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- Call 866-782-6258 (M-F, 8 AM-8 PM ET)
- Email customerservice@PhysicalTherapy.com
There’s no place like home (for health care)

Guest Editor: Nikki Gilroy, PT, DPT

9/10: The Role of Home Health Physical Therapy in Managing Urinary Incontinence
Jamie Lowy, PT, MSPT, and Sarah Haag, PT, DPT, WCS, Cert. MDT

9/11: Motivated for Success: Finding the Joy in Homecare
Jean D. Miles, PT, DPT

9/12: Understanding the 3 D's: Dementia, Delirium and Depression in Older Adults
Cathy Ciolek, PT, DPT, GCS, FAPTA

9/13: Management of the Patient with CAD and/or CHF in Home Health
Pamela Bartlo, PT, DPT, CCS

9/14: Putting the Plan into Action - Understanding Goal Statements and Selecting Interventions for the Home Health PTA
Diana L Kornetti, PT, MA, HCS-D, COS-C, and Sherry Teague, MESS, ATC, PTA

Understanding the 3 D's: Dementia, Delirium and Depression in Older Adults

Cathy Ciolek, PT, DPT, FAPTA

Board Certified Geriatric Clinical Specialist
Certified Dementia Practitioner
Certified Alzheimer's Disease and Dementia Care Trainer
President- Living Well With Dementia, LLC
Learning Outcomes:

- As a result of this course, participants will be able to:
  - Differentiate between the presentations of dementia, delirium and depression
  - Compare assessment tools to determine the most appropriate for home health client with dementia, delirium or depression
  - Implement 3 strategies for improving communication and engagement for people with impaired cognition
  - Utilize the AGS Beers Criteria for Inappropriate Medications for Older Adults when completing medication review to determine if medications may be impacting cognitive function
  - Identify situations where referral to another provider is warranted to optimally support a person with dementia, delirium or depression.

What is Dementia

- DSM-V: Neurocognitive disorder (APA, 2013)
  - Major (with functional impairment)
  - Minor (without functional impairment)
- “Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—and behavioral abilities to such an extent that it interferes with a person’s daily life and activities.” (NIA 2018)
Dementia  
(McKhann GM, 2011)

- Cluster of symptoms
- Severe enough to limit their everyday activities
- Decline from previous level
- NOT delirium or neurocog disorder

2 or more of following

- Impaired ability to acquire and remember new information
- Impaired reasoning and handling of complex tasks, poor judgement
- Impaired visual spatial abilities
- Impaired language functions
- Changes in personality or behavior

Alzheimer’s Disease Pathology

- Tau- accumulates inside the neurons
- Beta-Amyloid forms plaques between neurons
  - Toxic
  - Years before symptoms

(NIA, 2018)
Alzheimer’s Disease

Criteria of dementia discussed earlier
- Insidious onset
- Clear cut history of worsening
- Amnestic
  - Impairment learning and recalling new information
  - Evidence of at least 1 other area
- Nonamnestic
  - Language/word finding changes
  - Visuo-spatial- object agnosia, facial recognition
  - Executive dysfunction with impaired reasoning and judgment

Alzheimer’s Dementia

Statistics
- 60-80% of diagnosed dementia
- 5.7 million Americans
  - 5.5 million >65
  - 200,000 <65
- 10% of people over age of 65 have AD

(Alzheimer’s Association, 2018 Fact Sheet)
Alzheimer’s Disease- Early onset

- ~5-10% of cases show symptoms before age 65
  - In 30s and 40s
  - May be misdiagnosed as stress or depression
  - Family dynamics

Alzheimer’s Disease- Genetics

- Down Syndrome- extra chromosome 21 contributes to increase Amyloid production.
  - Shows signs of degeneration in 40’s
- Genetic mutation- 1% of PWD have genetic mutation in presenilin 2.
  - present- 95% changes of Alzheimer's Disease
- APOE-e4 – associated with higher risk of Alzheimer’s Disease

(Alzheimer’s Association, 2018 Fact Sheet)
Dementia with Lewy Bodies - Pathology

- Alpha-synuclein protein clumps cause the cells to die.
- Primary impact areas:
  - Limbic System - emotional regulation
  - Hippocampus - memory storage
  - Brain stem - sleep regulation
  - Cerebral Cortex - processing, perception, language

Lewy Body Dementia

- Some physical sx similar to Parkinson’s Disease - but cognitive symptoms appear earlier and motor symptoms are generally less until disease progresses
- Symptoms: visual hallucinations, sleep disturbance, managing emotions, recall, gait disturbance
- Key differential - responds poorly to dopamine-agonist therapy
- Statistics:
  - ~1 million Americans
  - Generally starts after age 50
  - Average duration 5-7 years
  - www.lbda.org
Frontotemporal Dementia

- Behavioral Variant - disinhibition, apathy, loss of empathy leading to loss of social competence. Executive functional are impacted, but less issues with memory or visuospatial skills.
- Language Variants - involve language as initial symptom including anomia, loss of word finding.
- Movement impacted - muscle stiffness, slow movements, "like walking through water"

- Majority of cases onset <65
- Memory is not impacted until later in disease*
  - Most “dementia” medications are not recommended

Vascular Dementias

- Symptoms: vary depending on area of brain impacted by blood flow

- Primary impact on depends on area impacted in brain. Could be related to motor area of brain for word production or thought processing area etc..
Mixed (Custodio N, 2017)

- Alzheimer’s types plaques with other cerebrovascular changes
- ~22% of people with AD show significant CV changes of mixed CV-AD
  - Lacunar infarct increase rate of dementia

Mild Cognitive Impairment

- Criteria for MCI (Albert MS, 2011)
  - Concern of a change in cognition
  - Impairment in 1 or more areas of cognition as noted previously
  - Preservation of independent functional abilities

- ~20-40% estimated to progress to AD (Roberts R, 2013)
  - ~10-15% conversion rate per year
  - Highest rate of conversion – episodic memory impairment
**Assessment - Screening**

- **Mini-Cog©**
- **General Practitioner Assessment of Cognition (CPCOG)**
- **Memory Impairment Screening**

---

**Mini-Cog© (mini-cog.com, used with permission)**

- 3 word recall
- Sets of words for multiple trials
- 1 point for each word
- Clock Drawing Test
- 2 points
- <3 indicative of cognitive impairment
- <4 indicates further testing

---

**Mini-Cog™ Instructions for Administration & Scoring**

**Step 1: Three Word Registration**

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are based on a list of words from the version below. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (Clock drawing).

This following and other word lists have been used in one or more clinical studies. For repeated administrations, use of an alternative word list is recommended.

---

**Step 2: Clock Drawing**

Say, "Next, I want you to draw a clock for me. First, put it in all of the numbers where they go." When that is completed, say, "Now, set the hands to 12 o'clock." Use preprinted clock face attached for this exercise. Repeat instructions as needed so this is not a memory test. Move to Step 3 if clock is not complete within three minutes.

---

**Step 3: Three Word Recall**

Ask the person to recall the three words you stated in Step 1. Say, "What were the three words I asked you to remember?" Record the word list section number and the person's answer below.

Word List Version: ______ Person's Answers: __________ __________ __________

---

**Mini-Cog©**

**General Practitioner Assessment of Cognition (CPCOG)**

**Memory Impairment Screening**
General Practitioner Assessment of Cognition (CPCOG)

- Repeat/Recall of name and address provided
- Date
- Clock drawing
- Current event


- Total 9 points
- Score- 5-8 should conduct informant interview

Memory Impairment Screening
(Buschke H, 1999)

- 4 word recall
- 2 points for each independent recall
- 1 points for each cued recall

- 4 or less points indicate cognitive impairment
Additional Assessments

- MMSE
- MOCA*
- Trail Making A&B
- SLUMS

MOCA (MOCATEST.ORG - used with permission)
MOCA (Nasreddine, 2005)

- Score of 26 or higher considered normal
- <26 is indicative of cognitive impairment
- Translated to multiple languages
- 3 versions allow for repeated testing
Pharmacological Intervention

- Cholinesterase inhibitors
  - Donepezil (Aricept™)
  - Galantamine (Razadyne™)
  - Rivastigmine (Exelon™)
  - Tacrine (Cognex™)
- Memantine (Namenda™)

- Review found - statistically significant but clinically marginal improvements of cognition (Roma P, 2008)

What else can mimic dementia?

- Depression
- Delirium
- Normal Pressure Hydrocephalus
- Thyroid dysfunction
- Vitamin deficiencies
- Alcohol
- Medication and polypharmacy
- NPH
Delirium

- DSM-V Criteria (APA, 2013)
  - Disturbance in attention and awareness
  - Acute and may fluctuate
  - Minimum of 1 other cognitive change
  - Evidence of underlying organic cause(s)

Characterized by...

- Attention deficits
- Reduced awareness of the environment
- Confused thinking
- Disorganized behavior
- Change from baseline
- Short/acute onset
- Associated with organic cause
Types of Delirium (Irwin SA, 2013)

- Hypoactive
  - reduced attention, sleepy, difficult to rouse
- Hyperactive-
  - Restless/agitated
  - Confused
  - Hallucinations
  - Mumbling/incoherent
  - Jerky movements
- Mixed
  - Between two states in fluctuation

Delirium

- High prevalence in older adults with advanced medical illness. 56-88% (Irwin SA, 2013)
- Causes (Varghese R, 2017)
  - Metabolic
  - Hypoxia
  - Infection
  - Toxic exposure
  - Medications
Delirium Impact

- Associated with
  - Unnecessary interventions and healthcare utilization
  - Prolonged hospitalization
  - Increased need for higher level of care
  - Functional decline
  - Increased mortality
  - Stress for person, family and caregivers

Delirium • By Ihor Podolchak [CC BY-SA 3.0 (https://creativecommons.org/licenses/by-sa/3.0)], from Wikimedia Commons
What is attention?

- “ability to focus on a selected stimulus, sustaining that focus and shifting it at will.” (Cohen RA, 1993)
- Functions of attention (Morandi A, 2017)
  - Orienting to sensory events
  - Detecting input/signals for processing
  - Maintaining an alert state
- Test of attention (Adamis D, 2016)
  - Stating months of the year backward

Arousal

- “the level of sensory stimulation that is required to keep the patient attending to the examiner’s question or following a command” (Morandi A, 2017)
  - Verbal
  - Tactile
Arousal: Measure

- Modified Richmond Agitation and Sedation Scale (M-RASS)
  - Change in M-RASS score was associated with 85% sensitivity and 92% specificity for incident delirium. (Chester JG, 2012)
  - State persons name and ask them to open eyes and look at speaker. Ask “describe how you are feeling today” (if <10 seconds, cue second question)
  - Scale +4 (combative) to 0 (normal) to -5 (unarousable)

Confusion Assessment Method (CAM)

- [https://www.hospitalelderlifeprogram.org](https://www.hospitalelderlifeprogram.org)
- CAM short is 4 questions
- Other version exist that are longer for research
- Suggested pairing with other cognitive tests
- assessment used for Delirium
SHORT CONFUSION ASSESSMENT METHOD (CAM) WORKSHEET

Note: This worksheet should be used as an alternative to the short CAM Questionnaire. Testing of orientation and sustained attention is recommended, such as digit spans, days of week, or months of year backwards. This page can only be used to identify delirium cases. Please note it cannot be used to score severity using the CAM-5 scoring system.

EVALUATOR: ____________________________

DATE: ____________________________

I. ACUTE ONSET AND FLUCTUATING COURSE
   a) Is there evidence of an acute change in mental status from the patient’s baseline? Yes _____ No _____
   b) Did the (abnormal) behavior fluctuate during the day, that is tend to come and go or increase and decrease in severity? Yes _____ No _____

II. INATTENTION
   Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? Yes _____ No _____

---

III. DISORGANIZED THINKING
    Was the patient’s thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? No _____

IV. ALTERED LEVEL OF CONSCIOUSNESS
    Overall, how would you rate the patient’s level of consciousness?
    - Alert (normal)
    - Vigilant (hyperalert)
    - Lethargic (drowsy, easily aroused)
    - Stupor (difficult to arouse)
    - Coma (unarousable)

Do any checks appear in the box above? Yes _____ No _____

If inattention and at least one other item in Box 1 are checked and at least one item in Box 2 is checked a diagnosis of delirium is suggested.

CAM Short Scoring

- Feature 1 Acute Change or Fluctuation (any symptom) OR/AND Feature 2 - Inattention AND EITHER
  - Feature 3 - Disorganized Thinking
  - OR
  - Feature 4 - Altered Level of Consciousness

- OR- best sensitivity
- AND- best specificity

Interventions (Irwin SA, 2013)

- Pharmacological
  - First generation antipsychotics (Haldol) for acute hyperactive
  - Benzodiazepines (Risperdone) for acute hyperactive
  - Assess polypharmacy

- Non-pharmacological
  - Engage mentally stimulating tasks
  - Re-orientation via signage, introductions (repeated with each encounter)
  - Minimize room changes
  - Ensure sensory aides
  - Monitor fluid/electrolyte
  - Promote sleep hygiene
Differentiating: delirium and dementia (Varghese R, 2017)

<table>
<thead>
<tr>
<th></th>
<th>Delirium</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>Rapid</td>
<td>Slow and progressive</td>
</tr>
<tr>
<td><strong>Symptoms occurrence</strong></td>
<td>Fluctuating</td>
<td>Generally steady in day*</td>
</tr>
<tr>
<td><strong>Arousal</strong></td>
<td>Impacted/cardinal sign</td>
<td>Not impacted until later stages of disease</td>
</tr>
<tr>
<td><strong>Attention</strong></td>
<td>Difficulty staying on task</td>
<td>Impaired in later stages</td>
</tr>
<tr>
<td><strong>Thinking</strong></td>
<td>Disorganized</td>
<td>Diminished</td>
</tr>
<tr>
<td><strong>Hallucinations</strong></td>
<td>Visual</td>
<td>Visual or auditory (LBD)</td>
</tr>
<tr>
<td><strong>Speech</strong></td>
<td>Incoherent</td>
<td>Word-finding difficulty</td>
</tr>
</tbody>
</table>

Delirium superimposed on dementia

- DSD is gaining recognition for people with dementia who are hospitalized (or other medical condition) that adds delirium on top of their already challenged cognitive state.
  - A change from the person with dementia’s baseline cognitive state
  - Associated with change of medical status, medication change or surgery
  - Worsened with further environmental changes
Depression (APA, 2013)

- DSM-V Major Depressive Disorder
  - Symptoms lasting at least two weeks
  - Significant change from previous status
  - 5 or more of other symptoms
    - Depressed mood most of the day
    - Decreased interest in most or all activities
    - Significant weight loss not associated with dieting
    - Insomnia
    - Psychomotor agitation or slowing
    - Fatigue
    - Feeling worthless or guilt
    - Decreased concentration
    - Suicidal ideation

Psychiatric Disorder Rates (Reynolds K, 2015)

- Decreasing rates of psychiatric disorders with increasing age.
  - Mood disorder- 6.8%
  - Anxiety Disorder- 11.4%
  - Personality disorder- 14.5%
  - Substance abuse- 3.8%

Risk Factors for Depression

- Disability and poor health status
- Complicated grief
- Chronic sleep disturbance
- Loneliness
- History of depression

Depression- tools

- US Preventative Services Task Force recommend screening older adults for depression. (Siu AL, 2016)

- Screening
  - PHQ-2

- Lengthier assessment
  - Cornell Scale for Depression in Dementia
Patient Health Questionnaire 2 (PHQ-2) (Whooley MA, 1997)

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by little interest or pleasure in doing things?

- Yes to either question indicates need for further testing.
  - Sensitivity 98%
  - Specificity 57%

Cornell Scale for Depression in Dementia (Alixopoulos GS, 1988)

- 19 items.
  - Scoring 0 (absent), 1 (intermittent), 2 (severe)
- Interview with patient and caregiver/significant other
- Questions
  - Mood
  - Behavior
  - Physical signs
  - Cyclic functions
  - Ideation disturbances
Cornell Scale for Depression in Dementia

- Initial study (Alexopoulos GS, 1988)
  - Score >8 indicates significant depression symptoms
- More recent study
  - Sensitivity (93%) and specificity (97%) with a cut-off value of ≥6 (Korner A, 2006)
- Full test available at

Depression-

- Psychotherapy (Pinquart M, 2007)
  - Large effect size 7-12 session
    - Cognitive-behavioral therapy
    - Reminiscence
  - Medium effect size
    - Psychodynamic therapy (medium)
    - Psychoeducation (medium)
- Nonpharmacological (Holvast F, 2017)
  - Exercise
  - Light therapy
Depression - Communication

- Avoid “I think” and “you should”
- Acknowledge physical and mental pain
- Validate without agreeing or disagreeing
- Silence is helpful
- Avoid driving the conversation - they pick topics

- https://nurseslabs.com/5-communication-techniques-for-individuals-with-depression/

Depression - Pharmacology (Frank C, 2014)

- Key facts to know
  - 3 phases of drug treatment
    - Initial sx management
    - Prevention of recurrence in same episode
    - Maintenance/prevent future episode
  - Initial dosage should be ½ of typical adult dose
    - Titrated until response, max dose or side-effects
  - Treatment continue at least 1 year post sx resolution
    - Recurrent depression continue indefinitely
Depression-Emergency

- Suicide Prevention Lifeline at 1-800-273-TALK (8255), or dial 911 in case of emergency
- Active suicidal thoughts
  - Stay with them until emergency services arrive
- Signs
  - Verbal threats
  - Giving away items
  - Expressing world would be better without them
  - Risk taking
- http://www.mentalhealthamerica.net/preventing-suicide-older-adults

Differentiating depression and dementia (Gagliardi JP, 2008)

- While people may present as having memory problems, people with depression should perform normally on neuropsychiatric assessment. Someone with depression is more likely to appear worried about the memory impairment.
  - Changes noted in weeks (versus months for dementia)
- Lack of engagement may be present but in depression it is associated with fatigue and other mood related components versus ability to engage.
Depression overlap with dementia

- May be as high as 87% of people with dementia (Strober LB, 2009)
  - Higher than PD and stroke
  - Debate - symptom of disease or response to it

When in doubt…

- Look at history of onset - quick, moderate, slow
- Refer for medical work up
  - Vitamin and electrolytes
  - Neuropsychiatric testing
  - Full medication review
Beers List 2015 (AGS, 2015)

- List of potentially inappropriate medications to be avoided in older adults.
  - Avoid in general
  - Avoid based on diseases and syndromes
  - Minimized/dose adjusted

- Link to Resource:

---

Beers Criteria 2015 Drugs that should be avoided in PWD (AGS, 2015)

Table 3.Potentially Inappropriate Medications—may exacerbate disease or condition: dementia

<table>
<thead>
<tr>
<th>Medications:</th>
<th>Rationale:</th>
<th>Recommendation/Evidence Level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticholinergics*</td>
<td>Avoid because of adverse CNS effects</td>
<td>Avoid/Strong</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Avoid antipsychotics for behavioral problems of dementia or delirium unless nonpharmacological options (e.g., behavioral interventions) have failed or are not possible and the older adult is threatening substantial harm to self or others. Antipsychotics are associated with greater risk of cerebrovascular accident (stroke) and mortality</td>
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Beers Criteria 2015 Drugs that should be avoided in PWD (AGS, 2015)

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Beers Criteria 2015 Drugs that may cause delirium (AGS, 2015)

Table 2. Potentially Inappropriate Medications – partial list

<table>
<thead>
<tr>
<th>Organ System/Therapeutic Category (partial list)</th>
<th>Rationale</th>
<th>Recommendation/Evidence Level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-cholinergics 1st Gen.</td>
<td>Confusion, dry mouth, constipation, memory loss, increased risk of falling</td>
<td>Avoid/Strong</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>Cognitive Impairment, delirium, falls, fractures and motor vehicle accidents</td>
<td>Avoid/Strong</td>
</tr>
<tr>
<td>Long Acting</td>
<td>Cognitive Impairment, delirium, falls, fractures and motor vehicle accidents</td>
<td>Avoid/Strong</td>
</tr>
<tr>
<td>Clonazapam Diazepam</td>
<td>May be appropriate for seizure disorder</td>
<td></td>
</tr>
</tbody>
</table>
### Beers Criteria 2015 Drugs that may cause delirium (AGS, 2015)

**Table 2. Potentially Inappropriate Medications – partial list**

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</tr>
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<tbody>
<tr>
<td>Antipsychotics, first- (conventional) and second- (atypical) generation</td>
<td>Increased risk of cerebrovascular accident (stroke) and greater rate of cognitive decline and mortality in persons with dementia. Avoid antipsychotics for behavioral problems of dementia or delirium unless nonpharmacological options (e.g., behavioral interventions) have failed or are not possible and the older adult is threatening substantial harm to self or others.</td>
<td>Avoid, except for schizophrenia, bipolar disorder, or short-term use as antiemetic during chemotherapy. Strong</td>
</tr>
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**Table 2. Potentially Inappropriate Medications – partial list**

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<tr>
<td>Antidepressants, alone or in combination: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin &gt;6 mg/d, Imipramine, Nortriptyline, Paroxetine, Protriptyline, Trimipramine</td>
<td>Highly anticholinergic, sedating, and cause orthostatic hypotension; safety profile of low dose doxepin (≤6 mg/d) comparable with that of placebo.</td>
<td>Avoid/Strong</td>
</tr>
</tbody>
</table>
Changes in DRAFT 2018 Beers List (AGS, 2018)

- Dextromethorphan/quinidine (Nuedexta)
  - Limited efficacy in treating patients with neurocognitive disorders while potentially increasing risk of falls and drug-drug interactions

Behavioral and Psychological Symptoms of Dementia (BPSD)

- First appeared as a term in 1996 Consensus Statement (Finkel S, 1996)
- Classify the “neurobehavioral” symptoms of dementia as psychiatric condition
  - Cause distress
  - Impact quality of life
- Medicalization led to over-medication?
Well-being (Power A, 2014)

Joy

Meaning

Growth

Security

Autonomy

Connectedness

Identity

Communications of their feelings

- Feelings are normal
- Negative feelings kept bottled up magnify
- Many expressions are “normal” response to situations that seem out of control
  - Example- bathing
While communication may be impacted—what is preserved? (Gowdin B, 2015)

- Preserved continuity in sense of:
  - Self
  - Moral awareness
  - Diversity of emotional reactions to living with dementia

- Methods to improve self for PWD
  - Increase sense of belonging
  - Experiencing autonomy
  - Experiencing engagement
  - Promoting imagining
  - Promoting sense of self

When she looks in the mirror, she may not recognize herself... instead she remembers her service as a nurse in Vietnam...
Considerations for nonpharmacological approaches

- Human behaviors are a dynamic, moving target
- We learn through trial and error
- Individualization is key
- Direct care workers are essential to IDT
- Share strategies for acute issues

http://www.nursinghometoolkit.com/nonpharmacological.html

Nonpharmacological - Agitation

- Assess for cause
  - Pain
  - Other physical needs
  - Boredom
  - Overstimulation
  - Fatigue
  - Fear/lost/insecure
  - Other medical

- Intervene to cause
  - Pain meds or movement
  - Food, drink, bathroom
  - Engagement, music
  - Diminish stim, quiet area
  - Sleep interventions
  - Engagement, comfort
  - Medical workup
Physical Approach

- Reduce or minimize environmental noise
- Consistent positive physical approach
  - Pause at edge of their space
  - Gesture and greet by name
  - Make eye contact and offer your hand
  - Approach slowly and stay in sight
  - Shake hands
  - Move to eye level and give them space (move to the side)
  - Wait for acknowledgement

Smile!

HTTP://SUCCESSIFY.NET/2014/04/10/WISDOM-HAPPINESS-92-YEARS-OLD/
Physical Approach: Larry Meigs

- **Eye Contact.** Maintain eye contact to convey that you’re paying attention to a person coping with Alzheimer’s. Don’t avoid eye contact during conversation. Doing so conveys dismissiveness. Eye contact should be made at their eye level or below — not above, which gives the impression of dominance.

- **Facial Expressions.** Always be conscious of what your facial expressions are saying. In day-to-day conversation, it’s easy to say one thing and have a raised eyebrow or a twist of the mouth say another. When these expressions are the only thing the recipient can understand, the words your using aren’t what matter.

- **Open Posture.** Keeping an open posture is a key part of body language. An open posture — facing the person, chest forward, no crossed arms or legs — tells a person that you’re focused on them, open to their concerns, and engaged with them emotionally.

- **Avoid Tics and Distractions.** Small tics and distractions can show that you’re agitated, angry, or bored when spending time with a person. Tapping your armrest, bouncing your knee, checking your phone, or multi-tasking can communicate that you’re not invested in the person.

- **Use Gestures.** Using your hands and objects around you to communicate simple messages can do wonders when caring for someone with Alzheimer’s. However, it’s important not to overuse gestures, which can agitate or confuse those with Alzheimer’s.

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Verbal

- One staff speaks at a time.
- Use yes-no rather than open-ended questions.
- Speak at an adult level. Avoid “elderspeak”.
- Allow time to process and respond. (10-30 seconds)
- Repeat or paraphrase if necessary.
- Do not correct the person.
- Do not argue.
- Do not pressure for response.
Pearls: Implicit Memory (Sabot S, 2018)

- Implicit Memory remains longer than explicit memory.
  - Asking about recent events that they are unlikely to remember causes anxiety, agitation or anger
- Using implicit memory
  - Mirror question back—rather than explicit memory (what time did I tell you), use implicit memory
  - Less pressure on response
  - Face saving with prompts

Pearls: Avoid Humiliation (Sabot S, 2018)

Avoid asking questions they are unlikely to know the answer to

Big challenge for families who want the PWD to remember

- We are unlike to “fix” them
- We can reminisce to discuss shared history
- PWD retain emotional memory
Pearls: You get to change your answer until you find the best fit

(Brackey J, 2017)

- When someone is starting to get distressed and you are trying to find the right answer. See their response... is it helpful or hurtful.
- Example: Gentleman searching for “Betsy”

- Conversational repair- when one or more parties in the conversation attempt to resolve misunderstandings or mis-hearing.
- As dementia progresses
  - sentence structure used may be come more fragmented with long pauses and disjointed thoughts
  - care partner will need to assume greater responsibility for conversational repair.
Pearls: Care partners need support too

- Be prepared to support spouse or care partner
- Refer to social services or support groups as needed
- Encourage them to find healthy outlets
- Recognize their loss, and potential for depression or anxiety

Alzheimer’s Association- Practice Recommendations for Person Centered Care (Fazio 2018)

1. Know the person living with dementia
2. Recognize and accept the other person’s reality
3. Identify and support opportunities for meaningful engagement
4. Build and nurture authentic and caring relationships
5. Create and maintain supportive community for individuals, family and staff
6. Evaluate practice regularly and make appropriate changes
Case: Ms. J

- 78 y.o. female
- Lives alone in ranch style home, large rural property
- Never married but had a roommate for years, she has since passed away.
- Teacher/Counselor
- Loves animals and kids
- Likes to help people

Referred to me because of concerns about recent abrupt worsening of memory
- managing meds
- managing bills
- managing medical appointments

Fallen several times
Increasing daytime sleep
Case Ms J.

- Long h/o depression
  - Sees counselor
  - Psychiatrist medication

- Several TIA’s

- Family physician wanted to start her on 2 cognitive enhancer medications

Medication List

- Valsartan – HTN
- Loratadine PRN-allergies
- Glipizide XL- DM
- Metformin BID- DM
- Meclizine TID PRN-Dizziness
- Levothyroxine-hypothyroid
- Venlafaxine XR- depr
- Lamotrigine- depr
- Bupropion- depr
- Aspirin- CAD
- Mirabegron-incontinence
- Rosuvastatin-hyperlipidemia
Medication List - BEERS List

- Valsartan – HTN
- Loratadine PRN-allergies
- Glipizide XL- DM
- Metformin BID- DM
- Meclizine TID PRN-Dizziness
- Levothyroxine-hypothyroid
- Venlafaxine XR- depr
- Lamotrigine- depr
- Bupropion- depr
- Aspirin- CAD
- Mirabegron-incontinence
- Rosuvastatin-hyperlipidemia

Medication List - Fatigue/Weakness/Dizziness

- Valsartan – HTN
- Loratadine PRN-allergies
- Glipizide XL- DM
- Metformin BID- DM
- Meclizine TID PRN-Dizziness
- Levothyroxine-hypothyroid
- Venlafaxine XR- depr
- Lamotrigine- depr
- Bupropion- depr
- Aspirin- CAD
- Mirabegron-incontinence
- Rosuvastatin-hyperlipidemia
Cognitive Testing

- MOCA
  - Score 24/30
- Points lost:
  - Visuospatial
  - Serial subtraction
  - 1 point on delayed recall

Cognitive Testing

- Trail Making A - 39 seconds, 3x lifted pen
- Trail Making B - stopped at 3 minutes
  - 4 errors
  - Did not finish
Referrals Needed?

- Geriatrician-total medication review
  - Primary Care- requested she either not start dementia meds or only 1
- Neurologist- further neuropsych testing
- Physical Therapy- balance testing, neck pain
- Neurologist- testing indicates her problem is associated
  - ADD
  - depression
  - NOT dementia
- Discussion with PT about communication strategies that work for her.

Take Home:

- Dementia, delirium and depression can co-exist and mimic each other.
- Assessments and good history can assist in determining possible causes
- Referral is essential to work with other team members
Questions?

- Reference are available in separate document.