Enlighten

Changing Minds in Memory Care

An individualized abilities-based therapy program intended to provide multi-disciplinary customized care for individuals with dementia by maximizing their safety, improving quality of life and decreasing the burden of care giving.

Weston Healthcare Group

Introduction

The Weston Healthcare Group is pleased to acknowledge the work of those who participated in the creation and ongoing development of Enlighten. Many hours have been spent with families, caregivers and staff who have worked diligently to provide the best possible care for individuals with dementia.

A special word of appreciation is due to the tireless efforts of two of Weston Healthcare Group's excellent therapists. Many thanks are extended to Jessica Byers M.Ed, MS, OTR/L and Adria Thompson MA CCC-SLP. Without their expertise and passion, this program would not have been possible.

"Enlighten was not created because we set out to develop a written therapy program. It is a collaboration of our training, education, clinical experience and creativity inspired by the residents we have been honored to serve over the last few years as clinicians. When we started to view "behaviors" as unmet needs or symptoms, it quickly became clear to us that we needed to rethink our approach to therapy for our residents with dementia. The burden of care for our staff was immense and we felt we had the ability to lighten it! As clinicians, we understood that caregiver education is a key component of any therapy for this population but we wanted to make that education useful, accessible, and consistent. We tackled the most challenging "behaviors" and tried a variety of therapeutic approaches to identify and meet the resident's need. As we worked together to solve these problems and communicate our ideas to staff, we began to have positive results. This helped the facility staff to better understand and appreciate our role as well as view therapy as a resource. This approach *worked* and it benefited our residents. Thus, the idea for Enlighten was born and continues to grow and expand every day. The Enlighten document and associated materials enclosed are to be considered fluid and a constant work in progress.

Through the implementation of this program, we hope to foster an approach to memory care that emphasizes the relationship between all persons involved in providing care for individuals with dementia. This not only includes therapists, but all other facility staff (resident assistants, aides, nurses, administration, etc). What sets this program apart from other dementia programming is that Enlighten is facilitated by therapists. We do not want this to be viewed as another job duty to complete or something to feel burdened by, but rather a way of changing your perspective on what therapy can look like for this population, what constitutes success or progress and what our expectations should be for our residents. It is a way to recognize and document your unique role and skill as a clinician to support caregivers and benefit our residents.

We look forward to working together to improve the lives of our residents with dementia."

Jessica Byers M.Ed. MS. OTR/L

Adria Thompson MA CCC-SLP

Table of Contents

Enlighten Overview

Enlighten is an individualized abilities-based therapy program intended to provide multi-disciplinary customized care for individuals with dementia by maximizing their safety, improving quality of life and decreasing the burden of caregiving.

1 **Evaluation.** Occupational, physical, and speech therapists use skilled analysis for all areas of physical, cognitive, and functional abilities to determine a baseline. The Brief Cognitive Rating Scale (BCRS) and the Global Deterioration Scale (GDS) are used to determine the resident's stage of dementia.

2 **Treatment.** Using evidence-based interventions, therapists provide treatment sessions intended to target areas of greatest need as determined through skilled evaluation and caregiver report. Montessori based activities are utilized to determine what functional, appropriate, meaningful and enjoyable activities can be used that appropriately challenge the resident's cognitive and physical abilities.

3 **Training.** Therapists develop individualized ***Resident Profiles*** for each person on therapy caseload which outlines the communication strategies, ADL techniques, activity recommendations and any other pertinent details to caregivers in order to generalize progress made in therapy and ensure carryover.

4 **Reassessment.** Reassessment occurs every 30 days for 90 days after the initial treatment certification period is complete. This is repeated quarterly or more often as needed. During reassessment, therapists utilize skilled analysis, caregiver interviews and clinical judgment to determine if recommendations are still appropriate. All information is compared to prior level of function.

Goal of Enlighten

We want to create memory care communities where residents are living purpose-filled, meaningful lives as independently and safely as possible. As clinicians, we understand that dementia is progressive and we will not restore someone to their neurotypical level. However, our skilled services are essential in maximizing independence, safety, and quality of life while reducing the impact of disease progression on the individual, families, and caregivers.

Enlighten will foster an approach to memory care that emphasizes the relationship between all persons involved in providing care for individuals with dementia. The unique feature of Enlighten is that it is facilitated by skilled clinicians who will make highly individualized recommendations to improve the care and lives of people living in memory care communities.

The goal of Enlighten is to empower and educate caregivers on the most appropriate ways to care for, communicate with, support and challenge residents based on his or her physical and cognitive abilities.

Why is this valuable?

Enlighten can also offer many benefits to a community that can not only enhance the quality of care, but serve as part of a marketing tool to attract new residents and qualified employees.

- ***Support aging in place.***

  Enlighten can help create an environment that anticipates and responds to the ever-changing needs of residents with dementia in order to maintain individuals at their maximum functional potential for as long as possible.

- ***Reduce caregiver burden.***

  Because resident assistants have numerous high-need residents to care for, they are not able to invest the time it takes to trial various approaches and strategies with each individual. As therapists, we use our skills to identify successful communication strategies and appropriate cueing methods for ADL support and mobility. This is accomplished by reducing the time and stress involved in caring for challenging residents. This approach should help caregivers feel more confident in addressing challenging behaviors and increase knowledge of specific residents.

- ***Reduce challenging, unsafe or adverse behaviors.***

  If residents feel purpose and their days are filled with meaningful, cognitively stimulating tasks, they are much less likely to wander, exit seek and fall. Therapists can help develop prevention strategies to empower the resident assistants' ability to take a proactive approach in managing problematic behaviors.

- ***Increase patient and family satisfaction and quality of life.***

  Enlighten helps residents feel content and stay as independent and safe as possible within the limits of the disease. Enriching their daily lives with cognitively stimulating activities that foster a sense of belonging, purpose, and joy will improve quality of life and overall wellness.

- ***Provide an alternative for the use of psychiatric medications and/or hospitalizations.***

  Through the use of skilled analysis and intervention, therapists can educate all caregivers on approach techniques, redirection strategies, sensory strategies and environmental factors that can be used to address aggression, agitation, anxiety and delusions.

- ***Increase resident retention.***

  Using the Resident Profiles, we can educate outside medical providers with recommendations for communication and prior level of function. This facilitates ease in transition from one facility to another. If all providers have a shared understanding of an individual, we can increase the likelihood that the resident will return to the community without experiencing further decline.

- ***Decrease the stigma among therapists, caregivers, families and community.***

  We may hear that it's "pointless" to have people with dementia on caseload because "there is no progression, no carryover, or seemingly no changes in abilities". We want to shift the focus of therapy from *restoration* to maximizing *safety*, improving *quality of life* and *decreasing burden of care*. We also want to encourage family members to consider memory care communities as a safe, supportive environment where their loved one can age in place with caregivers who understand the disease and its progression.

Foundational Knowledge

In order to provide the best care for our residents, we need to have a foundational understanding of their disease, the underlying neurological impairments, prognosis and expectations for physical and cognitive deficits. It is vital to then educate caregivers in order to advocate for our patients.

Use the following few pages to serve as a starting point in further researching the neurological intricacies of dementia and the other neurodegenerative diseases our residents experience. Once we have a thorough understanding of how the disease manifests itself, we can begin to change our perspective of "*managing behaviors*" to "*reducing the impact of symptoms*". We should encourage caregivers to view all "*behaviors*" as unmet needs. Our role as skilled clinicians is to help identify what needs are not being met and the best approach to take when trying to meet those needs.

For example, when treating an individual with congestive heart failure, we would not view symptoms of edema, shortness of breath or fatigue as ways the person is trying to manipulate us or gain attention. We understand these are physical manifestations of an underlying medical condition and respond in ways to reduce the effects of these symptoms on our resident's daily routine.

Similarly, when treating an individual with dementia with Lewy bodies, we would not view symptoms of hallucinations, aggression or paranoia as attempts to get attention or to make our jobs more difficult. We understand these are the ways in which the underlying neurological processes are impacting the patient's ability to process information, respond to his environment and communicate his needs.

Common Neurodegenerative Diseases: Hallmark Features

Alzheimer's Disease
Caused by plaques and tangles built up inside the brain affecting how cells communicate with each other. Hallmark Features: Individuals experience memory loss of recent events and learning new information.
Vascular Dementia
Caused by ischemic changes in the brain Hallmark Features: The symptoms depend on the part of the brain that has been damaged and the onset can be gradual or sudden. Common early changes are difficulty planning, thinking quickly, or concentrating. Memory loss is not always common in early stages.
Dementia with Lewy Bodies and Parkinson's Dementia
Involves clumps of protein inside nerve cells, called Lewy bodies Hallmark Features: Individuals experience changes in alertness, planning, reasoning, and problem solving with wide fluctuations noted from one day to the next or one moment to the next. Visual hallucinations, slow rigid movements, sleep disturbances, and balance issues are also common.
Frontotemporal Dementia
Also known as "Pick's Disease", this disorder affects the frontal and temporal lobe of the brain. People are often diagnosed in their mid-forties. Hallmark Features: Individuals experience drastic and sudden changes in personality which can cause social inappropriateness, impulsivity, and loved ones reporting individuals are "not themselves." Changes also occur in ability to communicate.
Creutzfeldt-Jakob Disease
Rare brain disorder which runs a rapid course causing death within one year. "Mad cow" disease is one cause of this disease. Hallmark Features: Individuals demonstrate poor memory, behavioral changes, coordination deficits, and visual disturbances
Korsakoff Syndrome
Caused by excessive alcohol consumption Hallmark Features: Individuals demonstrate difficulty learning new information, inability to recall recent events, and gaps in long term memory. These individuals confabulate, or make up information, and because they maintain the ability to verbally communicate and socialize, they can be very believable.
Huntington's Disease
Caused by a defective gene generally diagnosed when individuals are in their 30s-50s Hallmark Features: Individuals demonstrate uncontrolled movements (chorea), decline in thinking and reasoning, decline in memory, concentration, judgment, planning, and organization. Neurological symptoms include depression, anxiety, irritability, and obsessive-compulsive behavior causing the person to repeat the same question or activity over and over.

Heape, A. (2016, May). Forget Me Not...Evaluation and Treatment of the Patient with Dementia, Part 3: Evidence-based Treatments. *SpeechPathology.com,* Article 3236.Retrieved from: http://www.speechpathology.com

Stages of Dementia
Global Deterioration Scale (GDS)

The foundation of this program is determining a resident's stage of dementia which will guide our treatment, training and reassessments. One of the most well known (and the one used in this program) is the **Global Deterioration Scale (GDS)** designed by Dr. Barry Reisberg in 1983. It is widely used to describe cognitive decline of individuals with primary degenerative dementia such as Alzheimer's disease. There are 7 identifiable stages of dementia with 7 being the most severe.

Stage 1- No Dementia

- No subjective or objective evidence of cognitive decline

Stage 2- Age Associated Memory Impairment

- The individual begins to notice lapses in memory but other people don't notice
- No detectable deficits evident in a medical examination

Stage 3- Mild Cognitive Impairment

- Mental age equivalent: **teenager-20 year old**
- Others start to notice deficits
- Deficits can be detected with an *in depth* medical interview
- Trouble remembering names
- Losing or misplacing valuable objects
- Impulsive
- May skip steps to get things done faster – focus on instant gratification
- Defensive easily when addressing deficits
- Problems thinking of the right words to say

Stage 4- Moderate Cognitive Decline (Mild Dementia)

- Duration: approximately 2 years
- Mental age equivalent: **8 to 16 years old**
- 4oz brain tissue lost
- Clear cognitive problems are noticeable with medical interview
- Forgetfulness of **recent** events
- Frequently, these individuals will realize they have dementia or some cognitive changes. This loss of control often result in manifestations of **anger, confusion, and depression**
- Safety awareness decreases and the ability to multi-task deteriorate.
- Increased difficulty with word-finding
- Orientation and short term memory declines

Stage 5: Moderately Severe Cognitive Decline (Moderate Dementia)

- Mental age equivalent- **4 to 8 year old**
- 1lb of brain tissue lost
- Person can no longer live alone without help.
- Difficulty recalling major, relevant aspects of his/her CURRENT life (address, phone number), names of family members (grandchildren), and names of schools attended.
- Disoriented to time or place (may not know season, day of week, or where they are)
- Word finding deficits more noticeable
- Significant deficits in concentration (cannot count backwards from 20 by 2's)
- Easily distracted, short attention-span
- May be able to retain major facts about themselves or others (where they grew up, spouse's name)
- Has the physical abilities to complete self-care tasks (toileting, dressing, eating) but may need help choosing proper clothing for season or occasion)
- May start to resist help with self-care
- Sundowning is very common

Stage 6: Severe Cognitive Decline (Moderately Severe Dementia)

- Mental age equivalent- **2 to 4 year old**
- 1½ lbs of brain tissue lost
- **Personality changes** may occur
- Memory continues to worsen
- Person will lose awareness of recent experiences and surroundings.
- May remember own name but have trouble recalling personal history.
- Can recognize between familiar and unfamiliar faces but cannot recall names of spouse or caregiver.
- Requires extensive help with self-care (dressing self, toileting)
- Wandering is common, person may get lost.
- Incontinence is often present and major changes in sleep patterns occur.
- Increase in adverse "behaviors". Person may curse or use slurs.
- Major communication breakdown is obvious.
- Visual spatial changes occur (depth perception))

Stage 7: Very Severe Cognitive Decline (Severe Dementia)

- Mental age equivalent- **infant to 1 year old**
- 1 ½ to 2 lbs brain tissue lost
- Person loses ability to respond to their environment.
- Difficulty controlling movements.
- Person may still say words, phrases, unintelligible utterances, or may be non-verbal.
- May lose ability to smile, sit without support, or hold head up without assist.
- Reflexes become abnormal. Developmental neurological reflexes are present (grasp, tonic bite).
- Muscles grow rigid. Basic psychomotor functions are lost.
- Swallowing is impaired.

Heape, A. (2016, May). Forget Me Not...Evaluation and Treatment of the Patient with Dementia, Part 3: Evidence-based Treatments. *SpeechPathology.com,* Article 3236.Retrieved from: http://www.speechpathology.com

Neurophysiological Effects of Dementia

UNDERLYING IMPAIRMENTS	FUNCTIONAL DEFICITS
• Impaired alertness or arousal • Ideomotor/Motor apraxia • Ideational apraxia • Spatial Neglect (unilateral neglect) • Decreased proprioception (body awareness) • Decreased awareness of spatial relations • Receptive and/or expressive aphasia • Executive functioning deficits (working memory, emotional regulation, task initiation & completion, planning, prioritizing, processing speed, orientation, attention, self-monitoring, impulse control, cognitive flexibility, foresight, hindsight, self-talk, problem-solving, persistence, and shift) • Specific memory loss (STM, LTM, procedural) • Neurological dysregulation • Muscle rigidity/stiffness • Tremors • Balance deficits • Bradykinesia • Shuffling/Festinating gait • Akinesia • Dysphagia • Muscle weakness or changes in tone (hyperflexia) • Vision/Perceptual changes • Psychological conditions (anxiety, mood) • Dysmetria • Agnosia • Paratonia (involuntary resistance to passive movement)	• Falls • Poor safety awareness • Wandering/Exit seeking • Agitation • Physical aggression • Confusion • Disorientation to time, place, situation, person • Difficulty following directions/commands • Perseveration • Sexual inappropriateness • Paranoia/Persecutory thinking • Fear • Changes in sleep patterns • Difficulty/lack of communication • Flat affect/emotionally flat • Emotional lability • Impulsivity • Personality changes • Inability to start or finish familiar tasks • Inability to learn new tasks • Incontinence • Neglect of self-care/poor hygiene • Changes in eating or appetite • Hallucinations • Lack of interest in preferred activities • Social isolation • Verbal outbursts/calling out • Apathy • Repetitive questioning • Depression • Mood swings • Psychosis • Choking/coughing (when eating) • Weight loss • Difficulty adapting to change • Lack of sense of direction • Inability to see color • Disinhibition • Decreased topographical orientation

Memory

Sensory Memory- Less than 1 second in length, this information comes from our 5 senses and is either recognized and utilized or unconsciously ignored.

Short Term Memory- about 30 seconds long (different theories state different durations). This is the holding of a small amount of information that is readily available to be used.

- *Working Memory*- limited to the person's attention, working memory utilizes and manipulates information obtained from short term memory and long term memory in order to carry out cognitive tasks.

Long Term Memory- information stored for a long period of time.

- *Declarative Memory*- also referred to as explicit memory. This information you are aware of and has been consciously learned.
  - Episodic- events
  - Semantic- facts

- *Procedural Memory*- also known as implicit memory because it is unconsciously stored. This is the knowledge of *how* to do things.

Step One: Evaluation

Determination of Stage of Dementia

The foundation of this program is determining the individual's stage of dementia, often referred to as staging. This information will be the basis of our treatment, training and reassessments. Dr. Barry Reisberg developed the **Global Deterioration Scale (GDS)** in 1983. It is widely used to describe cognitive decline of individuals with primary degenerative dementia such as Alzheimer's disease. There are 7 stages of dementia with 7 being the most severe. One of the most effective ways to determine an individual's GDS stage is through the administration of the **Brief Cognitive Rating Scale (BCRS)**. The BCRS can be completed by any therapist (PT, OT or SLP) utilizing questions provided and with caregiver interview. The BCRS assesses five axes including four related to cognition and one related to functional abilities. The **Functional Assessment Staging (FAST)** can be helpful in scoring the fifth axis of functional abilities. The GDS, BCRS, and FAST are available for free online.

Other Assessment Tools

In addition to determining an individual's stage of dementia, other assessments will aid in developing a treatment plan. Please utilize any assessment for your discipline that will help create a full picture of the individual's abilities and deficits. Examples of assessments include but are not limited to the following.

- Cognition and Communication
    - Cognitive screening instruments- Mini-Mental Status Examination (MMSE), Montreal Cognitive Assessment (MoCA), Saint Louis University Mental Status (SLUMS) – these return a basic pass/fail or normal/abnormal score
    - Ross Information Processing Assessment Geriatric 2nd edition (RIPA-G:2)– comprehensive assessment battery for cognitive-linguistic deficits for individuals with mild cognitive impairment or mild dementia
    - Functional Linguistic Communication Index (FLCI) – assessment of functional communication for individuals with moderate-severe dementia
    - Allen Cognitive Level Scale (ACLS)- assessment of cognitive processes that affect functional performance
    - Loewenstein Occupational Therapy Cognitive Assessment Geriatric (LOTCA-G) – assess persons with neurological deficits with subtests in six cognitive areas of orientation, visual and spatial perception, praxis, visuomotor organization, and thinking operations

- ADLs, Functional Mobility, and Gait
    - Tinetti Test- clinical test for assessing a person's static and dynamic balance abilities
    - Barthel Index of Activities of Daily Living- assessment of functional independence
    - Functional Independence Measure (FIM)- measures patient's burden of care with self-care and functional mobility
    - Routine Task Inventory (RTI)- based on the ACLS- activity analysis and a functional evaluation instrument
    - Timed Up and Go Test (TUG)- assessment of a person's mobility and requires static and dynamic balance
    - Berg Balance Scale- test of a person's static and dynamic balance
    - Functional Reach Test- measure of balance

Additional Evaluation Considerations

- ***Adverse Behaviors***- If the individual demonstrates adverse behaviors, consider documenting frequency over a time frame as a baseline to compare after treatment. For example, if the resident frequently exit seeks, document how many times he attempts to open outside doors over the course of an hour.
- ***Falls***- Consider documenting frequency and details of recent falls in order to find any patterns. Consult with nursing as they may have this information.
- ***Caregiver Questionnaire and Interview***- Use the questionnaire provided to determine what areas are difficult for caregivers in their interactions with each resident. These areas should be a focus for treatment and training.
- ***Personal History-*** Collaborate with activity staff and family to determine resident's interests, hobbies, past occupation, etc. to guide treatment to include preferred and meaningful details.

Plan of Care

It is important to be flexible when creating your plan of care for an individual with dementia. You may often find you have to make more modifications to goals, skilled interventions or frequency and duration throughout your certification period.

When treating residents with a progressive neurological disease, it is also crucial to monitor and reevaluate your goals at each session or 10th visit progress note to ensure they are still realistic, attainable and appropriate for that individual. You may realize that goals you originally set are not appropriate. Either they are too difficult or they were met quickly with intervention. Update and modify your goals as needed to reflect the individual's strengths, functional deficits, response to treatment and progress.

It may also be necessary to do a recertification to change the frequency and/or duration of therapy to meet your resident's needs. If you find yourself spending more time with a particular resident or struggling to provide skilled services at every session, modifications to the plan of care may be indicated. For example, you may need to increase frequency for high-need residents.

Goals for the individual may also differ from those you created for neurotypical patients. Goals should be focused on function. This is where your information obtained from caregivers and family will be utilized most. What tasks and activities are the most difficult to complete and what are the underlying neurological impairments causing these functional deficits?

Examples of Goals
OT: In 3 weeks, Bill will complete upper body dressing with min assist and use of appropriate verbal cues for patient's cognitive stage of 5.2 from trained caregivers. PT: Rodney will perform sit <> stand transfers with min assist and verbal cues from a variety of surfaces (chair, bed, toilet) in 2 weeks to increase safety. ST: In 3 weeks, Alice will increase sustained attention to meaningful activities with set up assist for at least 30 minutes, 5/7 days per week.

Tips for Goal Development

- ✓ Avoid making goals that are too specific that might limit your intervention choices or narrow your thinking.
    - General: *Joe will utilize external memory aids for temporal concepts to compensate for poor short term memory 80% of opportunities in 4 weeks.*
    - Specific: *Joe will utilize daily planner in order to record appointments 80% of opportunities in 4 weeks.*
- ✓ Refer to the expected functional independence levels based on the resident's cognitive stage so you aren't setting goal expectations too high and creating unattainable outcomes.
- ✓ Include application of the cognitively appropriate cueing methods you develop and train caregivers on during treatment.
    - Example: Jean *will decrease physical aggression during showering 50% of the time with utilization of de-escalation strategies and cueing techniques by trained caregivers in 6 weeks.*
- ✓ Refer to the Enlighten Guide for Environmental & Task Analysis to help identify specific aspects of a task or skills to address during the goal setting process.

The Global Deterioration Scale for Assessment of Primary Degenerative Dementia

The **Global Deterioration Scale (GDS),** developed by Dr. Barry Reisberg, provides caregivers an overview of the stages of cognitive function for those suffering from a primary degenerative dementia such as Alzheimer's Disease. It is broken down into 7 different stages. Stages 1-3 are the pre-dementia stages. Stages 4-7 are the dementia stages. Beginning in Stage 5, an individual can no longer survive without assistance. Within the GDS, each stage is numbered (1-7), given a short title (i.e., Forgetfulness, Early Confusional, etc.) followed by a brief listing of the characteristics for that stage. Caregivers can get a rough idea of where an individual is at in the disease process by observing that individual's behavioral characteristics and comparing them to the GDS. For more specific assessments, use the accompanying Brief Cognitive Rating Scale (BCRS) and the Functional Assessment Staging (FAST) measures.

Level	Clinical Characteristics
1 **No cognitive decline**	No subjective complaints of memory deficit. No memory deficit evident on clinical interview.
2 Very Mild Cognitive Decline **(Age Associated Memory Impairment)**	Subjective complaints of memory deficit, most frequently in following areas: (a) forgetting where one has placed familiar objects; (b) forgetting names one formerly knew well. No objective evidence of memory deficit on clinical interview. No objective deficits in employment or social situations. Appropriate concern with respect to symptomatology.
3 Mild Cognitive Decline **(Mild Cognitive Impairment)**	Earliest clear-cut deficits. Manifestations in more than one of the following areas: (a) patient may have gotten lost when traveling to an unfamiliar location; (b) coworkers become aware of patient's relatively poor performance; (c) word and name finding deficit becomes evident to intimates; (d) individual may read a passage or a book and retain relatively little material; (e) individual may demonstrate decreased facility in remembering names upon introduction to new people; (f) individual may have lost or misplaced an object of value; (g) concentration deficit may be evident on clinical testing. Objective evidence of memory deficit obtained only with an intensive interview. Decreased performance in demanding employment and social settings. Denial begins to become manifest in patient. Mild to moderate anxiety accompanies symptoms.
4 Moderate Cognitive Decline **(Mild Dementia)**	Clear-cut deficit on careful clinical interview. Deficit manifest in following areas: (a) decreased knowledge of current and recent events; (b) may exhibit some deficit in memory of one's personal history; (c) concentration deficit elicited on serial subtractions; (d) decreased ability to travel, handle finances, etc. Frequently no deficit in following areas: (a) orientation to time and place; (b) recognition of familiar persons and faces; (c) ability to travel to familiar locations. Inability to perform complex tasks. Denial is dominant defense mechanism. Flattening of affect and withdrawal from challenging situations frequently occur.

5 Moderately Severe Cognitive Decline **(Moderate Dementia)**	Individual can no longer survive without some assistance. Individual is unable during interview to recall a major relevant aspect of their current lives, e.g., an address or telephone number of many years, the names of close family members (such as grandchildren), the name of the high school or college from which they graduated. Frequently some disorientation to time (date, day of week, season, etc.) or to place. An educated person may have difficulty counting back from 40 by 4s or from 20 by 2s. Persons at this stage retain knowledge of many major facts regarding themselves and others. They invariably know their own names and generally know their spouses' and children's names. They require no assistance with toileting and eating, but may have some difficulty choosing the proper clothing to wear.
6 Severe Cognitive Decline **(Moderately Severe Dementia)**	May occasionally forget the name of the spouse upon whom they are entirely dependent for survival. Will be largely unaware of all recent events and experiences in their lives. Retain some knowledge of their past lives but this is very sketchy. Generally unaware of their surroundings, the year, the season, etc. May have difficulty counting from 10, both backward and, sometimes, forward. Will require some assistance with activities of daily living, e.g., may become incontinent, will require travel assistance but occasionally will be able to travel to familiar locations. Diurnal rhythm frequently disturbed. Almost always recalls their own name. Frequently continue to be able to distinguish familiar from unfamiliar persons in their environment. Personality and emotional changes occur. These are quite variable and include: (a) delusional behavior, e.g., may accuse their spouse of being an impostor, may talk to imaginary figures in the environment, or to their own reflection in the mirror; (b) obsessive symptoms, e.g., person may continually repeat simple cleaning activities; (c) anxiety symptoms, agitation, and even previously nonexistent violent behavior may occur; (d) cognitive abulla, i.e., loss of willpower because an individual cannot carry a thought long enough to determine a purposeful course of action.
7 Very Severe Cognitive Decline **(Severe Dementia)**	All verbal abilities are lost over the course of this stage. Frequently there is no speech at all -only unintelligible utterances and rare emergence of seemingly forgotten words and phrases. Incontinent of urine, requires assistance toileting and feeding. Basic psychomotor skills, e.g., ability to walk, are lost with the progression of this stage. The brain appears to no longer be able to tell the body what to do. Generalized rigidity and developmental neurologic reflexes are frequently present.

Reisberg, B., Ferris, S.H., de Leon, M.J., and Crook, T. The global deterioration scale for assessment of primary degenerative dementia. American Journal of Psychiatry, 1982, 139: 1136-1139.

Brief Cognitive Rating Scale (BCRS)

The **BCRS** is an assessment tool to be used with the Global Deterioration Scale (GDS) to help stage a person suffering from a primary degenerative dementia such as Alzheimer's Disease. Developed by Dr. Barry Reisberg, this assessment tool tests five different areas known as Axis (4 cognitive and 1 functional). For the first four axes, the tester will ask a variety of questions to determine the level of impairment. The results of the fifth axis (Functioning) are determined primarily by observation. After a score is determined for each Axis, total the results and divide by 5. This answer will result in a stage corresponding to the GDS.

Assessment					**Brief Cognitive Rating Scale (BCRS)**
Date	Date	Date	Date	Date	
Rating	Rating	Rating	Rating	Rating	
(Circle the Highest Rating Attained)					**Axis I: Concentration**
1	1	1	1	1	No objective or subjective evidence of deficit in concentration.
2	2	2	2	2	Subjective decrement in concentration ability.
3	3	3	3	3	Minor objective signs of poor concentration (e.g., subtraction of serial 7's from 100)
4	4	4	4	4	Definite concentration deficit for persons of their backgrounds (e.g., marked deficit on serial 7s; frequent deficit in subtraction of serial 4s from 40).
5	5	5	5	5	Marked concentration deficit (e.g., giving months backwards or serial 2s from 20).
6	6	6	6	6	Forgets the concentration task. Frequently begins to count forward when asked to count backwards from 10s by 1s
7	7	7	7	7	Marked difficulty counting forward to 10 by 1s

Rating	Rating	Rating	Rating	Rating	**Axis II: Recent Memory**
1	1	1	1	1	No objective or subjective evidence of deficit in recent memory
2	2	2	2	2	Subjective impairment only (e.g., forgetting names more than formerly).
3	3	3	3	3	Deficit in recall of specific events evident upon detailed questioning. No deficit in recall of major recent events.
4	4	4	4	4	Cannot recall major events of previous weekend or week. Scanty knowledge (not detailed) of current events, favorite TV shows, etc.
5	5	5	5	5	Unsure of weather; may not know current President or current address.
6	6	6	6	6	Occasional knowledge of some events. Little or no idea of current address, weather, etc.
7	7	7	7	7	No knowledge of any recent events
Rating	Rating	Rating	Rating	Rating	**Axis III: Past Memory**
1	1	1	1	1	No subjective or objective impairment in past memory.
2	2	2	2	2	Subjective impairment only. Can recall two or more primary school teachers.
3	3	3	3	3	Some gaps in past memory upon detailed questioning. Able to recall at least one childhood teacher and/or one childhood friend.
4	4	4	4	4	Clear-cut deficit. The spouse recalls more of the patient's past than the patient. Cannot recall childhood friend and/or teachers but knows names of most schools attended. Confuses chronology in reciting personal history.
5	5	5	5	5	Major past events sometimes not recalled (e.g., names of schools attended)
6	6	6	6	6	Some residual memory of past (e.g., may recall country of birth or former occupation).
7	7	7	7	7	No memory of past

Rating	Rating	Rating	Rating	Rating	**Axis IV: Orientation**
1	1	1	1	1	No deficit in memory for time, place, identity of self or others
2	2	2	2	2	Subjective impairment only. Knows time to nearest hour, location.
3	3	3	3	3	Any mistakes in time > 2 hours; day of week > 1 day; date > 3 days.
4	4	4	4	4	Mistakes in month > 10 days or year > 1 month.
5	5	5	5	5	Unsure of month and/or year and/or season; unsure of locale
6	6	6	6	6	No idea of date. Identifies spouse but may not recall name; Knows own name
7	7	7	7	7	Cannot identify spouse. May be unsure of personal identity
Rating	Rating	Rating	Rating	Rating	**Axis V: Functioning and Self Care**
1	1	1	1	1	No difficulty, either subjectively or objectively.
2	2	2	2	2	Complains of forgetting location of objects. Subjective work difficulties
3	3	3	3	3	Decreased job functioning evident to coworkers. Difficulty traveling to new locations
4	4	4	4	4	Decreased ability to perform complex tasks (e.g., planning dinner for guests, handling finances, marketing, etc.)
5	5	5	5	5	Requires assistance in choosing proper clothing.
6	6	6	6	6	Requires assistance in feeding, and/or toileting, and/or bathing, and/or ambulating.
7	7	7	7	7	Requires constant assistance in all activities of daily life.
					TOTAL SCORE
÷5=	÷5=	÷5=	÷5=	÷5=	**Stage on Global Deterioration Scale (GDS)**

Functional Assessment Staging (FAST)

Check highest consecutive level of disability

Stage	
1	**No difficulty**, either subjectively or objectively.
2	Complains of forgetting location of objects. **Subjective work difficulties**.
3	Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. **Decreased organizational capacity**.
4	**Decreased ability to perform complex tasks**, e.g. planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc.*
5	**Requires assistance in choosing proper clothing** to wear for the day, season, or occasion, e.g. patient may wear the same clothing repeatedly, unless supervised.*
6a	**Improperly putting on clothes without assistance or cuing** (e.g. may put street clothes on over night clothes , or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.*
6b	Unable to bathe (shower) properly (e.g., **difficulty adjusting bath-water (shower) temperature**) occasionally or more frequently over the past weeks.*
6c	**Inability to handle mechanics of toileting** (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*
6d	**Urinary incontinence** (occasionally or more frequently over the past weeks).*
6e	**Fecal incontinence** (occasionally or more frequently over the past weeks).*
7a	Ability to speak limited to approximately **a half a dozen intelligible different words or fewer**, in the course of an average day or **in the course of an intensive interview.**
7b	Speech ability limited to the use of **a single intelligible word** in an average day or **in the course of an interview** (the person may repeat the word over and over).
7c	Ambulatory ability lost (**cannot walk without personal assistance**).
7d	**Cannot sit up without assistance** (e.g., the individual **will fall over if there are no lateral rests [arms] on the chair**).
7e	**Loss of ability to smile**.
7f	**Loss of ability to hold up head independently**.

*Scored primarily on the basis of information obtained from a knowledgeable informant and/or caregiver.

FAST Scoring Instructions:

The **FAST Stage** is the highest consecutive level of disability. For clinical purposes, in addition to staging the level of disability, additional, non-ordinal (nonconsecutive) deficits should be noted, since these additional deficits are of clear clinical relevance.

Reisberg, B. Functional Assessment Staging (FAST). Psychopharmacology Bulletin, 1988; 24:653-659.

Tips for Successful Administration of the BCRS and FAST

- ✓ Take some time to build rapport and establish a connection with the resident before jumping in to the assessment. Even residents with advanced dementia will feel more comfortable if they don't feel as though they are being "tested".

- ✓ Familiarize yourself with the entire test and what you will be asking so you are not tied to a structured format. It may be more natural to begin by asking the resident where they are from rather than asking them to subtract 7 from 100.

- ✓ It may be helpful to know some background information prior to administration or be able to readily fact check answers before scoring so you know if the information provided is accurate. Some residents can be VERY convincing!

- ✓ It is generally more successful to administer these questions conversationally rather than formally. An individual will be less guarded if they feel you are just chatting with them.

- ✓ It is not necessary to start at the hardest question and move in sequential order. Get a feel for where you think an individual might be and start there.

- ✓ You may find that developing some "go to" phrases/questions is beneficial for sounding natural and creating a flow to the conversation.

- ✓ The last axis on the BCRS is "Functioning and Self Care" and it corresponds with the FAST assessment. The FAST breaks down the rating of 6 and 7 into more specific categories of dysfunction and need for assistance.

- ✓ If most of the scores on the first four axes are 3s and 4s, and the score on Axis V is a 6, this discrepancy indicates that the resident is likely capable of more independence with self care. Staff may be providing too much assistance or the environment may not be facilitating independence as well as it could.

Resident Name: _____

Enlighten Caregiver Questionnaire

As therapists, we use our skilled services to decrease the demand on caregivers. These questions are intended to help therapists know what areas to target in treatment.

Caregiver Name: _____ **Date**: _____

Instructions*: Please circle the numeric response to each question.*

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
1. I know how much assistance to provide when transferring the resident.	5	4	3	2	1
2. It is easy to tell when the resident needs to go the bathroom.	5	4	3	2	1
3. I can calm the resident when he or she becomes agitated.	5	4	3	2	1
4. I feel confident in giving the resident a shower.	5	4	3	2	1
5. It is easy to get the resident dressed and undressed.	5	4	3	2	1
6. I know what the resident enjoys doing.	5	4	3	2	1
7. I know what kinds of activities are appropriate for his or her cognitive level.	5	4	3	2	1
8. I know how much assistance the resident needs during meals.	5	4	3	2	1
9. I know how much assistance to provide to help the resident get from here to there.	5	4	3	2	1
10. Overall, I feel confident in providing care to this resident.	5	4	3	2	1

Total Score: _____ Divide by 10 (**Average Confidence Score**): _____

How can we make your job easier with this resident?

_____

What tips/tricks have you learned when working with this resident?

_____

Step Two: Treatment

Since most of our residents will not retain the capacity for new learning or carryover of skills, it is important to clearly define the purpose of skilled services and how we measure progress. We must change our focus from a restorative approach to ***improving quality of life, increasing safety and reducing the burden of care***. If we successfully target these goals, with skilled intervention we can expect to

- Reduce fall risk
- Maximize independence and skill retention
- Decrease adverse behaviors/anxiety/agitation
- Increase caregiver confidence and competence in working with those with dementia
- Facilitate aging in place with the least restrictive care
- Improving/increasing participation in preferred tasks

Common Pitfalls

There are some misconceptions surrounding individuals with dementia or neurodegenerative diseases that interfere with receiving therapy referrals or picking up patients on caseload. We often hear

"He's not appropriate for therapy."
"She just does that for attention."
"He can stand when he wants to, he just doesn't want to do it."
"We've tried therapy in the past and it didn't do anything."
"They have dementia, nothing we do will make a difference."

As skilled clinicians, we have the experience, education, and clinical expertise to analyze the underlying neurological impairments which are manifesting as "behaviors" and interfering with the provision of care. Caregivers cannot say "Bill isn't appropriate for toileting" or "Sharon has dementia, there's nothing I do can help her" because they cannot follow directions, cannot communicate their need for care, or because they are difficult to transfer. These tasks *have* to be done and they *have to* provide care for every resident regardless of how aggressive, agitated or confused they are. It is our role to analyze the cognitive and physical abilities and deficits and provide guidance for how to complete these tasks in the safest and most efficient way possible.

Maybe it is not that "he is not appropriate for therapy".
Maybe our therapy is "not appropriate" for him!

Rethink Intervention

To reframe our thinking, let's ask ourselves the following questions.

Can my skilled interventions…

1 *Improve this resident's quality of life?*
2 *Make a task safer?*
3 *Lighten the burden of care for staff?*

If we can answer "yes" to any of these questions, this individual is appropriate for therapy and would benefit from skilled therapy services.

The next step is to ask yourself or caregivers these questions.

1. *What are the problems we encounter in caring for this individual?*
2. *What strengths does this individual have to compensate for those problems?*
3. *In **the resident's reality**, what would help solve their problems?*

It may be difficult to perform structured treatment sessions for residents with moderate-severe dementia. Many residents in the later stages have limited body awareness, altered spatial awareness and decreased motor processing. Therapeutic exercise might not be the best approach for this population. Many therapy sessions will include both skilled direct and indirect interventions. Do caregivers report toileting is difficult? In your treatment session, you should toilet them while trialing different environmental modifications, cueing hierarchies, care partner training, external memory aids, and/or use of assistive devices. Determine the least amount of assistance we can provide to facilitate the highest level of independence.

Staff providing too much assistance

is just as much of a reason for therapy and education as if

they are providing too little assistance.

Staging and Treatment

The first step of staging a resident is crucial to guiding this step of the process. Knowing the cognitive stage gives you a starting point for knowing what goals are attainable and realistic as well as what types of therapeutic interventions will be most successful in achieving progress. For example, an individual with moderate dementia (Stage 5.5) may never reach the goal of being independent with showering because she no longer has the ability to recognize the need for one, no longer has new learning capacity to recall use of adaptive equipment and due to short term memory loss takes over an hour to wash due to repetitively cleaning the same areas.

Consider the table below as a starting point when developing treatment goals and setting your own expectations for therapy. However, each resident presents with very specific abilities and/or deficits that may not fit in these categories. It is important to set a goal that is achievable and realistic. This may not be evident at the time of evaluation. Through your skilled analysis and clinical reasoning during treatment, you may realize that your initial expectations do not match the resident's abilities or deficits. This is why it is crucial to assess an individual's progress toward goals during treatment sessions and update the plan of care as indicated.

Stages of Dementia and Functional Ability Levels

Dementia Stage	Highest Level of Independence Possible
3-3.5	• May need some supervision with IADLs (may not be able to drive) • Is independent with simple, familiar ADLs
3.5-4.5	• Needs max assist with IADLs (could not manage medication, finances, pet/child care safely) • Begins to need some supervision/verbal cues for ADLs (e.g., reminders to change clothes)
Stage 4.5-5.5	• Total assist/dependence with IADLs • Needs one-on-one assist for all ADLs, but can participate in aspects of self-care with the appropriate adaptations, approach, and cues • Mod Ind or Supervision are likely NOT appropriate goals.
Stage 5.5-6.5	• Requires increased assist for ADLs; however, can still participate in highly familiar tasks with appropriate adaptations, approach, cues • Mod Ind, SBA, Supervision are likely NOT appropriate goals
Stage 6.5-7	• Requires total assist in both IADLs and ADLs

*Adapted from https://www.crisisprevention.com/Blog/December-2015/stages-of-dementia

Interventions

Interventions to utilize with individuals with neurodegenerative diseases include but are not limited to:

- Staff/caregiver/family education
- Environmental modifications
- Task modifications
- Compensatory strategies
- Sensory therapy (music, touch/tactile input, aromatherapy, etc.)
- Validation
- Spaced Retrieval Training
- Communication techniques
- Therapeutic exercise/physical activity
- ADL/IADL training/retraining
- Assistive technology/adaptive equipment assessment & training
- Cognitive stimulation (such as Montessori-based tasks)

Get Creative!

We often find that the simplest changes can have the biggest impact on a resident's function and response to care. Is your resident anxious to leave her room in the morning and refuses to walk to breakfast? Maybe putting on her signature red lipstick has always been the last thing she did before leaving the house and she does not feel ready without it. If she is unable to communicate this or even identify what she is forgetting, this can be viewed as "mealtime refusal". If a woman who refuses showers gets her hair done weekly, maybe she does not want to get her hair wet and a shower cap can be a useful strategy to reduce resistance to showering. Think outside the box and ask yourself "WHY is this person responding in this way?" Place yourself in their position and try to view the situation from their perspective.

Montessori Based Activities

Cognitive stimulation is important but sometimes overlooked for individuals with dementia. The **Montessori Method** is an educational approach developed for children by Dr. Maria Montessori over 100 years ago. This method is also used with individuals with dementia and research has shown benefits in its implementation.

We have created the acronym **FAME** to help remember the criteria for choosing activities for residents with dementia. The activities chosen are **F**unctional, **A**ppropriate, **M**eaningful, and **E**njoyable.
• Activities that are **functional** are practical, real-life tasks that our residents have completed possibly hundreds of time throughout his or her lifetime. • Activities that are **appropriate** are suitable for a resident's age, gender, culture, cognitive and physical abilities and occupational background. • Activities that are **meaningful** are important to give our residents a sense of purpose and that they are a productive member of this community. • Activities that are **enjoyable** give our residents pleasure and are looked forward to.

We have included an extensive list of 50 Montessori based activities grouped by difficulty level and color coded to correspond with each cognitive stage. The difficulty levels listed on the side of the activities list correlate loosely with a GDS stage. For example,

- Sensory: Stages 6-7
- Easy: Stages 5-6
- Medium: Stages 3.5-5
- Hard: Stages 1-3.5

It is important to note that these levels are not strictly limited to a specific stage. This is where our skills as a clinician are necessary to grade activities based on our resident's strengths to maximize function and independence. Try different Montessori tasks to determine what is appropriate for your resident's abilities. Some activities may be *functional* and *appropriate* for a resident, but may not be preferred or meaningful. For example, you may give a 75 year old female, Stage 5.8, former homemaker a task to fold washcloths. This activity is within her cognitive ability and it is appropriate for her age, gender and occupational background. However, you may not know that she has always *hated* doing the laundry and folding. This would not be an appropriate task for her.

Consider also utilizing these activities in therapy sessions to target specific movements or skills in functional ways that are more likely to elicit participation from your patient. Use these as one of your therapy tools to target standing balance, weight shifting, or reaching outside base of support when the resident has difficulty following structured therapeutic exercise. For example, a resident who declines to ambulate with a physical therapist may be agreeable to assist with determining what keys go to what doors in the facility.

One of the most important techniques to train caregivers and activities staff is how to set up the task appropriately and how to provide the verbal cue to the resident to elicit participation. It is crucial to understand ***what*** to say and ***how*** to say it in order to fully engage the resident's cooperation. It is not the task itself that instills a sense of purpose and meaning, but how we communicate it to the resident. It is also necessary to emphasize the importance of knowing the resident's cognitive stages so people at a similar stage can work on the same task safely to facilitate socialization and environmental engagement. Work with your facility to develop an appropriate method to easily identify residents according to stage (i.e. a color coded list or visual).

Documentation

It is important for us to document our SKILL as a clinician. This is where we communicate to others why we are needed and how our services are helping to maximize a resident's potential. Much of this is information we already know and use but it is important to specifically explain our work with residents who have dementia so our services are reimbursable and effective. When documenting our therapy sessions, we want to make sure the focus is on what **we did** (what skilled service we provided) and **how the patient responded**. For example, "Occupational therapist developed external memory aid (visual schedule) to assist with appropriate sequencing of ADL routine in order to compensate for poor working memory. Patient completed ADL routine with set up assist and occasional verbal cues to direct attention to visual schedule with accurate sequencing of all steps."

Words to Use	Words to Avoid	Example
Analyze Assess Adjust Modify Adapt Instruct Upgrade Implement Facilitate Model Reduce Develop Determine Compensate	No change Little change Steady Progress Minimal progress Non-compliant Non-participatory Not appropriate	PT analyzed Bill's gait patterns over various surfaces within PCF to determine risk of falls and appropriate cueing strategies for caregivers to use for increased safety. OT determined most effective cueing strategies for caregivers to facilitate increased independence during toileting appropriate for Alice's GDS of 5.2. ST facilitated Esther's participation in Montessori based activity by utilizing written cues to maximize attention and compensate for poor working memory.

Enlighten Environment and Task Analysis

Mobility

- Do they need an assistive device to ambulate?
- If using an assistive device, what do they call it? Are they able to operate and care for their assistive device without help (locking brakes, charging power chair)?
- How long can they stand?
- How far can they walk?
- Are they able to walk from their room to necessary places within the facility (dining room, hair salon, front door, etc.)
- What surfaces are they safe to walk on? Grass? Wet surfaces? Uneven surfaces? Do changes in flooring surfaces impact their safety (door thresholds, carpet to hardwood)
- Can they go up steps? How many? Do they need a railing? Which side should the railing be on?
- Can they pick things up off the floor?
- Can they safely reach above their heads?
- Can they lean across a table while standing?
- Can they recognize obstacles in their way without help?
- Can they lift heavy objects safely? How much weight can they lift?
- Is their leg strength and ROM adequate for mobility?
- What footwear is appropriate for walking?
- For those patients who frequently refuse walking, what phrases or cues are encouraging?
- Are there any special instructions for medical equipment when walking (oxygen, catheter, braces, etc)?

Cognitive-Communication

- How reliable are their yes/no answers?
- What is the best way to approach them?
- Are they capable of asking for help appropriately?
- How are they most successful in following directions? Ex. One, two, three step commands vs automatic speech cues such as “Let’s go!”
- Can they read?
- Can they write?
- How is their hearing? Do they use amplification devices? If so, are they independent in use?
- How do they express themselves nonverbally? Do their facial expressions and tone of voice reflect their emotions accurately?
- Do they understand and respond to gestures?
- Do changes in volume and rate of speech improve comprehension?
- Does their attention improve with eye contact?
- Do they need extended processing time to follow commands?
- How intelligible is their speech?
- How relevant is their speech to the context of conversation?
- How long is their short-term memory?
- Do they demonstrate appropriate social cues and boundaries?
- How to they express agitation or anxiety when their language is limited?
- Does building rapport increase compliance with requests or participation in tasks?
- Do they enjoy socializing with other residents and staff?

Enlighten Environment and Task Analysis

Dressing

- What surfaces do they get dressed on the safest? Bed? Toilet? Recliner?
- Can you lay out the clothes or do you need to hand it to them one at a time?
- What article of clothing do they ALWAYS wear? Belt? Bowtie? Brooch?
- Do they understand directional/spatial concepts such as front, back, inside out, etc.?
- Can they manipulate clothing fasteners?
- Can they pick the appropriate clothing for the season or occasion independently?
- Can they carry out the steps of dressing in appropriate sequential order? (Bra, then shirt, then jacket)
- Do they recognize the need to change soiled clothing?
- What level of assistance do they need for upper body vs lower body dressing?
- What is the biggest limiting factor for independent dressing? Cognition, strength, mobility, etc?
- Are they capable of learning to use adaptive equipment?

Toileting

- How do they communicate their need to toilet – verbally or nonverbally?
- If incontinent, how does this impact behavior? Do they become agitated when brief is soiled?
- Do they recognize when brief is soiled and change or dispose of it appropriately?
- Is a toileting schedule appropriate for incontinence management?
- What undergarment do they prefer or is most appropriate?
- What adaptive equipment maximizes their safety?
- Can they find the toilet independently? What will they do if they don't find it? Does labeling it help?
- If using adaptive equipment such as toilet rails, are they adjusted to the appropriate height? Can they visually distinguish the rails or is a contrasting color visual cue needed?
- Do they recognize the need to pull down pants when standing at toilet? Do they need assistance?
- Are there any modesty considerations?
- Do they have a tendency to become combative or are they usually compliant?
- Can they independently manage hygiene or what level of supervision/assistance is necessary?
- Do they flush and wash their hands after?

Activities/Miscellaneous

- What hobbies and activities did they enjoy?
- What was their past occupation and how does that impact their interests now?
- What types of activities are they able to participate in taking into account their cognitive-communication abilities (sorting, organizing, matching, etc.)?
- Do they perform well in a group or individually?
- Consider impact of mobility restrictions to determine what they can participate in safely.
- Can they independently refer to a calendar and arrive on time for activities?
- Can they navigate the facility to locate their room, bathroom, dining room without assistance?
- Can they recognize their caregivers and/or know them by name?
- Do they become overstimulated or anxious in certain areas/rooms of the building?

Transfers

- How much assistance do they need to transfer from one surface to another? A chair with arms verus a couch? A firm surface versus a soft or moveable surface (rolling chair)?
- Do they transfer better to the left or to the right?
- How do they use adaptive equipment/device during transfers?
- What visual or tactile cues are most appropriate?
- What phrases help them transfer? Do they need extended processing time?
- Is there more assistance required for certain transfers such as wheelchair to shower or bed to wheelchair?

Enlighten Environment and Task Analysis

Showers/Bathing

- What terminology to they prefer? Bath? Shower? Get clean? Wash Up?
- Historically, did they take their showers in the morning or at night?
- Are they safe to stand or do they need to sit?
- Are they very sensitive to cold or hot water? Can they adjust water temperature appropriately?
- What are the considerations to ensure modesty? Male vs female caregivers, using a robe or towel, etc.
- What environmental modifications can improve safety and comfort during the process? Ex. Placing a towel on cold shower chair, preheating water and room, etc.
- What types of cues maximize participation and completion of task? Providing one step at a time or just providing the supplies?
- What is the best pace for this task? Working slowly to ensure patient participation or quickly to avoid agitation?
- How many caregivers are appropriate during task?
- What supplies do they prefer? Bar soap vs body wash or loofa vs washcloth?
- Can they carry out the steps with appropriate sequencing or thoroughness? Do they use shampoo before conditioner or try to wash without soap?
- How often do they wash their hair? Do they get it done weekly? Are they concerned about getting hair wet?
- Do they recognize the need for taking a bath? Do they like participating in hygiene tasks? Will they initiate showering or bathing independently?

Mealtime

- What is their diet?
- What adaptive equipment is recommended for self-feeding?
- Are there any vision limitations that affect self-feeding? How do you compensate for it?
- What portion size encourages appetite? Are big portion sizes overwhelming?
- What is the best placement of individual food items? Several items on one plate or each item served in individual containers?
- What type of drinkware is most appropriate for their cognition and physical abilities?
- Do they stay seated during meals? If not, what can be done to ensure adequate PO intake?
- With whom should they be seated during meals?
- Are they sensitive to certain textures or temperatures?
- What compensatory strategies are recommended to ensure safety with swallowing?
- What positioning is appropriate for safety and comfort?
- What are their preferred foods? What is their response to being served food items they don't like?
- What environment maximizes their attention to the task of self-feeding? Consider lighting, noise, etc.
- What obstacles keep them from wanting to eat? For example, do they believe they have to pay for it or they wait for everyone to be served before eating?
- Do they wear dentures? If so, are they adequately positioned and secured in their mouth to support eating?
- What level of assistance do they need to initiate self-feeding? Hand over hand assistance? Placing utensil in hand? Loading utensil with food?

Enlighten Environment and Task Analysis

Grooming

- Do they recognize the need to complete grooming tasks such as brushing teeth or combing hair? Will they initiate these tasks independently?
- What level of assist or supervision is needed to help them begin the task? Placing brush in hand or hand over hand to get started?
- Do they have dentures? Can they efficiently manage care and storage of dentures? Do they have a tendency of losing them or placing them in inappropriate places?
- Do they complete grooming tasks thoroughly? Do they leave out steps such as putting toothpaste on a toothbrush?
- Are they safe for shaving independently? What type of razor is most appropriate? How often do they or their family want them to shave?
- Can they find grooming items if they are placed in drawers out of sight? Is labeling necessary in finding them?
- Can they safely recognize the difference between items and products (creams, gels, sprays, etc.)? Is there a risk of ingesting a product not intended for oral use?
- Can they complete grooming tasks in an appropriate sequence or do they leave out tasks entirely? Do they repeat a task multiple times?
- Do they have someone else fix their hair on a specific schedule? Are they able to reach behind their head to complete hair care?
- What items and/or schedule do they prefer when completing grooming tasks? Do they like to use a washcloth to wash their face? Do they need a cup to rinse mouth? What do they like to do first?
- Do they have the endurance to complete multiple grooming tasks consecutively? Should they stand or sit to conserve energy or reduce fall risk?
- Do they wear glasses and do they wear them continuously or only for reading? Do they forget them or place them in inappropriate places?
- Do they wear hearing aids? Are they able to recognize the need to change batteries? Can they change the batteries without help?

Enlighten Montessori Based Activities

	Activity	Supplies	Example Cues
Sensory	**Aromas**	Contains with familiar smells such as coffee, vanilla, lavender, cinnamon, etc.	"Oh this smells so good!"
	Fidget Box/Junk Drawer	Safe items (No small pieces that can go into mouth) with varying textures, sounds, and shapes such as clean mop head, scarves, sand timer, rain stick, belts with buckles, etc. For patients who rummage, place safe items in a drawer.	"Help me look through this."
	Music	Portable music player (CD, iPod, etc.) with various genres of music	"I love Elvis! Let's listen."
	Nail Care	Nail polish, cotton balls, nail polish remover, manicure sticks, nail brush, etc.	"Let's do your nails!"
Easy	**Cleaning Kit**	Cleaning rags, spray bottle with water or vinegar solution, feather duster	"I was noticing these bookshelves needed dusting. Could you help me?"
	Dish Washing Kit	4 plastic cups, 4 plastic plates, 4 utensils, 4 plastic bowls, drying rack, dish soap, sponge, washcloth, drying towel	"Would you possibly have time to help me clean up the dishes?"
	Eyeglass cleaning	Glasses and soft cloth (check lost and found for unclaimed glasses)	"These glasses are dirty. Could you help me clean them?"
	Flower Arranging	Various types of fake flowers with small plastic vase and styrofoam insert	"I think we need some new flower arrangements on the dining room table. Would you like to put something together for me?"
	Folding Washcloths	12-15 multi-colored washcloths	"I am so behind in laundry. Do you have a minute you can help me fold these washcloths?"
	Jewelry Box	Various necklaces, earrings, bracelets, and rings with corresponding papers to sort them out on	"My jewelry box is so disorganized! Could you help me separate these out?"
	Laundry	Various clothing items of various colors, two baskets labeled "colors" and "whites"	"Can you help me sort this laundry? Whites will go in here, and colors will go in here."
	Pipe Construction	PVC pipes and connectors	"I need to clean out the garage. Can you make sure all these pipes and connectors are the same size. Do they all fit?"

Easy	**Purse Rummaging**	Purse with common items such as hairbrush, lotion, makeup, gum, keys, etc.	"I need to clean out this purse. Can you help me figure out what all is in here?"
	Rice Treasure Hunt	Hidden small objects such as erasers, plastic figurines, etc. in a tub of rice	"The kids have made a mess. I think they lost their toys in this tub. Can you look through this and find them for me?"
	Sanding Wood	Various pieces and sizes of wood and fine grain sandpaper	"I'm making a new project and this wood is just too rough on the top. Could you sand this for me?"
	Sock Sorting	15-20 multi-colored and patterned ankle socks	"I am embarrassed to ask you this, but do you have time to help me with this laundry?"
	Stringing Beads	Large plastic or wooden beads with yarn or string	"My necklace broke this morning. Do you think you could help me put the beads back on this string?"
	Stuffed Bear or Pillow	Stuffed animal or small pillow with some stitching removed to filling pulled out	"Oh no! This pillow is coming apart. Can you put the stuffing back inside?"
	Untying Knots	Strip of fabric that unties easily such as satin or a scarf	"Someone tied knots in this fabric. Can you help me get it out?"
Medium	**Coin Sorting**	Multiple nickels, dimes, and pennies, coin wrappers or containers to sort them into	"I need to go to the bank after lunch. Could you help me sort these coins so I can take them with me?" *provide model*
	Key Sorting	Keys (check with maintenance for unlabeled keys- they might even appreciate the help in determining what they go to!)	"We have a lot of keys we don't know what they are for! Can you help me walk around and see if these keys fit the doors?" **This is a great motivating task for physical therapy to use during ambulation and standing**
	Lid and Container Match	~10 small plastic containers (like Tupperware) with lids	"I was cleaning out my kitchen and found all of these containers. Do they all have lids? Can you help me?" *Provide model*
	Marker and Lid Match	Dried markers and corresponding lids separated	"These markers have lost their lids. Can you help me match them all back up?"
	Nuts and Bolts	10-15 3-5 inch carriage bolts with matching nuts	"I have been trying all morning. Can you get these nuts off this bolt for me?"
	Office Supply Organization	Utility box, paperclips, rubber bands, pencils, binder clips, etc. Label each section with a picture and/or written cue of what to put in each section	"We need to get organized. Can you help me put all of these things where they go?"
	Paint Chip Matching	2 of many different colors and shades of paint chips	"I was thinking of painting a desk blue. Could you find all the blue paint chips and we can decide which may be the best for this project?" or "I think there is a match to each of these colors. Can you find them all?"
	Picture Scavenger Hunt	Go around to different areas in the facility and take pictures of objects or areas. Print them in color.	"I took some pictures and I want you to see if you can find the areas/things I took pictures of? Ready?"
	Shoe Shining Kit	Shoes, polish, brush, rag	"I have no idea how to polish shoes but my dad needs these polished for tomorrow. Can you show me how?"

Medium	**Sort Pamphlets for Display**	5-7 pamphlets of various kinds of places in the area (like the ones you would find at a rest stop)	"We want to display these in the lobby but they are all mixed up. Do you have time to help me find the ones that go together?" *provide model*
	Sorting Greeting Cards	Various thank you, Christmas, get well, birthday , etc. cards and	"I was going to send a birthday card to my sister but I noticed all these cards were mixed up. Could you help me separate them into Birthday, Christmas, get well, etc.?"
	Sorting Pasta Shapes	Rotini, macaroni, farfalle, penne, etc. in a container and 3-5 cups to separate them into	"I think my husband dumped all the pasta into one container! My recipe calls for rotini pasta. Can you separate these back out into the various shapes?" *Provide model*
	Sorting Sport Cards	Multiple baseball, basketball, and football cards and a paper (preferably laminated) that says each sport on the top to sort the cards onto. For example, I created a 5 x 7 cut out of a football that says "Football" on it and laminated it. I have the resident place all the football cards on that picture.	"My brother has collected all these cards but I only want to keep the baseball cards. Can you sort them into basketball, football, and baseball?"
	Sorting/Polishing Silverware	Cloth napkins, spray bottle, washcloth, various silverware, silverware tray	"Lunch will be in an hour. Can you help me sort/polish these silverware?"
	Stuffing Envelopes	50 envelopes and folded colored cardstock or paper. To increase complexity, add addresses to envelopes in order to sort by state, city, etc.	"I'm running a little behind. We need to send these out tomorrow morning. Could you put these flyers in the envelopes for me?" *With model*
	Sugar Packet Sort	20-30 multicolored sugar packets (yellow, pink, white) and sugar packet holders like you would see at a restaurant	"We are going to have coffee in a few minutes and someone mixed all these up. Can you put he pink in here, the yellow here, and the white in here?" *with model*
	Tackle Box	Tackle box, lures (remove hooks)	"Let's sort these by size/color/type so we can get to them easier when we go fishing"
Hard	**Bible Study Prep**	Bible, post it notes with familiar verses written on them (John 3:16, Romans 8:28, etc.)	"We will be doing a Bible study later and I had some verses I wanted to mark in my Bible. Could you find these verses and put a post it note at the top so I can find it quickly?"
	Checkers/Chess	Checker/chess board and pieces	This activity will be for residents who know how to play already. Supplies can just be provided to them. They may need cues to get started.
	Coupon Clipping	15-20 coupon flyers and scissors. Optional: Recipe or grocery list	"I am running behind and after lunch I will be going to the grocery. Could you possibly help me find some coupons for the things on this recipe?" or "Can you cut them all out?"
	Coupon Organization	Coupons cut and laminated and enveloped with labels of "food", "medicine", "drinks", "cleaning supplies", etc.	"I like to sort my coupons by their purpose. Can you help me divide these up?"
	Crossword, Sudoku, Word Find, etc.	Container with multiple types of word games	This activity will be for residents who know how to play already. Supplies can just be provided to them. They may need cues to get started.
	Document Sorting	A filing container such as an accordion expanding file with sections labeled and receipts, manuals, flyers, or any other documents. You can even print off fake phone bills, paystubs, utility bills, etc. from the internet.	"I could use some help filing these documents away. Do you have some time to help?"
	Flashlight Assembly	Flashlight taken apart	"This flashlight hasn't been working. Do you think you can look at it and see if you can get it to work?"

	Knitting	Knitting needles and yarn	This activity will be for residents who know how to knit already. Supplies can just be provided to them. They may need cues to get started.
	Math Problems	Binder with various kinds of math worksheets which can be found online	This activity will be for residents who know how to do math already. Supplies can just be provided to them. They may need cues to get started.
	Polishing Coins	Old pennies or other coins, vinegar, salt, plastic bowl, teaspoon, 1/4 measuring cup, small brush, and instruction card (Pour 1/4 cup vinegar in bowl, add 1 tsp salt, place coins to soak and scrub to clean)	"Let's clean these coins up. Everything you need is in this container! Let me know if you need my help."
	Price Matching	Grocery list with common items such as chips, chicken, bread, etc. and multiple grocery store ads (Kroger, Meijer, Dollar General, etc.)	"I am having some friends over for dinner this weekend and these are a few things I need. Now, I don't want to spend a lot of money so could you help me find these items in these ads and maybe we can figure out who has the best price?" *provide model*
	Rolodex Activity	~50 index cards, index card box, A-Z dividers. Write fake names, birthdays, phone numbers, etc. on each index card for resident to sort alphabetically. These can also be sorted by birth month, area code, sorted by year born, etc. Consider also making a key typed with all information listed on cards to compare cards to for further complex activity.	"I have a list of individuals and their information. Do you have time to help me? I need them sorted alphabetically/by year/by area code."
	Sharpening Pencils	25 unsharpened pencils and manual pencil sharpener	"I bought these pencils yesterday and I just can't find the time to sharpen them this afternoon. Do you have time to help me?" *Provide model*
	Solitaire Board	Poster board- Create a placemat to provide cues for how to set up the game. Using a marker, trace a playing card 7 times side by side to detail where to place the cards for solitaire. In each spot write how many cards to place there. For example, "3 cards face down, 1 card face up"	This activity will be for residents who are familiar with the game and used to play but maybe just can't set it up independently. Supplies can just be provided to them. They may need cues to get started.

Step Three: Training

Once you have worked with a resident during your treatment sessions and determined the level of assistance and cueing they need to ambulate, communicate, toilet, etc. it is crucial to communicate these recommendations to the staff in your facility in a succinct and effective way.

Create a **Resident Profile** outlining these recommendations in an easy-to-read fashion. Customize these documents in whatever way best communicates the needs of the resident. Consider providing following information.

- GDS stage
- Communication Recommendations
- ADL recommendations
- Appropriate activities
- De-escalation techniques

Information for these Resident Profiles can also be obtained from nursing staff and family.
Utilize the Enlighten Environmental and Task Analysis document as a template for the information.
Communicate with nursing staff to determine where they would like these documents to be placed in the facility for staff review.

When creating these documents, **avoid**

● **clinical language or abbreviations**.
  ○ I.e.; "Alice requires CGA with UB dressing."
● **listing limitations or deficits.** This document should be a strengths-based narrative of what your patient CAN do with the appropriate support.
● **describing behavior in a negative or derogatory way.**
  ○ I.e.; "Resident is very aggressive and combative during showering". Instead, describe the behavior "To minimize agitation during showering, provide resident with a towel or robe for modesty."
● **vague language or descriptions.**
  ○ I.e.; "Provide verbal cues during toileting." Instead indicate "Speak slowly and give resident one step at a time with plenty of time to process what you've said during toileting task."

Inservices

Monthly in-services are a perfect opportunity to not only educate facility staff on important clinical topics and/or resident care strategies but also can generate therapy referrals. Through communication with facility staff (nurses, administration, kitchen staff, resident assistants, maintenance, etc.) you can gather feedback on specific residents that staff recognize as having issues with the topic at hand.

Education provided on a variety of skilled/clinical topics that is relevant to patient care includes but are not limited to the following.

- Communication Strategies/Approach Techniques for Dementia
- Transfer Training
- Gait Belt Training
- Cognitive Staging
- Wheelchair/Walker Training
- DME/Adaptive Equipment Training
- Minimizing Adverse Behaviors
- Fall Prevention
- Resident specific in-services to train caregivers on strategies for ADLs, Mobility or Communication pertinent to individual residents
- Therapeutic Diets (differences/reasons for diet modifications)
- Self-Feeding issues with dementia

Consider utilizing documents and forms from this packet as inservice materials. In the following pages you will find a sample Resident Profile and a handout for communication strategies for working with individuals with dementia.

Jane Resident Profile
Stage 4.5

Jane has moderate dementia characterized by short term memory loss, disorientation, and unable to understand that she needs assistance

Communication:

- Jane demonstrates difficulty finding the words she wants to say and may not be able to express herself clearly. She uses a lot of general language like when she refers to "it" or "that" but it is difficult to determine what she is referring to. Despite her difficulty, make her feel heard.
- Jane responds well to encouragement. Thank her often for helping by saying things such as, "Jane, I don't know what we would do without you! I am so glad you are here with us!"

ADLs:

- Jane only ever took baths at home, not showers. She might refuse if you say "Let's take a shower". Try saying "Let's get clean" or "Let's go take a bath".
- During ADLs, Jane needs a verbal cue and reminder of how to sequence each step. For example, she can wash her own hair if you put the shampoo in her hair and say "you can put that in your hair and wash it". Or when getting dressed, you can start the pants on each foot and she can finish the task.

Mobility:

- Jane uses a rollator walker at all times when walking. Giving her a simple verbal cue before standing helps reminder her to use her rollator safely. It may be helpful to point to the brakes as a visual cue to remind her as well. Ex. "Lock those brakes before you stand up"

Activities

- Jane's mood and orientation is best when she feels busy and purposeful. She does not like "silly" tasks, so ask her if she can "help" you with something. She can do sorting tasks, put things in order, and look at recipes. Jane says she likes to read and often carries around a book. She likes looking through the books but doesn't actually sit down to read.

<u>When she gets agitated or tries to get out:</u>

Keeping her busy will keep her from getting too agitated or anxious. When you start to see her wander and try to open doors, try the following:

- Approach her gently and without a harsh or confrontational tone. For example:
  - **Do not** say from afar, "What are you doing? You can't get out that way. Stop!"
  - **Do** walk up to her calmly and once she sees you say, "Oh hi! It's good to run into you. Do you need help with anything?"
- Redirect her to another area and going something productive. If she states she has to go to work, tell him, "Actually I'd like you to work here today! We are swamped! Follow me and I'll show you what I need help with!" She can do the following:
  - Sweep the dining room or classroom area
  - Take the books off the bookshelf (when she isn't around) and ask her to put them back up
  - Pull out all the chairs (When she isn't around) and ask her to push them back in
  - Wiping down furniture
  - Place things around the room and ask her to collect them (Look in the activity closet for ideas)

Enlighten Communication Strategies

Communication Strategies	Description	Example
Positive Reinforcement	Provide encouragement and praise when a resident completes a difficult task or to reinforce appropriate behavior.	"Thank you so much for helping with cleaning up the courtyard. I don't know what I'd do without you! You are always so helpful!"
Modeling	Act out the task you want the resident to do.	When walking up to the sink to wash hands, either actually wash your hands first or just act out the movements.
Redirection	Draw the resident's attention away from one situation to another. This is very useful when a resident is anxious or agitated.	While a resident is upset due to her belief that she is late for work, you say, "Oh! I forgot to tell you they called and you have the day off! (validation) I could use your help, though. I need some help washing these dishes from breakfast (redirection)." Use this as an opportunity to set the resident up with an activity.
Forced Choice vs Open Ended Questions	When asking questions, it decreases the demand on a resident's failing memory to ask a question with choices rather than open ended questions.	Do: "Would you like coffee or milk?" Please limit the choices to 2 or 3 options. Do Not: "What do you want to drink?" There are thousands of choices and for a resident with dementia, They may not be able to come up with an answer.
Yes/No Questions	Even providing choices may be too difficult as described above. Modify a question so that a resident can answer it either yes or no.	Do: "Are you having a good day?" Do Not: "How's your day going?"
Validation Technique	Instead of orienting a resident into your reality, enter theirs. Make them feel heard and **do not argue**. This may include having to deal with false accusations with empathy. Try to solve their problem in their reality and acknowledge their feelings.	A resident states her mother passed away today. Do: "I am so sorry. I imagine that is very difficult for you. I know you loved your mother very much! Have people said you look like your mother?" Do Not: "No, she didn't. Think about it, you are 88 years old. You're too old to have a mother still living."

Calm Attitude	Keep your voice, face, and body relaxed, friendly, and positive. Our residents know when we are tense and impatient.	If you find yourself getting frustrated or overwhelmed, ensure the safety of the resident and remove yourself from the situation and ask for someone to take your place.
Increased Latency during Conversation	Latency refers to the amount of time between when you state a command or question and it is followed through with or answered. Research shows it can take up to 90 seconds for an individual with dementia to process information. Don't be afraid of silence and don't interrupt!	Do: "Would you like orange juice or coffee?" *wait up to 90 seconds* Do Not: "Would you like orange juice or coffee?... huh?... Which do you want?.... What do you want to drink?... Do you like orange juice? I know you drank it yesterday… What do you want?"
Approach Techniques	Although you may care for a resident every day, every moment can be a first impression. The way you first encounter a resident makes a difference!	Do: Approach our resident from the front so they see you coming (dementia and aging can cause the loss of peripheral vision). Make and maintain eye contact. Do not start speaking to them until you are an arm's length away. Talking or yelling from across the room is not effective in this population and it can cause agitation. Do Not: stand too close or over them which can feel intimidating. Do not approach from behind or touch them before they are aware of your presence
Don't Use Questions for Important Tasks	When you need a resident to do a specific, important task such as toileting, eating, or bathing, use straightforward phrases and sentences rather than asking questions. If you ask a resident with dementia if they "want" to bathe, they will almost always say "No". When you continue to then do it anyway, it appears as if you are going against their wishes and they will get defensive.	Do: "It's time to go to the bathroom" or "Let's go get clean now." Do Not: "Do you need to go to the bathroom?" or "Would you like to shower now?"
Decrease Complexity of Directions	Provide one step of a task at a time. Because of short term memory loss, residents may only be able to remember one thing to do at a time.	Do: "Turn on the water. *pause* Rub soap into your hands *pause* rinse your hands." Do Not: "Turn on the water and after you rub soap all over your hands, rinse them well."

Use Automatic Speech Cues	Use common phrases that will elicit the desired response. Some residents may respond better to this than providing one step at a time as described above.	Automatic cues: "Ready? Let's Go!" One step cues: "Lean forward. Push up from the chair. Stand up. Follow me."
Slow Rate of Speech	Speak slowly so they can clearly understand you. Be careful not to mumble or speak too quickly	
Decrease Visual/ Auditory/Tactile Stimulation	To compensate for poor attention, try and modify the environment to decrease distractions **or** decrease stimulation when a resident appears to be overwhelmed	Taking a resident into another room when they are demonstrating agitation during a musical performance.
Reminiscing Topics	Use the life history and experience of an individual to improve his or her sense of well-being. You can discuss past activities, events, and experiences and you can even use tangible prompts, such as photographs, familiar items, and music from the past.	Do: "Today we are having spaghetti for lunch. My mom makes the best spaghetti. I bet your mom was a good cook too! Do you remember helping out your mother when she would cook dinner?"
Topic Maintenance	Sometimes our residents lose their train of thought during conversation. If you notice this happening, repeat a summary of what you have talked about and ask a question or make a statement to get them back on track.	"So you were saying that your daughter took you out to lunch today and you had pizza. I bet you had a great time!"
Use Visual Cues	Because comprehension of verbal communication can be negatively impacted by dementia, help your resident understand what you are saying by gesturing or using objects or pictures when you talk.	While holding up a pair of pants say, "Let's change your pants." Gesture to your own and mimic the movement of pulling pants down. "Pull your pants down."
Speak with Dignity	Avoid use of terms of endearment and although language often needs to be simplified, do not talk down or "baby talk". Not only can this be disrespectful, but individuals with dementia may not recognize you are talking to them if you do not use their name.	Do Not: "Hey sweetie pie, it's time to eat." Do: "Mrs. Jones, it's time for dinner!"
Physical Touch	Physical reassurance can often be beneficial for individuals with dementia to reduce anxiety, redirect attention, increase trust, and promote the feeling of safety. As with individuals without dementia, physical touch may have an adverse effect so be considerate to their preferences.	A wandering patient is walking away from the dining room during lunch. Walk around to the front of the resident and provide a gentle touch to her arm and say, "I made you supper. Come sit with me!" take her hand and lead her back to the dining room.

Decrease Use of Pronouns (pronouns take the place of another word such as he, she, it, they, etc.)	Due to short term memory impairments, the resident may not know what/who your pronoun is referencing.	Do Not: “Pick *it* up” Do: “Pick *your cup* up”
Acoustic Highlighting	Stress or emphasize the most important parts of your message.	Do: “Would you like ***chicken*** or ***beef*** for lunch today?”

Step Four: Reassessment

When all recommendations have been clearly communicated and trained with staff, place the resident on **Preventative Therapy Protocol (PTP)** in order to reassess every 30 days for the next 90 days. During these reassessments you can re-stage the residents, update and review the Resident Profile, and interview staff for any changes in function. When discharged, screen regularly and keep communication open with staff.

Due to the nature of the disease, our residents will decline and some recommendations that worked for them at the end of the first certification period may not be working at the 90 day reassessment. This is the perfect way to track the function of our residents with dementia and ensure that we are constantly providing the most appropriate support.

Note: For more information or comments related to the Enlighten Dementia Program, its primary authors can be contacted at

EnlightenSupport@WestonGroupInc.com

Helping Seniors Stay Healthy and Safe!