentiality: Read the scenarios and then write down what you believe is the proper response. Then go to the following page for the answer.

**Scenario 1: The Retirement Party (Confidentiality)**

Joan, an Activity Professional, attends a retirement party for an individual in Service Delivery. She mills around the crowded room among other conversing professionals and meets another activity director she has had professional conversations with by phone. The Activity Director begins to discuss a client who was transferred to Joan's nursing home.

Should the Joan discuss the case? Why or why not?

**Ethical Considerations:**

One should consider the extent to which the activity director wishes to discuss the client. Is the activity director merely inquiring how the client is doing in general? Is this an inquiry motivated by professional concern, or gossip fueled by alcohol served at the retirement party? And, of course, no matter what is said, how confidential is the conversation? If others are able to hear what’s said, that violates the client’s confidentiality. Joan's best course of action is to politely steer the conversation to another topic. She could make a date for another confidential phone meeting with the colleague to discuss any activity ideas that may benefit the client in her new home.

**Scenario 2: When does Assisted Living become a necessity? (Autonomy and Beneficence)**

Ann Perdita is 72 and in the very early stage of Alzheimer's. While she experiences confusion at times, her daughter Janet drops in every third day to check on her. In addition, she has an old friend who lives next door.

Janet wants her mother to move to an assisted living facility while she is still in the early stage of the disease, so that Ann has time to adapt to her new surroundings while her mental abilities are less deteriorated. Also, it's becoming increasingly difficult for Jan to make regular visits since she has a husband and children of her own to look after. However, while Ann understands that her cognitive abilities are diminishing, she has cherished her independent life and wants to keep it as long as possible.
Janet turns to you, a friend and assisted living facility administrator. She wants you to use your professional authority to convince Ann that she move into a facility sooner rather than later. What should your response be?

**Ethical Considerations:** You can explain to Ann the benefits of moving into a facility at this point. However don’t allow your sympathy for Janet’s position and point-of-view blind you to the importance of Ann’s wishes.

**Scenario 3: A Conflict between Residents (Justice)**

Mr. Hussein, a staff favorite for his gentle demeanor, is a middle stage Alzheimer’s sufferer, and has been a resident of your facility for over a year. He likes to listen to tapes of old baseball games. He finds listening to them soothing. Although the tapes belong to the facility’s library he often keeps them in his room since residents are allowed to check out books and tapes, and no one else at the facility appears interested in them.

During a brief period when the tapes were back in the library, a nurse played them for Mr. Preece, a new resident who also has a dementia-based illness. Mr. Preece, a frequently ill-tempered man, has been having trouble adjusting to living in the facility. The tapes have proven to be the first effective tool in calming Mr. Preece’s frazzled nerves.

When Mr. Hussein comes to get the tapes as he does every week, he gets very upset when he finds they are not available. He appears inconsolable without them. Since he listens to them alone at night, he is not assuaged by the possibility of sitting in a room with Mr. Preece during the day and listening to them.

The tapes are copyrighted and it will be two weeks before the facility can obtain an additional copy. Both residents have grown dependent on these tapes. How can you reconcile their conflicting needs without depriving one or the other?

**Ethical Considerations:** Despite Mr. Hussein’s “seniority” and established pattern of using the tapes, he has no greater right to them than Mr. Preece. Nor should the respective personalities of the two residents be a consideration. Whatever temporary solution the staff works out, it cannot come at the expense of one resident or the other. A just and equitable solution must treat their needs as equally important.

**Topic Summary:** The ethical decisions we make are based on our moral principles, such as justice and beneficence. These inner judgments rely on our accepted standards of right and wrong to identify the best alternative for a decision. These inner judgments are represented by values, or value systems, which operate at the individual or personal level, institutional or professional level, and societal or national level.
References

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20. Gold MF. Ethics: blending resident rights with safety, Provider (June 1996), pp. 36-45).
38. Rogers PD and Bocchino NL. Restraint-Free Care: Is It Possible?. The *American Journal of Nursing*. 1999; 99(10): 26-34

**Internet Resources**

*General Information about ADRD*
[http://www.coa.uky.edu/ADReview/contents.htm](http://www.coa.uky.edu/ADReview/contents.htm)
[http://www.alz.org](http://www.alz.org)
[http://www.alzheimer.ca/](http://www.alzheimer.ca/)
[http://www.clinicaltrials.gov](http://www.clinicaltrials.gov)

*For ADRD Caregivers*
Administration on Aging: [http://www.aoa.dhhs.gov](http://www.aoa.dhhs.gov)
Alzheimer’s Disease Education and Referral Center: [http://www.alzheimers.org](http://www.alzheimers.org)
Florida Agency for Health Care Administration – Florida Nursing Home Guide Update: [http://www.fdhc.state.fl.us](http://www.fdhc.state.fl.us)
Author Biography

Jeanne Christian MA-CCC

Jeanne Christian obtained her B.S. and M.A. from St. Louis University, St. Louis, Missouri. She possesses over twenty-five years of healthcare experience in both hospital and skilled nursing home settings, always with the adult population. In addition to her extensive experience (over 10 years) as a Speech Pathologist working with the geriatric population, she has performed the duties of an Operations Manager, Clinical Manager and in-house trainer. Her special expertise is in the areas of documentation, denials management and regulatory and accreditation management.

Jeanne’s love of training and program development led her to become a co-founder of online HealthNow, Inc., a provider of online educational courses. She currently serves as the senior learning partner, where her focus is on curriculum development and implementation. In this new venture, she continuously demonstrates her enthusiasm and energy for people and life.

Jeanne Christian’s credentials include being a Certified Trainer of Alzheimer’s and Related Disorders, accredited by the Florida Department of Elder Affairs- Nursing Home Alzheimer’s Disease or Related Disorders Training Provider Certification number NH504. This special certification is only awarded to those individuals who demonstrate extensive clinical/practical experience in working with and developing programs for those individuals experiencing Alzheimer’s disease or other related disorders such as dementia, etc. She is also a former C.A.R.F. surveyor.
Alzheimer’s Disease & Related Disorders (ADRD): Handle with Care - Posttest

1. Which of the following environmental factors can cause an AD resident distress?
   a. Unsettling noises  
   b. A lack of sensory or environmental stimulation  
   c. Both a and b  
   d. None of the above

2. Which of the following ways can be a cause of unwanted behavior in a resident?
   a. Tasks are too complicated  
   b. Tasks have too many steps  
   c. Staff speak too fast when giving directions  
   d. All of the above

3. Which of the following is an aspect of the "Show and Tell" technique of working with persons with ADRD?
   a. Showing with gestures  
   b. Showing with facial expressions  
   c. Using an open posture while telling in short, simple statements  
   d. All of the above

4. Which of the following is an inappropriate technique for communicating with persons with ADRD?
   a. If a person is unreceptive, speak again in a clear, firm voice, raising your tone slightly  
   b. Use names of things and words the resident knows. For example, say “fork” instead of “utensil.”  
   c. Pay attention to nonverbal cues you are giving and receiving from residents.  
   d. None of the above

5. Which of the following are examples of good techniques to use with residents with Middle Stage ADRD?
   a. Maintain focus with gentle therapeutic touch  
   b. Offer multiple (more than three) choices to stimulate cognitive activity  
   c. Use sensory stimulation, like touch and smell, perhaps during meals and while bathing and grooming.  
   d. Both a and c

6. Which of the following conditions can cause stress that leads to problem behaviors?
   a. Medical / Physical problems  
   b. Emotional problems  
   c. Both a and b  
   d. None of the above

7. According to the author which of the following are signs of agitation in a person with ADRD?
   a. Hysterical laughter  
   b. Name-calling  
   c. Disrobing  
   d. Both a and b

8. Which of the following could be responsible for aggressive behavior in a person with ADRD?
   a. Anger  
   b. Depression  
   c. extreme frustration  
   d. Both a and c

9. ________ is the name given to behavioral problems that increase in the late afternoon or evening.
   a. Late day melancholy  
   b. Sundowner’s Syndrome  
   c. Sundowner’s Depression  
   d. Evening Blues

10. ________ can be visual, auditory, tactile or gustatory (perception of a bad taste)
    a. Delusions  
    b. Hallucinations  
    c. Both a and b  
    d. None of the above

11. ________ are fixed false beliefs that persist in the face of evidence to the contrary.
    a. Delusions  
    b. Hallucinations  
    c. Both a and b  
    d. None of the above

12. The proper way to view problem behaviors is to see them as:
    a. Disobedience that must be actively fought to slow the disease’s progression  
    b. The resident’s attempt to send a message, to communicate a physical or emotional need  
    c. Always a sign of ineffective caregiving  
    d. None of the above
13. Which of the following is NOT a good technique when working with problem behaviors?
   a. Approach the resident from the front and smile.
   b. Keep your voice stern, using an assertive tone
   c. Use the resident’s name and identify yourself. Do not expect the person to remember you.
   d. None of the above

14. Which of the following is NOT one of the five “R”s of managing catastrophic behavior?
   a. Remain
   b. Reason
   c. Remove
   d. Return

15. The use of restraints is typically limited to __________
   a. Situations that may be dangerous without them
   b. Any situation where a problem behavior becomes apparent
   c. Both a and b
   d. None of the above

16. Which of the following areas should a healthcare worker be familiar with in order to work with a resident with ADRD?
   a. The person’s habits
   b. The person’s preferences
   c. The person’s behavioral issues
   d. All of the above

17. For residents in middle stage, which of the following should caregivers not do?
   a. Offer multiple choices to stimulate brain activity
   b. Give simple directions
   c. Redirect problem behavior with a positive option
   d. None of the above

18. Which of the following is NOT a good approach to helping ADRD residents with dressing habits?
   a. Lay out items of clothing on the bed, placing them in order of use
   b. Encourage the resident to select clothing, but simplify the choices
   c. Ask the family to bring familiar clothing with belts & zippers for residents to practice with
   d. Group outfits together on hangers

19. Which of the following is NOT a good approach to helping ADRD residents with bathing?
   a. Give the resident a toy or something to hold to redirect his attention during the bath.
   b. Allow the resident to do as much of the bathing as possible.
   c. Check the person’s skin for any sign of sores or a rash.
   d. Allow the resident to dry themselves

20. According to the national Alzheimer’s Association, how many hours weekly do caregivers employed outside the home dedicated to providing care?
   a. 20
   b. 35
   c. 40
   d. 45

21. When caregivers neglect self-care, they are vulnerable to a specific type of stress called __________.
   a. Compassion Fatigue
   b. Caregiver’s Depression
   c. Care Weary
   d. Caregiver’s Syndrome

22. Which of the following is NOT a benefit of Self-care activities?
   a. Adding purpose to the resident’s daily routine
   b. Improving the resident’s overall quality of life
   c. Offering the resident an opportunity for pleasure
   d. None of the above

23. Social Interaction for AD residents can be provided by:
   a. One-on-one meetings
   b. Small group programs
   c. a and b
   d. None of the above
24. Which of the following items are useful when helping AD residents reminisce in groups?
   a. Jewelry  b. Pictures of families  c. Pictures of movie stars  d. All of the above

25. Which of the following is NOT a recommended guideline for reminiscing with residents?
   a. Always speak slowly. Allow the resident time to absorb questions or materials used to stimulate memory.
   b. Remember to focus on the resident and what he has to say. Let him be the teller and you the listener.
   c. Do not share your own memories. This takes the focus off the resident.
   d. None of the above

26. What is the name of the approach to ethics that attempts to bind a professional's behavior and actions within certain parameters that are good and right for clients and patients, healthcare professionals, and professional organizations?

27. Which moral principle refers to the right of self-determination?

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