CARING FOR PEOPLE WITH DEMENTIA

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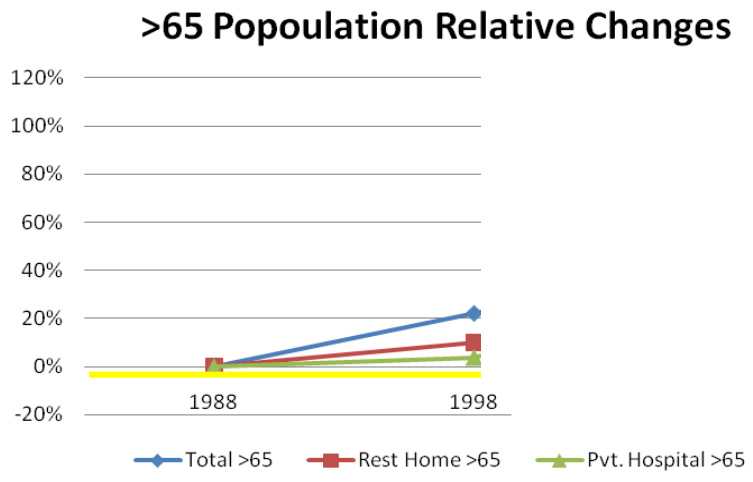
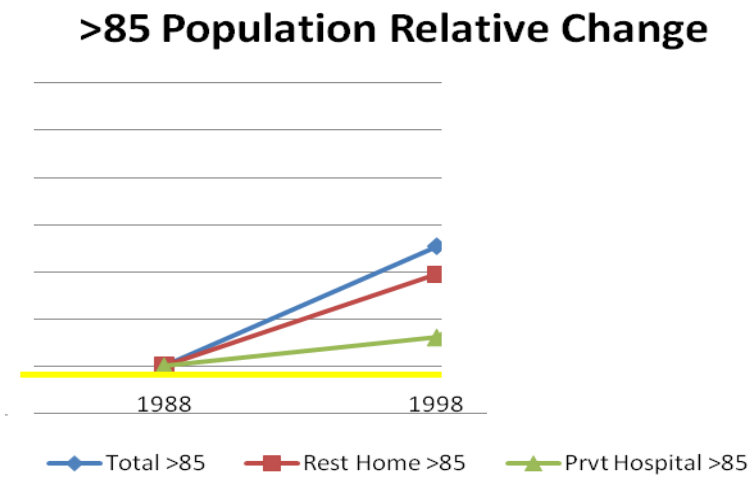
OLDER ADULT POPULATION CHANGES

	1986 total	1988 RH	1988 PH	1996 total	1998 RH	1998 PH	2006 total	2008 RH	2008 PH
>65 yrs	90,860	4,691	2,139	110,898	5,157	2,222	129,864	3,998	3,039
>85 yrs	7,230	1,944	914	10,898	2,700	1,025	15,366	2,406	1,666





Dementia in New Zealand

- Approximately 48,000 People Now
- 12,000 Newly Diagnosed Each Year
- 75,000 Estimated in 2026

DEMENTIA CLASSIFICATION

CORTICAL FEATURES

Alzheimer ’s Disease
Pick ’s disease
Lewy Body Disease
Fronto-Temporal Dementia

ISCHEMIC FEATURES

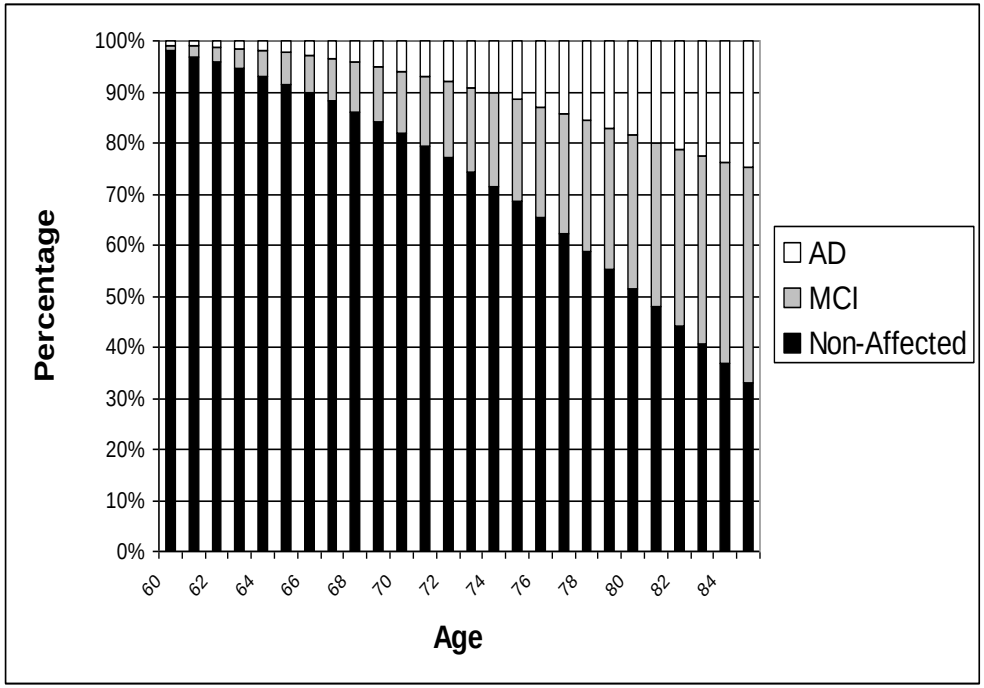
Vascular Dementia subtypes...

MOVEMENT DISORDERS

Huntington Disease
Parkinson’s disease

Mild Cognitive Impairment (MCI)

- Memory impaired but are otherwise functioning well and do not meet clinical criteria for dementia
- Symptoms include
  - Memory complaint, preferably with corroboration
  - Objective memory impairment
  - Normal general cognitive function
  - Intact activities of daily living
  - Not demented
- Increased risk for subsequent dementia
- There are currently no recommended treatments for MCI



Petersen RC. *Neurology*. 2001;56:1133-1142.
Petersen RC et al. *Arch Neurol.* 1999;56:303-308.

	Dementia	***Delirium***	***Depression***
Onset	Insidious, Slow, gradual & Relentless	Rapid over a short period of time, hours to days	Usually able to date onset with some precision
Course	Progressive or remitting	Fluctuates over 24 hours	Often not recognised or misdiagnosed in the elderly
Duration	Usually progresses until death	Brief, usually 1 week, rarely over 1 month	Self limiting, may last up to two years

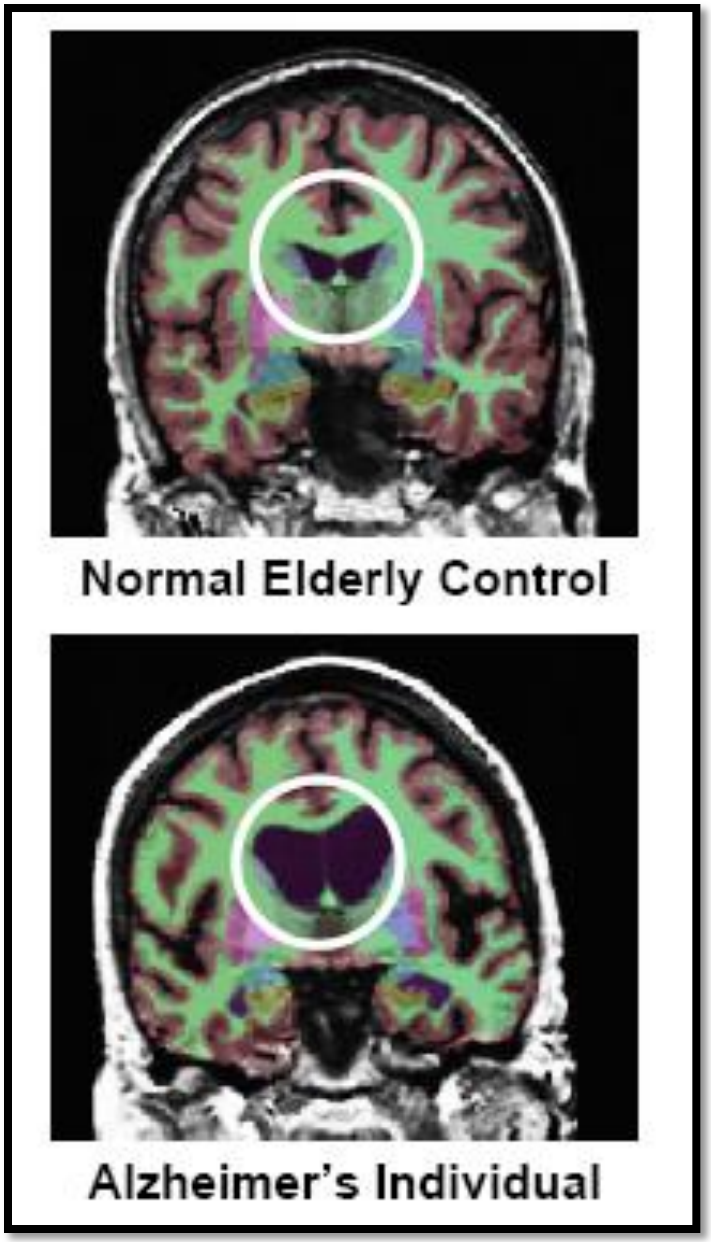
DELERIUM VS DEMENTIA

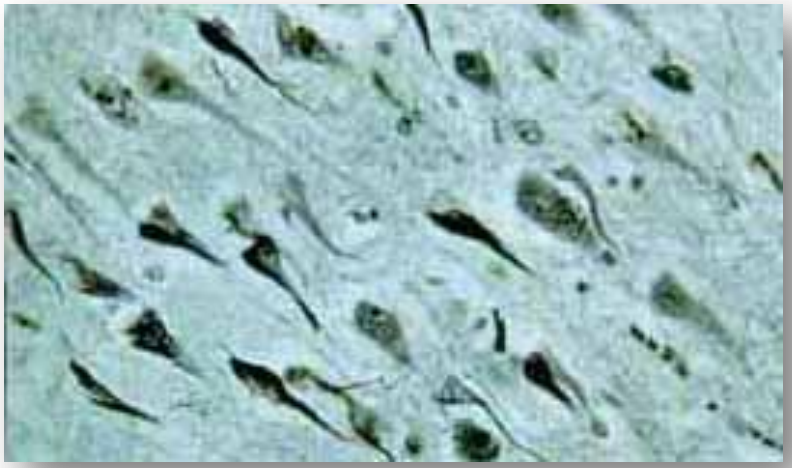
Confusion Assessement Method (CAM) of DELERIUM

1. Rapid Onset
2. Change in ability focus attention
3. Ability to focus fluctuates frequently
4. Disorganized Thinking
5. Altered Consciousness
6. Disorientation
7. Memory difficulties
8. Perceptual disturbance – hallucinations
9. Psychomotor Agitation or retardation
10. Altered Sleep/Awake cycles

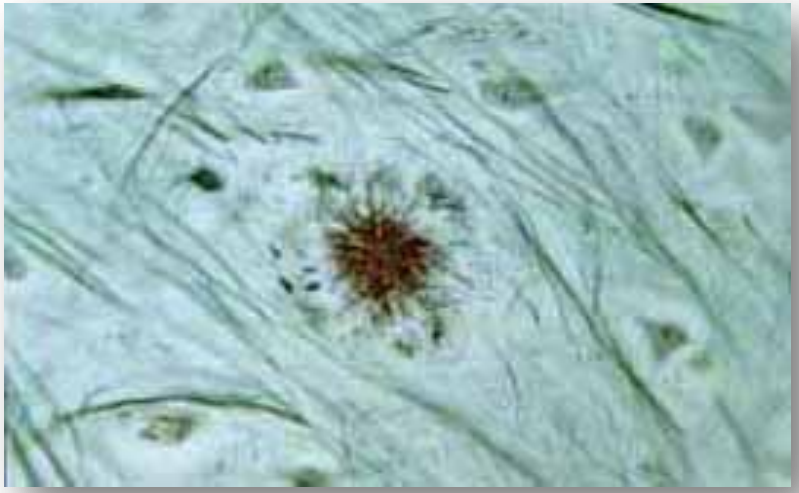
Laplante & Cole (2001)

Alzheimer's Disease Pathology

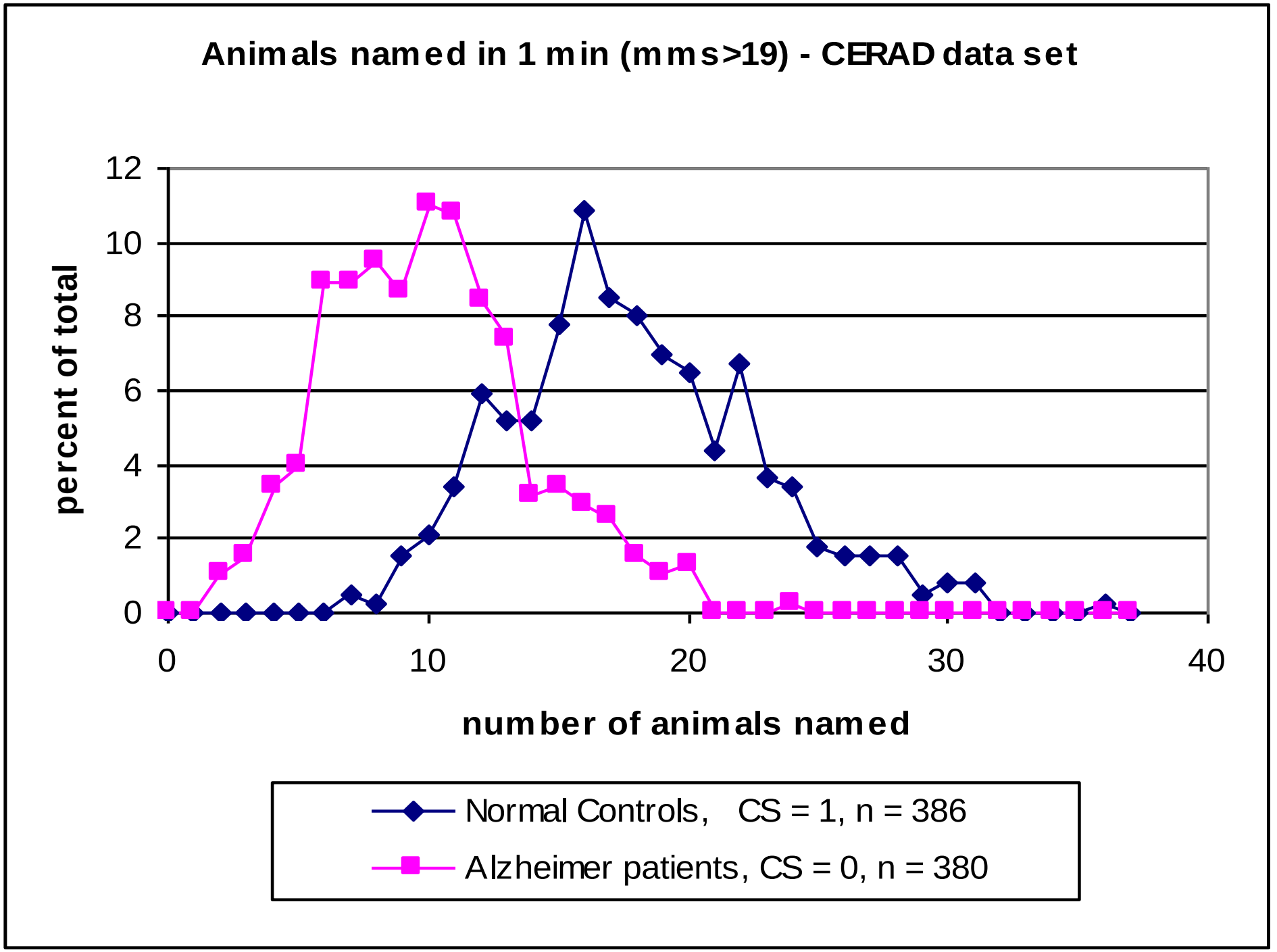




Neurofibrillary Tangle



Amyloid Plaque


Animals named in 1 min (mms>19) - CERAD data set
percent of total
12
10
8
6
4
2
0
0
10
20
30
40
number of animals named
Normal Controls, CS = 1, n = 386
Alzheimer patients, CS = 0, n = 380

CLOX:
an executive clock drawing task

J Neurol Neurosurg Psychiatry
1998;**64:**588-594

Donald R Royall, Jeffrey A Cordes, Marsha Polka

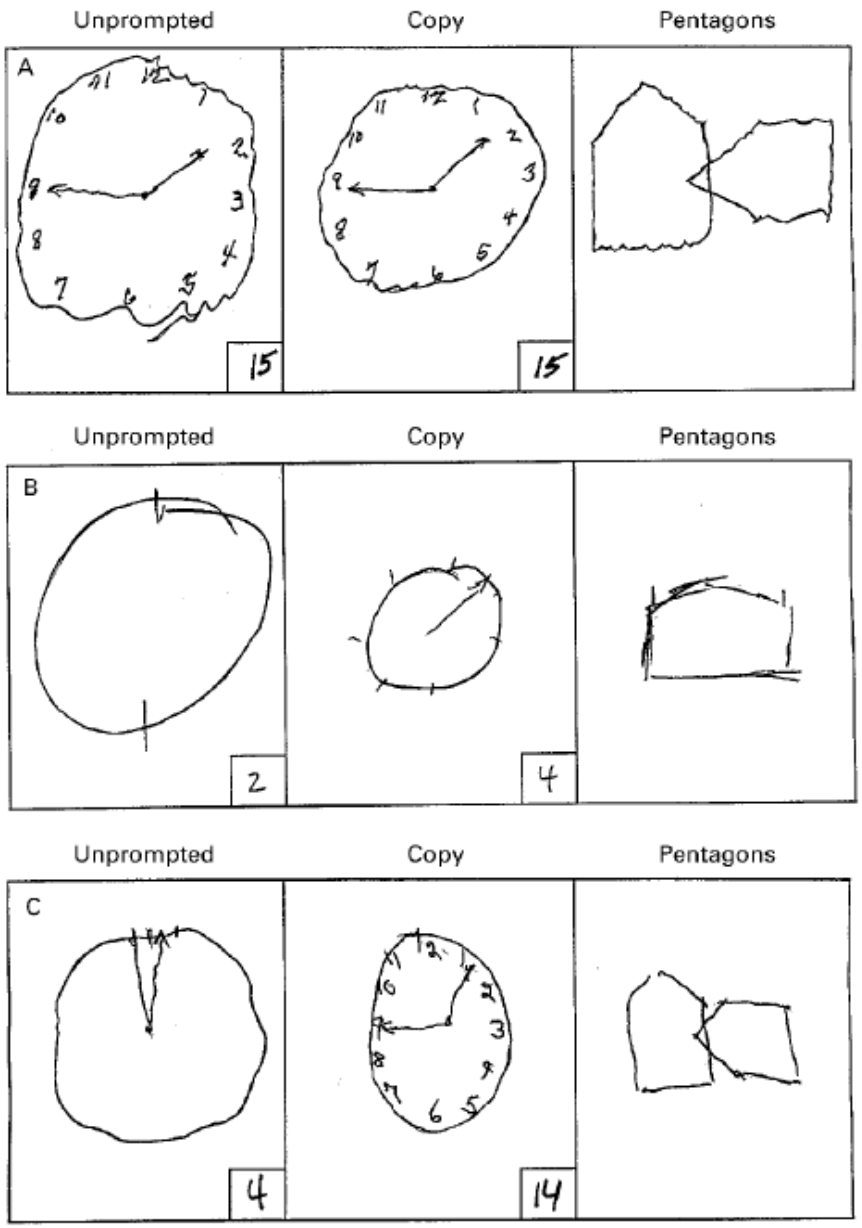
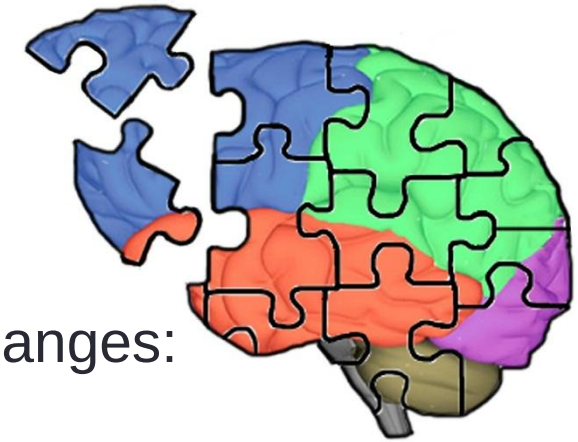


Figure 1 Qualitative differences in CLOX performance. in a normal elderly control, a patient with Alzheimer's disease, and a patient with non-cortical vascular disease. (A) An 82 year old elderly control. EXIT25=08/50 (scores>5/50 impaired), MMSE=29/30 (scores<24/30 impaired). (B) A 74 year old married white woman with Alzheimer's disease. EXIT25=21/50(24/50 comparable with six year old children or residents requiring skilled nursing), MMSE=12/30. (C) A 74 year old right handed white man with a history of coronary artery disease (status post myocardial infarction), hypertension, non-insulin dependent diabetes mellitus, and falls. EXIT22=24/50, MMSE=28/30.

Frontotemporal Dementia



- Decline in personal
- hygiene and grooming

- Mental rigidity and inflexibility

- Distractibility and impersistence

- Hyperorality and dietary changes

- Perseverative and stereotyped behavior

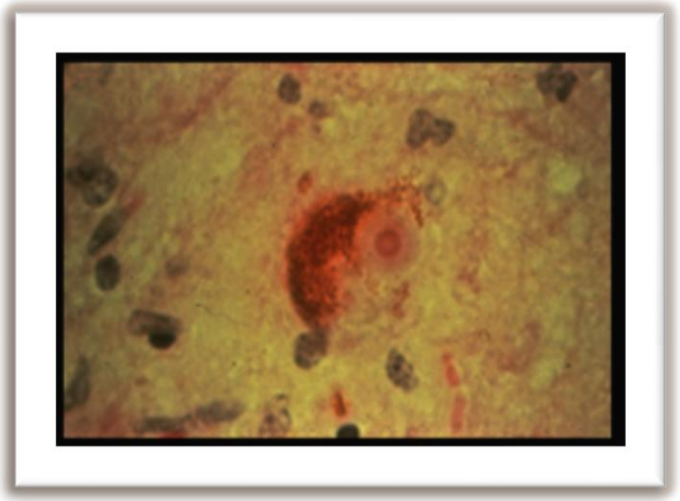
Behavioral Changes:

- Disinhibition
- Impulsiveness
- Tactlessness
- Impaired social judgment
- Apathy
- Depression

Perry RJ. *Neurology*. 2001;56:46-51.
Perry RJ. *Neurology.* 2000;54:2277-2284.
Morris JC. *Neurology*. 2001;57:173-174.

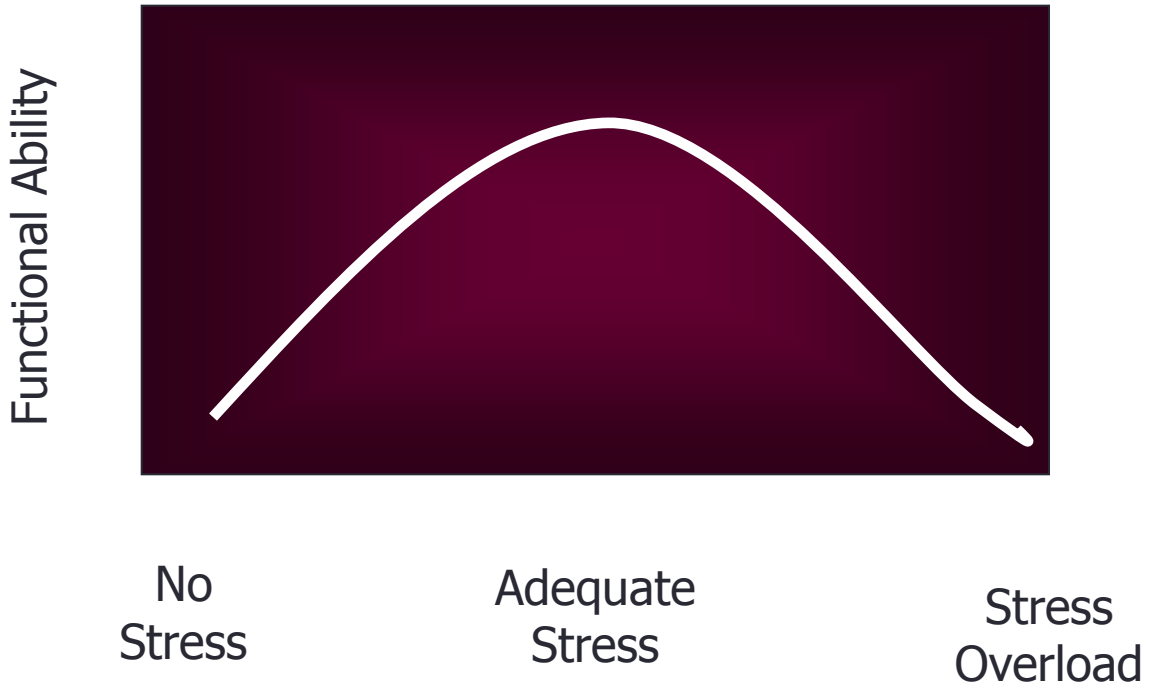
Dementia with Lewy bodies (LB)

- **LB contain deposits of the protein alpha-synuclein that is also linked to Parkinson's disease**
- **Symptoms**
  - **can range from traditional Parkinsonian effects**
    - **loss of spontaneous movement (bradykinesia)**
    - **rigidity (muscles feel stiff and resist movement)**
    - **tremor and shuffling gait**
  - **to effects similar to those of AD**
  - ***acute confusion & Hallucinations***
  - **loss of memory,**
  - **some loss of cognition**

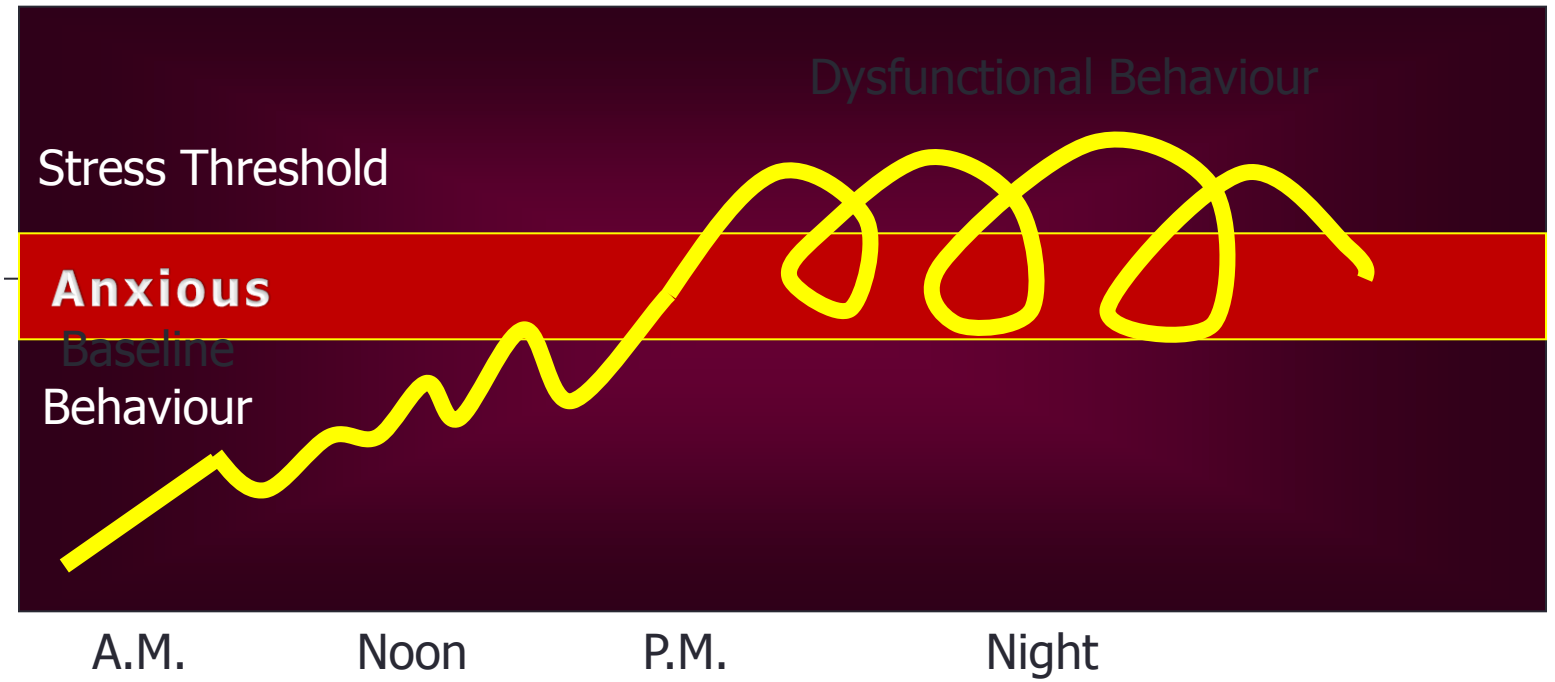


Progessively Lowered Stress Threshold (PLST)

- Stress is a necessary part of all of our lives
- Continuum of Stress



Progressively Lowered Stress Threshold



G. Hall 1994

Stressor: Fatigue

- ***Fatigue is the most common reason for stress overload***
  - Usually occur late in the day
    - Particularly after a taxing event – MD visit, party
- ***Frequent rest breaks are needed***
  - usually twice a day
  - Doesn't have to be sleep
  - Music, folding laundry etc.
- ***Physical exercise actually decreases fatigue and helps sleep patterns***

Stressor
Change in Environment or Routine

- Daily routines require are less stressful because they become automatic and require less thought

- Daily routine disruption can result in fear, frustration, anger and dysfunctional episodes

Timing is not as important as sequence

Stessor: Inappropriate Stimulus Levels

Overstimulation

- Large dining rooms can be noisy and disorienting for older people that are confused
- Look for symptoms of anxiety
  - Loss of eye contact
  - Aggression

- Follow the lead of the older person and protect them from prolonged exposure to an over-stimulating environment

Under stimulation is distressing as overstimulation

Stressor: Excessive Demands

Internal or External expectations are too high

- Short, simple requests
- Break a task down into simpler requests

Frustration, fear, anger and anguish results

- from trying activities that exceed ability

Ability may change from day to day

Reorientation to time or day or location may be too much

- Validation techniques may help instead of reorientation

Visual or Hearing impairments may increase demands

Behavioral Approaches

- Break down activities that may be overwhelming into simple tasks
- Use structured activities and routines to combat boredom and provide external structure
- Change environment rather than patient (e.g. disable stove, make all clothes pull-on sweats in matching colors)
- Quiet voice, simple words and sentences
- Music
- Touch

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

Q1. Vocalisation (eg whimpering, groaning, crying)
Absent 0 Mild 1 Moderate 2 Severe 3

Q2. Facial expression (eg looking tense, frowning, grimacing, looking frightened)
Absent 0 Mild 1 Moderate 2 Severe 3

Q3. Change in body language (eg fidgeting, rocking, guarding part of body, withdrawal)
Absent 0 Mild 1 Moderate 2 Severe 3

Q4. Behavioural change (eg ↑ confusion, refusing to eat, alteration in usual pattern)
Absent 0 Mild 1 Moderate 2 Severe 3

Q5. Physiological changes (eg temp, pulse/BP outside normal limits, perspiring, flushing, pallor)
Absent 0 Mild 1 Moderate 2 Severe 3

Q6. Physical changes (eg skin tears, pressure areas, arthritis, contractures)
Absent 0 Mild 1 Moderate 2 Severe 3

Total pain score

Tick the box that matches the total pain score

0-2 No pain	3-7 Mild	7-13 Moderate	14+ Severe

Tick the box that matches the type of pain

Chronic	Acute	Acute on chronic

Abbey, J 'Ageing, Dementia and Palliative Care' in O'Connor, M and Aranda, S (Eds) 2003 Palliative Care Nursing . A guide to practice , Ausmed Publications, Melbourne, pp. 313-339 (the pain scale is on page 323).

Jennifer Abbey, Neil Piller, AnitaDe Bellis, Adrian Esterman, Deborah Parker, Lynne; Giles and Belinda Lowcay (2004) The Abbey pain scale: a 1-minute numerical indicator for people with end-stage dementia , *International Journal of Palliative Nursing*, Vol 10, No 1pp 6-13.

Communication Skills to Reduce Confusion

- Observation is important
  - Focus on the feeling behind the communication
  - Look for non-verbal messages
  - Base your interaction on the persons reality

- Caregiver Attitude is important
  - Unconditional positive regard
  - Give full, undivided attention
  - Be respectful and sincere
  - Know as much as you can about the persons background/likes/dislikes

Intervention into Difficult Behaviours

- Write out a plan of action
- Work the plan and continue observation for several days
  - What works
  - What is not working
  - All caregivers to write observations
- Team communication and cooperation
- Re-evaluation after a few days

The advantage of a bad memory is that one enjoys several times the same good things for the first time.

Friedrich Nietzsche