Dryness in older patients:
What caregivers can do

By Rhonda Shephard, Pharm.D

Excessive dryness is a condition often seen in elders. It’s not only a persistent irritation to these elders, but can also lead to very serious conditions if not quickly and properly treated.

For those elders with Alzheimer’s, caregivers need to be particularly alert for dryness conditions, for the elder may not realize they have a problem, or are unable to report it.

Many times the changes noted by a nurse during care and assessments can improve treatment, provide information to other members of the healthcare team, and allow improvement of overall treatment.

Dryness in elders is normally found in eyes, nose, mouth, and skin.

And even though it may not be considered life threatening, the care and treatment of these conditions improves patient’s mental status, and quality of life factors.

Dry skin: Xerosis

B.A., a student nurse helping with health histories and medication lists in a free-clinic is talking with an 83-year-old man, complaining of a recurrent cough.

During the interview, she notices the patient is fidgeting, rubbing his arms and legs through his clothing. She asks if he is cold, and he snorts: “I’m itchy.”

She asks him to remove his coat and roll up his sleeves.

She notices his arms are covered with scabs and long excoriations

“Have you had this long?” she asks. His response: “All winter long.”

These changes in skin are generally dryness, discomfort, and itching, resulting from:

• Loss of elasticity
• Cell renewal and repair
• Decreased gland secretions
• Decreased blood flow

Itching and dryness

Itching and dryness are the two most common complaints, and close monitoring is important. The medical term is called xerosis.

Skin functioning normally performs several benefits for the body.

• Barrier to bacterial or irritants
• Connection of skin layers
• Protection of the body from excessive friction

Dermal thickness, which determines the skin health, decreases in aging.

Blood vessels, sweat glands, and the fat layer beneath the skin all decrease with age, which causes a reduction in cell renewal and repair, lubrication, and protective oil production to the skin.

(Dryness, cont’d next page)
(Dryness, cont’d)

Symptoms of dry skin include:
- Dryness, and flaking
- Redness, excoriations found on lower legs, elbows, forearms, lips, hands, and cheeks.
- Tenting of skin, showing dehydration.

Some solutions
There are simple approaches that will help in the care of your elder.
- Bathing less, and showering more increases the hydration of skin. Keep the shower warm, and limit to less than 10 minutes daily.
- Pat them dry with a soft towel, avoiding vigorous rubbing.
- Apply the appropriate moisturizer within three minutes of shower or bath.
- Use mild cleansers: unperfumed, non-deodorant, and alcohol free.
- Maintain a proper environment, using a humidifier if necessary.
- Avoid wool and rough fabrics for the elder, and be sure they wear gloves in cold weather...you need to treat their hands and lips with care.
- Use sunscreen and lip balm as necessary, and limit sun exposure.

Dry mouth: xerostomia
A.E., a nurse working for an endocrinologist, is taking vital signs. While talking to the patient, she learns that he has diabetes, Parkinson’s disease, and sometimes has swelling ankles.
She comments to him “I noticed you’ve lost eight pounds.”
“Nothing tastes very good anymore, so why bother eating. It’s hard swallowing sometimes, unless I drink a lot of water.”
A.E.’s patient may be suffering from xerostomia or dry mouth. Generally considered a nuisance condition, it can create long-term problems for the sufferer.

Causes and problems
Age reduces saliva output by 30%. Other major causes of dry mouth are drugs...including antihistamines, diuretics, anti-Parkinson drugs...and OTC cough medications. Frequently it occurs from an adverse reaction to a drug. Diseases like diabetes, depression, Parkinson’s, and radiotherapy to the head may also cause the problem.
This lack of saliva can cause all kinds of problems, since saliva is necessary for swallowing food. If food lacks enough softening, the patient is discouraged from eating. Saliva also aids in the taste and smell of food.

Problems caused by a lack of saliva include:
- Difficulty swallowing. This may eventually lead to possible aspiration.
- Difficulties with dentures. Saliva is also important for placement of dentures. Sores in the mouth from the dentures can result from xerostomia.
- Tooth problems. Teeth suffer the most from the presence of dry mouth. Cavities and periodontal disease increase in older adults, eventually leading to the need for dentures.
- Lack of good nutrition. Poor nutrition is a major problem for geriatric patients. And checking for dry mouth can frequently help considerably to improve nutrition, as dry mouth may be a contributing factor to poor nutrition.

When examining the mouth, a tongue blade can indicate if saliva is lacking.
Press a tongue blade against the tongue for five seconds. If the tongue blade falls off when released, saliva production is normal. However, if it sticks, then that may indicate dry mouth.

Dry mouth is more than just a nuisance: It can create long-term problems for the sufferer

Treatment
Treatment of dry mouth depends on its cause.
Therefore, you should report any complaints of dry mouth, so that a physician can make an examination.
There are several medications that can be used to help the condition.
Also, there are over-the-counter products that can be tried, including various rinses and chewing gum.
Note: Elders with dry mouth should avoid mouth rinses containing alcohol, as they can worsen the condition.

Nasal dryness
M.R., a home healthcare nurse is visiting her patient for the first time after she returned home from a rehabilitation facility.
The time of year is winter, and the house is very warm. During her evaluation, she notices her patient sniffs frequently; the end of the nose is very raw and scaly. In the trash container nearby, there are several tissues dotted with blood. “Do you have a stuffy nose?” “Yes, and it’s so sore, and bleeds constantly.” Her patient agrees.
Dry nasal passages occur for a variety of reasons, and is another condition found in older adults. In many cases, dry nose can result from
- Hot, dry, air-from central heating systems, or radiant heat.
- Drugs, such as antihistamines, nasal sprays, steroid nasal inhalers, and bronchodilators.
- Sjogren’s syndrome...a disease in which the white blood cells attack the moisture producing glands.
- Heavy smoking.
Chronic dry nasal membranes cause problems especially for elders.
Dysfunction of smell effects taste, as earlier discussed decreases appetite.
Though not considered life threatening, they frequently do not receive the medical attention they need.
Quality of life decreases with loss of smell. Reduced ability to smell decreases the perception of salty, sweet, sour, and bitter, or the inability to distinguish the two.
Nasal bleeding can result from nasal dryness, and can be related to:
• Nasal blowing
• Nose picking
• Nasal dryness
• Anticoagulant use
• Liver disease

Treatments
Excessive, ongoing nasal dryness should be checked by a physician for proper treatment.
Treatment possibilities include:
Use a humidifier in the elder's room, especially if in a dry climate, or wintertime when the air is much drier.
Nasal saline solutions can be effective, but be sure to check with medical personnel first.
Coating the lining of the nose with an ointment, or petroleum jelly type product, can bring relief. Use a Q-Tip.
However, it’s a good idea to check with medical personnel, first, as there have been reports of petroleum jelly causing pneumonia in some cases, if it is ingested into the lungs.

Dry eye problems
T.J., a house supervisor, is following up on a report of one of her shift staff who reported an elder with eye problems in a long-term nursing facility. The elder’s eyes are red, with tears running down her cheeks.

She is complaining of burning and irritation to sunlight. She admitted to rubbing them frequently.
T.J. determined that the patient returned from a family outing... a picnic in the park... and has been bothered by the condition since.
Dry eyes are a condition when an insufficient number of tears lubricate and nourish the eye.
Tears help provide clear vision and lubricate the front of the eye.
This condition is considered a chronic problem in older people. Glands around the eyelid produce tears, and this production diminishes with age. There are a variety of causes for dry eyes.
• Ketratoconjunctivitis sicca or dry eye syndrome
• The aging process
• Hormonal changes in women
• Medications
• Exposure to smoke, wind, and sun
• Smoking or second-hand smoke
• Other eye problems drooping eyelids
• Sjogren’s syndrome
• Blurred vision.

The most telltale symptoms include:
• Gritty, scratching, and burning sensations
• Feeling of object in eyes,
• Excessive watering,
• Blurred vision.
Blinking causes the tears to move across the eye. Anything that impairs the movement of the tears or creates excessive evaporation from the eyes may cause drying out.
Infection, blocked tear ducts, cataracts, corneal disease, and glaucoma may also cause tearing, and need further medical evaluation.

In assessing an eye problem in a patient, determine some of the following problems
-Does the problem cause pain?
-Do eyelids open and close easily?
-Does dryness seem related to environmental causes?
-Are new cosmetics being involved?
-Any allergies unknown?
-Are other symptoms such as dry mouth coexisting?
Dry eye can be a challenge to treat... and can be a symptom of serious disease... so you should report it for further medical evaluation. END

(Sjogren’s Syndrome)
Sjogren’s Syndrome is a serious disease, and major symptoms are dry eyes and dry mouth.
It’s an autoimmune disease that can also cause damage to other organs, and even the central nervous system. 90 percent of sufferers are women.
The Sjogren’s Syndrome Foundation says that about half the time it occurs alone, half the time with other autoimmune diseases such as rheumatoid arthritis, lupus, or scleroderma.
Sjogren’s can be very difficult to diagnose... diagnosis can often take years, in fact. But there are certain blood tests that provide valuable clues, and this is why it’s important for you to report cases of dry eyes and dry mouth, just in case this serious disease may be involved.
Relative to treatment, the Sjogren’s Foundation recommends over-the- counter eye drops and mouth rinses designed to combat dryness.
But, physician involvement is essential in treating this disease, as serious internal organ damage can occur. Treatment often involves rheumatologists who may use immunosuppressive drugs.
The Foundation says that the disease, while serious, is generally not fatal as long as its complications are spotted and treated early. This is another case of alert caregiving paying big dividends for the elder.
Therapeutic games
Memory game proved to be effective in severe Alzheimer’s now available

The game, called ‘Making Memories Together’, is a one-to-one intervention developed within a multi-university study by the National Institute on Aging led by Dr. Gene Cohen of The George Washington University Medical Center, in Washington.

Making Memories Together was tested on 33 nursing home elders with severe Alzheimer’s disease (AD).

Each elder received three interventions:
- A visit as usual from a family member;
- A visit from a family member who engaged the elder in a discussion using pictures from the TIME magazine; and
- Making Memories Together.

In order to avoid potential flaws due to the fact that AD patients perform differently on different days, participants received the interventions one after the other on the same day.

Also, each intervention lasted no more than 10 minutes, in order to prevent fatigue, and the game was the last in the sequence to make it even more challenging.

All interventions were videotaped.

The findings, which have been reported in the January 2009 issue of the American Journal of Alzheimer’s Disease and Other Dementias, show that engaging in the game:
- reduced feelings of sadness and depression;
- increased pleasure among participants, who smiled and laughed significantly more; and
- promoted interest and satisfaction.

How the game works
Making Memories Together is a non-competitive game, where the Alzheimer’s elder and family members, friends, staff or volunteers play together, all on the same team. It consists of:
- A playing board with four categories of squares – people, animals, places and special events, and favorite objects – each in a different color (e.g., blue for people, red for animals, etc.).
- Playing cards matching, in color and category, to the board squares.
- One marker: a small beanbag.
- Memory cards with borders of the same color as the board squares.

Young volunteers add to the intergenerational aspects of the game... they can also help families make the individualized cards (e.g., by assisting them with scanning, creating text, taking new pictures, etc.), and they warm up the setting with their youthful presence.

Not only Alzheimer’s patients have quality time while the game is played, but families are given the opportunity to create their loved one’s life history in a new way, and staff get to know better their patient’s earlier life.

The game is available for purchase from Dr. Cohen. More information about the study’s results, the game’s benefits and uses, and how to purchase it, are available from the researcher at GENCOWDC@aol.com.

Elders had reduced depression, more smiling and laughing, and a better response to music

Elders were more likely to follow objects with their eyes, move towards people and objects, establish and maintain eye contact, and attempt to respond vocally to music.

As Cohen points out, Making Memories Together also “facilitates visits... and, in the end, provides the family with a biography in the form of a game.

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Try a dance activity for exercise, cognitive improvement

*Any group size*

**Benefits:**
- Improves mobility and balance
- Promotes social interaction
- Improves mood

**Materials needed:**
- A spacious empty room
- A variety of ballroom music recordings
- Audio equipment
- Long pieces of colored fabrics, scarves, etc.

You may also want to consider asking family members, friends of staff, and friends of residents, if they know someone who can play an instrument and is willing to provide live music for your dancing session.

**Steps to follow:**
1. Start playing the music and encourage all residents to dance.
2. If elders with dementia and Parkinson's disease are in your group, help them to join the others, because they may find it difficult to begin movement.
3. Note: A dance activity can provide you with a great opportunity to use volunteers. Check with your local dance groups, dance instructors, or college students interested in dance.

Also, in order to make sure that wheelchair-bound residents enjoy dancing, give them one end of a colored scarf or piece of fabric, while one of the other residents holds the other end.

Then, teach them to move their hands holding the fabric. Although elders confined in a wheelchair are unable to move around freely, the waves in the fabric, which originate from their hands' movements, will provide them with a simple way to express themselves during the dancing.

Make sure that all elders have periods of rest.

At the end of the session, invite all of them to clap their hands and congratulate each other.

In one study, aimed at investigating potential links between participation in leisure activities and risk of dementia, researchers of the Albert Einstein College of Medicine, Bronx, New York, found that, in a group of 469 older persons aged 75 to 85, dancing was the only physical activity associated with a reduced incidence of dementia and Alzheimer's disease.

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**Certified Dementia Practitioner CE registration information**

Follow these directions to get CE credit for Dryness article, p. 2

**Instructions for completing**

1. Study article and test questions.
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Evidence-based activities that work for cognitive stimulation

By Lorena Tonarelli, M.Sc.
Care Guide Research Reporter

Research shows that cognitive stimulation plays an important role in the care of older adults with Alzheimer’s disease (AD) or a related dementia illness, but need to be proven effective.

Following are examples of evidence-based cognitive activities currently, and successfully, used in hospitals, nursing homes and other settings to improve memory and cognition.

Ideas for cognitive activities that prevent delirium, or help affected elders recover from it, are included.

Improve mental function

You probably know that cognitive stimulation activities help maintain and, in some cases, even improve mental function in dementia.

In fact, studies show that cognitive activities are, in this respect, as effective as Alzheimer’s drugs.

For this reason, the Centers for Medicare and Medicaid Services (CMS) recommends them in their new Activities Guidance for all elders with AD or other dementia.

Evidence required

You may not know, however, that all such activities should be evidence based; meaning that there has to be some proof, from studies or anecdotal, that they are effective.

This may present a few challenges when you are developing activities programs for your elders with dementia, as the CMS now requires, and need to decide which activities should be included and which shouldn’t.

Examples of activities that work

To help you with this, here is a selection of evidence-based cognitive activities by professor of gerontology and therapeutic recreation, Dr. Linda Buettner, of the University of North Carolina Greensboro.

They have been created especially for those with cognitive impairment, and are successfully used by Buettner and her team in various healthcare settings to enhance memory, thinking, and self-expression.

Each activity includes variations for the different stages of Alzheimer’s disease.

Online CEU credits available for Alzheimer's Association course

The Alzheimer’s Association is partnering with Midland College Health Science Continuing Education to provide professional CEUs such as type II for nursing, social workers, activity directors and other healthcare professionals that accept online training as professional CEU.

This seminar has been approved for 3 hours of CEU.

In order to receive CEUs, the Midland College Registration form must be completed.

Certificate Request, Evaluation and the post-test must be completed and payment received.

The fee is $21 and may be paid by credit card or check (made out to Alzheimer’s Association). You can take the course online, after registering, at www.alz.org.

For more information ph: 1-800-272-3900. Check the course out at: www.alz.org.
House map

Materials: paper and pencils for all participants.

Mild cognitive impairment. Invite your elders to draw the floor plan of the house where they lived during childhood. This should include windows and doors, and all rooms should be labeled. Next, ask the following questions to prompt discussion:

- Is the house still there?
- Did it have any special features?
- When was the last time you visited it?

Moderate cognitive impairment. In this variation, the elders are encouraged to draw the house (instead of the floor plan) and the people who used to live there.

Questions to prompt discussion should include such things as:

- Was the house in a rural area? Or in town?
- Did the house have a garden?
- What was your favorite room?

Severe cognitive impairment. Ask your elders to draw the house they grew up, and ask them:

- Was the house small/large?
- Who lived there?
- What state/town was it in?

Naming things

Materials: paper and pencils for all participants, and a blackboard.

Mild cognitive impairment. Ask the elders to think of a series of items that share particular features, and to write them down in a list. For example, things that

- can’t be touched or seen (e.g., memories, dreams, wishes);
- fit in a thimble (e.g., rice, pea); or
- “go bump in the night” (e.g., cat, ghost).

Write all the answers on the board for all participants to see, and encourage them to think of more answers.

Moderate cognitive impairment. Invite participants to write down a list of such things as different:

- jobs;
- sports;
- states;
- and so on.

Next, continue as described for elders with mild impairment.

Severe cognitive impairment. Ask the elders to say the name of something they

- like;
- can wear;
- hold;
- and so on.

You may also want to ask them to think of boys/girls names that begin with a certain letter. The same goes for animals, and so on. Write all the answers on the board and encourage everybody to think of more.

(Activities, cont’d next page)
If you were...

This activity is slightly simpler, as participants only need to answer questions verbally. Here are sample questions for different stages.

*Mild cognitive impairment:*

- If you were a plant/musical instrument/language, which one would you be?

*Moderate cognitive impairment:*

- If you were a piece of clothing, a type of weather, or a form of transportation which would you be?

*Severe cognitive impairment:*

- If you were an animal/ice cream flavor/color, which would you be?

If the answers are difficult for any of your elders, provide hints, or ask others in the group to help.

Activities should be ongoing

Cognitive stimulation should be part of an individualized program that also provides opportunities for exercise and social contact, and should be offered on an ongoing basis.

In a study published in the *American Journal of Recreation Therapy*, by professor Buettner and colleagues, an activities intervention of this kind, delivered for 12 months, allowed 40 elders with dementia to retain their cognitive skills for the overall duration of the study, as assessed with the Mini Mental State Examination (MMSE) scale.

In contrast, a matched control group of 40 elders who did not participate in the program had their cognition reduced by two points, which is about equivalent to the annual decline in MMSE score normally observed in people with Alzheimer’s disease.

These results are even more impressive if we consider that all elders involved in the study were on medication.

And that’s not all. Participation in the activities intervention also led to a dramatic reduction in depression, as the group’s average score on the Geriatric Depression Scale (GDS) decreased from 3.55, at the beginning of the study, to 2.29, at the end of it.

Prevents delirium

Also, something you may not know about cognitive stimulation activities, is that they are also increasingly used within therapeutic programs for the prevention and treatment of delirium, a condition characterized by sudden loss of attention and cognition, which develops in 89 percent of hospitalized older people with dementia, up to 76 percent of whom die.

Participation in the activities intervention also led to a dramatic reduction in depression

For example, cognitive activities are at the core of the Hospital Elder Life Program (HELP), which is used in several facilities around the country, following findings in the *Journal of the American Geriatrics Society* showing that it reduces the risk of delirium in dementia by 35.3 percent, and saves a 40-bed facility $626,261 over a period of six months.

Cognitive activities include trivia, reminiscence and current events. They are provided to the elder on a daily basis, by CNAs or volunteers, initially in hospital and, after discharge, in their usual place of residence, most often skilled nursing facilities, but also assisted-living centers.

Helps with recovery

Providing cognitive stimulation after hospital discharge is effective for helping the full recovery of those who had delirium. But, it’s also important for those who avoided it, because they are still at risk of developing the condition.

A program of cognitive stimulation, specifically for dementia elders discharged from hospital, who are recovering from delirium, has been developed by a team of researchers led by professor Ann Kolanowski, director of the Hartford Center of Geriatric Nursing Excellence (HCGNE), Pennsylvania State University.
Providing cognitive stimulation after hospital discharge is effective for helping the full recovery of those who have delirium.

“Older adults in the program are encouraged to read aloud, point out facts, describe things, ask/answer questions, and make choices.

Those with language deficits might be involved in solving increasingly difficult puzzles or following step-by-step directions in a therapeutic cooking program.

Animal-assisted therapy... might be used to engage an older adult in cognitive activities even while in bed.”

Those who are unable to concentrate can be involved in other forms of cognitive stimulation, such as listening to music or to a poem being read.

Kolanowski’s team investigated the effect of such interventions within a study partially funded by the National Institute on Aging.

The results, which appear in the journal *Annals of Long-term Care*, show that elders who participated in the program had a decline in cognition, from before hospitalization to one month after, of 0.5 points on the MMSE scale.

Those who did not participate in the program experienced a decline of 3 points, which is more than the average 2.2-point decline, per year, reported in studies for AD patients.

“Based on the extent of the problem of delirium following hospitalization and the clinical success of several cognitive rehabilitation programs, we encourage staff... to adopt these programs in an effort to shorten recovery time, reduce costs, and improve quality of life for older adults who experience the condition.”

**Tips for successful cognitive programs**

- Conduct the activities with small groups of elders with the same level of cognitive impairment.
- Choose frequency and duration of the activities according to the individual’s preferences and attention span.
- Always start with the easiest tasks and gradually increase the level of difficulty.
- Avoid interruptions during the implementation of cognitive activities.
- Take note of which activities work best, and your elders enjoy the most, so that they can be incorporated into their care plan.
- Encourage participants to perform their tasks as much independently as possible, but to help one another if they have difficulties.
- Ensure the activities are stimulating and fun, and never frustrating.

**A doll for your Alzheimer’s elders**

Findings from a small study at the University of Essex, Colchester, United Kingdom, confirm that dolls can be a valuable help in the care of persons with Alzheimer’s disease.

Clinical pathologist Dr. Ian James, of Newcastle General Hospital, and coworkers, studied 14 Alzheimer’s residents over a period of three months. Of these, 13 chose a doll and one a teddy bear.

Consistent with previous research, James’ team found that having a doll, or a teddy bear, improved communication, and reduced withdrawal, agitation and distress. Examples of their use include reminiscence scenarios where life like dolls have been introduced to residents and used to stimulate memories of an earlier rewarding life role, such as that of a parent.
Therapeutic activities for severe Alzheimer’s disease

Reminiscence photo video

Elders with severe Alzheimer’s disease (AD) have very short attention span, which limits participation in therapeutic activities, like reminiscence, that could improve their quality of life. Now, researchers in Japan have developed a reminiscence intervention, called personalized photo video, which successfully holds the attention of those with advanced AD, while stimulating their long-term memory and reducing the likelihood that they engage in disruptive behaviors, such as wandering, delusions and agitation.

“Each photo video lasts about 10 minutes... and consists of about 40 photographs... arranged chronologically from childhood to adulthood,” says the study’s lead researcher, Dr. Kiyoshi Yasuda, of Chiba Rosai Hospital, Ichiharashi.

Each photograph is shown for about 15 seconds... with pan/zoom effects.

Importantly, the video includes only photos of the elder’s past; there are no photos of traditional events or old customs in general.

This is for two reasons, says the researcher. Firstly, because AD patients develop what is known as ‘semantic amnesia,’ which makes them unable to recall generic memories, such as public events and traditional practices, whereas autobiographical memories, specially of younger years, are often maintained.

Secondly, because evidence shows that Alzheimer’s elders just love seeing their old photos.

The video has background music, consisting of the person’s old favorite tunes plus children songs, and is narrated by a female narrator who speaks slowly and gently, using short sentences of no more than five words.

Importantly, say Yasuda, no open-ended questions (e.g. “Who is sitting next to you in that picture?”) are included in the video, because they are too difficult to answer. “Instead, the narrator frequently praises the subjects in the photographs, saying for example, “You look beautiful,” and “Your dress is very nice.”

Elders enjoyed watch for hours

The video was tested on 15 elders with Alzheimer’s disease attending a hospital’s memory clinic, who watched it twice.

Yasuda’s team found that the video reduced problem behaviors, giving caregivers some respite time, improved the elders’ self esteem, and increased their alertness and ability to talk.

It was “impressive,” he says, how some of them gave extensive verbal responses to photos and narration. “Their interactions seemed like real dialogue.”

The success of the intervention, published online February 21, 2009, in the journal *Neuropsychological Rehabilitation*, can be summarized by a caregiver’s comment says a researcher.

“I showed her old photograph albums on several occasions. She did not look at the albums very long, but she enjoyed this photo video for several hours.

This video met my expectations.”

Tips

- Elders should watch the video in a quiet room.
- Caregivers should sit with them, and be ready to provide cues and prompts, if necessary.
- Yasuda says many children enjoy watching the video with their parents with dementia. It is, therefore, recommended to provide opportunities for elders and their children to participate in the activity together.
Music reduces heart failure risk in dementia by more than two-thirds

For elders with cognitive impairment, music therapy may be even more important than previously thought, and could potentially be used to save their lives.

A randomized study in the Jan. 2009 issue of the International Heart Journal found that older people with a dementia illness, who listened regularly to familiar music, had lower risk of congestive heart failure (CHF) – the most common cause of death and disability in elders – than matched controls who did not receive the music intervention.

Dr. Karou Okada, of Tama-Nagayama Hospital, Tokyo, Japan, and colleagues, randomized 87 elders with advanced dementia to 45-minute weekly sessions of music therapy (MT) or no music therapy (non-MT) for ten weeks.

Sessions were held during the morning, between 11.00 and 11.45 am, when patients with dementia are usually calmer and more alert.

They involved listening to well-known nursery rhymes, folk songs, hymns and popular music under the supervision of a music therapist.

At the end of the study, the risk of developing heart failure for elders in the MT group was more than two-thirds lower (10.9%) than in the non-MT group (34.4%).

The extraordinary protective effect of music against CHF is due to the ability of soothing music to reduce anxiety, and slow down heart and breathing rate, says the researcher.

“We conclude,” he says, “that MT might be a useful and inexpensive method for the prevention of CHF events in elderly dementia patients and could contribute to economically efficient health management as our society continues to age.”

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New depression therapy more effective than usual care

A recent paper in the Jan. 2009 issue of the American Journal of Alzheimer’s Disease & Other Dementias reports that Group, Individual and Staff Therapy (GIST) – a variant of cognitive behavioral therapy – is more effective than usual care in improving depression in affected elders with, and without, dementia living in nursing home.

The GIST intervention was administered for 15 weeks to 13 out of 25 residents with depression of a veteran’s nursing home in Central New Jersey.

The remaining 12 received usual care, consisting of daily activities, mostly games, as regularly offered by the facility.

Residents included cognitively intact elders and elders with early dementia. Dr. Lee Hyer, of the Institute for Mental Health Policy, Research, and Treatment, Cedar Grove, New Jersey, led the team who examined the effects of the GIST intervention.

This consisted of two individual sessions plus 13 weekly group sessions of 75 to 90 minutes each.

Setting goals...

During the first individual session, each elder is encouraged to think of a positive goal they’d like to achieve.

These should be written down, with the staff’s help, on a ‘goal sheet’ and should be “positive and meaningful,” says Hyer.

For example, calling a son/daughter, seeing a special doctor, and so on. The second individual session serves to address any physical or other barrier that may prevent participation in the GIST program.

The elder is also encouraged to choose a member of staff, who will become part of their support network during the intervention.

... And working towards them together

Each one of the 13 group sessions is structured as follows.

The therapist introduces the GIST intervention and encourages each elder to explain their goal. Then, the whole group works at solving any problem and/or difficulty encountered by individual members in trying to achieve such goals.

The group shares negative experiences and tries to address them together.

“Goals should be referred to as much as possible in all sessions,” says Hyer, “as they become the target for group discussion and intervention.”

Additionally, sessions included breathing relaxation exercises, as most participating elders enjoyed them, and were able to perform them easily.

Keys to success

Four elements are essential to the success of the intervention:

Behavioral activation. Elders are actively encouraged to say what kind of support they want from the group.

For instance, one elder may want help in the form of encouragement to strive towards their goal.

Social support. The group asks individual members to do something that helps them interact more with other people.

“This intervention can be very low-key, as in encouraging the member to just get out of their room,” says Hyer. “This is especially helpful when a member feels sad.”

Staff assistance. This ensures that the elder can, and will, do the task.

Motivation. Elders are reminded of the reasons why they are trying to achieve their goal.
Long-lasting improvement

At the end of the intervention period, elders in the GIST group had significantly fewer and less severe depressive symptoms (e.g., persistent sadness, negative mood, crying with no apparent reason, and lack of interest in activities previously enjoyed) than those who received usual care.

What’s more, such improvement, as assessed with the Geriatric Depression Scale Short Form (GDS-S), a screening tool for the detection of depression in older adults and people with dementia, was maintained for 14 weeks after the end of treatment.

Better cognition, too

At the end of the intervention, elders in the GIST group also had better cognition, as measured with the Mini-Mental State Examination (MMSE) scale.

The fact that the GIST intervention was effective in participants with early dementia is of particular relevance, for these elders are among those with the greatest risk of developing depression.

Up to 60 percent of patients with dementia in long-term care have the condition.

This is more likely to occur in early dementia, because, at this stage, the person is still well aware of their cognitive problems.

Therefore, they are more vulnerable than those with severe dementia to experience persistent feelings of embarrassment, isolation, and worthlessness, which are known to lead to depression.

“Finally,” concludes the researcher, “the GIST model is inherently flexible enough to be applied in other LTC venues, such as assisted living facilities, congregate housing, and senior centers.”

Answers to delirium quiz

1. T
2. T
3. a,b,c,d
4. a,b,c,d,e
5. T
6. T
7. T
8. T
9. T
10. T

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CE Training
Reminiscence
Therapeutic Activities
Help the new resident by being you

By Garda Cuthbert, RN, CNHA

Not too many people are comfortable with change or with new situations. Admission to a health-care facility is one of those changes and situations that is difficult for the resident as well as for family and friends.

As a caregiver, you can help new residents feel welcome by remembering and using what helped you face some of the changes and new experiences you had in the past and what helped you to feel more comfortable with them.

You can help new residents by relating to their fears, using empathy and by being yourself.

In order to truly help the resident and the family overcome any misgivings and feel welcome and anticipated, follow these practical tips:

- **Be yourself – be personable.**
  Be proud of your facility and tell why you enjoy being a part of all it has to offer.
  Offer “newsy” information – not usual details from the marketing brochure.
  Give honest reasons why you think the resident will begin to like the facility.

- **Smile at every opportunity**
  A smile says a lot about you, what you think, and what the facility is like.

- **Relate to the resident and family**
  Anticipate questions and answer them honestly. Be alert to facial expressions and body language. If either indicate distress, don’t be afraid to mention them and ask if you can help.

- **Introduce all staff and residents**
  Especially those in nearby areas. Allow time for dialogue and comments from all.

  Don’t be in a hurry. Take your prompts from the new resident and family and respond accordingly.

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• **Have everything prepared** – a welcome sign on the resident’s door, a small bouquet of flowers on the night stand, a reading light turned on, window shades opened...think of what a four star hotel might do for its guests and try to do the same as much as possible.

Be responsive to needs and offer superb “customer” service. Put yourself in your resident and family member’s place – what would you want?

• **Help place personal items.**

Hopefully, the family of the new resident has brought with them some important, meaningful items for the new room.

Help with placing them where the resident wants them. Move other things out of the way if necessary.

Perhaps the family already transferred in some larger items to make the new room even more home-like and comfortable.

Ask the resident if anything else is wanted from home and follow-up to make sure it is delivered in a timely fashion.

• **Ask another resident to be the new resident’s buddy** – and accompany to meals and activities and anything else going on for the next few days.

Ask the buddy to answer resident and family questions as they come up during the first few days.

• **Give as detailed a tour as the resident and family seem interested in.**

Be sure to point out the dining rooms, mention meal times and where and when snacks may be found.

Show activity, tv, craft and game rooms, and the library if you have one. Some facilities have chapels or meditation rooms – be sure to show where they are located.

• **Ask about special interests and needs and try to accommodate as much as possible.**

If the resident likes to do puzzles, for example, show where puzzles can be set up and where to find new ones.

• **Allow for private time** for the resident and the family member to talk with you about any concerns or problems that may be arise.

Let each know you are available and very interested in the welfare of the resident and the family.

Express your understanding of adjustment periods for both and how new experiences are sometimes difficult to face.

• **Call the family member on a daily basis** (with your supervisor’s approval) to give an update of happenings and offer the family member a chance to talk.

• **Plan to see the new resident as often as possible** throughout your time at the facility.

Even if you are assigned to another wing or section, make it a point to see the new resident several times a day.

• **Remember, you can’t do everything alone.** Make it your priority to involve all staff members in making the new resident and all residents feel at home, wanted and cared for.

Encourage those smiles.

• **Involve the other residents in helping the new resident** be included in all aspects of facility life. Involve other family members, too. Besides family or resident council meetings, there are many other opportunities to include everyone in day to day occasions.

Welcoming a new resident and family member should be a heartfelt experience.

It should be driven by empathy and a genuine desire to help make the experience a good and positive one.

If you remember to be yourself and understand that change is difficult, you can offer the resident and family member what is needed to make the new experience a good one.
One in every 20 Americans over the age of 50 has P.A.D., a condition that raises the risk for heart attack and stroke. Peripheral arterial disease, or P.A.D., develops when arteries become clogged with plaque—fatty deposits that limit blood flow to the legs. Just like clogged arteries in the heart, clogged arteries in the legs mean that an elder may be at risk for heart attack or stroke.

Timely detection and treatment of P.A.D. can improve the quality of your elder’s life; help them keep their independence and mobility; and reduce risk of heart attack, stroke, leg amputation, and even death. Report symptoms of P.A.D. to medical personnel.

What are the Signs and Symptoms of P.A.D.?
If they are present, the typical signs and symptoms of the disease include:
- Claudication—fatigue, heaviness, tiredness, cramping in the leg muscles (buttocks, thigh, or calf) that occurs during activity such as walking or climbing stairs. This pain or discomfort goes away once the activity is stopped and during rest. Many people do not report this problem to their health care providers because they think it is a natural part of aging or due to some other cause.
- Pain in the legs and/or feet that disturbs sleep.
- Sores or wounds on toes, feet, or legs that heal slowly, poorly, or not at all.
- Color changes in the skin of the feet, including paleness or blueness.
- A lower temperature in one leg compared to the other leg.
- Poor nail growth and decreased hair growth on toes and legs.
- Poster is from the National Institutes of Health.

If you believe you are at risk for P.A.D., discuss this concern with your health care provider. Find out if you should be tested for P.A.D. and what you can do to lower your risk.

Certified Dementia Practitioner CE registration information

Successful completion of the quiz over this article earns the participant 2 NCCDP continuing education credits toward renewal of the DEMENTIA PRACTITIONER CERTIFICATION (C.D.P.)
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3. Click on “Free CEUs.”
4. Click on “Take Test.”
5. Enter your CCDP account ID and password.

Note: You can preview a copy of the test, prior to taking it, by logging onto your Alzheimer’s Care Guide subscriber account. Logon instructions on p. 2.

6. Take the test online at www.nccdp.org. A score of 75% or better must be obtained in order to receive credit.
7. Your CEs will be automatically credited to your account, and a certificate printed for you.

Evidence-based dementia caregiving

Want to bring happiness in your elders’ life? UK study tells how

A first-of-its-kind study in The Gerontologist found that almost nine out of ten dementia elders are extremely unhappy, and experience “a sense of isolation that contributes to feelings of fear.”

One in two spend most of their time doing nothing and want more independence.

A lot can be done to bring happiness and meaning in the life of these elders, say the researchers, nothing complicated or expensive, just simple acts of kindness, compassion and caring.

You’ve probably heard that putting yourself in the ‘shoes’ of elders with dementia helps better understand their needs, so you can effectively care for them.

Importantly, this also helps reduce your risk of burnout.

Research shows that, although nursing staff spend up to 40 percent of their time dealing with some aspect of dementia care, many don’t know how to do it properly, which puts them under enormous pressure and makes them vulnerable to stress and burnout.

However, unless you’ve heard it from the patients themselves, there is no way to know what it is like to live with dementia, and putting yourself in their ‘shoes’ may not be as easy as you think.

So, professor Linda Clare and colleagues, from Bangor University, in the United Kingdom, asked the elders directly about their views of life in a nursing home.

The team identified 80 elders with moderate to severe dementia, who had some communication skills left, from ten residential homes.

They recorded up to eight conversations with each elder, for a total of 307 transcripts.

Given the severity of the participants’ impairment, the team used a special interviewing technique, whereby the elders themselves led an unstructured conversation instead of answering questions.

Want to do more

The results showed that 89 percent of the participants felt lonely, isolated, fearful and worthless.

What’s more, 50 percent of the participants complained that they felt confined and wanted more independence.

They also complained about the “dullness and boredom” of life in the home.

Making their life better

These findings allowed the researchers to determine what can bring happiness and meaning in the life of elders with dementia.

Their recommendations are:

• Take your elders’ feelings seriously. Share their joys, but offer support and reassurance if they feel sad, worried or fearful, so as to provide sense of safety and security.

• Talk with them a lot about their past life and their memories. Reminisce together about pleasant events and achievements.

• Give them compliments for things they can still do, no matter how small.

• Take active steps to facilitate the development of friendships, “for example by introducing residents to one another repeatedly,” says Clare, “and engaging them in group activities.” Consider that having a ‘buddy’ seems to be particularly important for these elders.

• Provide opportunities for conversation with fellow residents with the same level of impairment.

• Give choices and encourage independence.

  This includes making your elders feel they are still in control of things. So, ask them about their wishes and preferences, and do your best to meet them.

• Make them feel useful and helpful, by engaging them in meaningful activities, such as helping with cooking and shopping, putting books on shelves, and so on, chosen according to the elders’ interests.

• Be sensitive to their need for privacy. Provide opportunities for quiet time, especially to the less outgoing.
What you can do to help with delirium in your cognitively impaired elders

Inservice training for CNAs in the latest in evidence-based caregiving

As one of the most common and serious medical conditions among elders, delirium poses a major health problem, particularly for older adults who suffer from dementia, where it may easily go undetected with often dramatic consequences.

Nevertheless, rapid recognition of symptoms and a non-drug approaches aimed at restoring and maintaining awareness of the environment can help prevent complications and ensure recovery.

Delirium is a common, sometimes life-threatening, condition occurring in up to 50 percent of all hospitalized and community elders aged 65 or older, and in up to 60 percent of nursing home residents over the age of 75.

Delirium is an acute stage of confusion that comes and goes over the course of the day. Its symptoms can include such things as:

• altered level of consciousness
• inattention
• disorganized thought and speech
• disorientation
• behavioral disturbances

Delirium is particularly common among elders with dementia.

Since delirium has some of the same symptoms as dementia—such as anxiety, agitation, hallucinations, confusion, and aggression—it often goes undetected in the cognitive impaired elderly, and can be mistakenly diagnosed as worsening dementia.

And when it is not properly diagnosed, or overlooked as dementia, that can be a serious problem for the elder. For if left unresolved, ongoing delirium can make the elder’s medical situation much worse.

“Delirium in a patient with preexisting dementia is a common problem that may have serious complications,” says Donna Fick, RN, PhD, of the Medical College of Georgia.

It may worsen the outlook of their dementia... and may be associated with substantially worse long-term outcomes than in people without delirium, including prolonged hospitalization, decline in cognitive and physical functioning, rehospitalization, nursing home placement, and death.”

In one study, involving patients with and without dementia, nurses and physicians failed to recognize delirium in those elders with dementia in 88 percent of the cases, says the researcher.

In contrast, all of the cases of delirium in those without dementia were detected.

“Delirium in those elders with dementia should not be regarded as unimportant, and labeled as an exacerbation of dementia that will resolve when the patient returns home,” says Fick.

In other words, delirium needs prompt diagnosis and treatment for the well-being of the elder.

This is where front-line caregivers can be very important, for they are often the first ones to notice subtle changes in their elders, which may be signs that delirium is developing.

What is delirium?

On the whole, the main characteristics of an episode of delirium can be summarized as follows:

• Deterioration in cognitive functions, like memory, orientation, and language.
• Disturbance of consciousness, including reduced attention, inability to concentrate, and improper awareness and responsiveness to the environment.
• Sudden onset of symptoms, which may develop over a short period of time, usually hours.
• Tendency of symptoms to fluctuate considerably during the course of a day.
• Delirium can last from several hours to several days.
Underlying causes
Diseases such as diabetes, hyper- or hypo-thyroidism, hypoglycemia, kidney disease, and pulmonary disease, are all important causes of delirium.

Other potential causes include
• fever;
• infections;
• dehydration;
• immobility;
• sleep deprivation;
• visual and hearing impairments;
• head trauma;
• cancer.

In addition, studies have shown that certain medications—benzodiazepines, edatives, antipsychotics, antihistamines, and nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen—may also induce delirium.

Recognizing delirium in dementia
Although the sudden onset and the fluctuating nature of delirium remain the key features for the prompt identification of this condition in the cognitive impaired elder, other important clinical features allow caregivers to distinguish delirium from dementia.

Frontline caregivers...who have close contact with their elders... are often the first to recognize these early mental and behavioral changes characteristic of delirium.

Anyone caring for someone with dementia should therefore be on the outlook for the following symptoms that could indicate delirium:
• Increased mental confusion.
• Increased irritability, anxiety, and agitation.
• Visual and auditory hallucinations, and delusions.
• Shifts in mood.
• Excessive sensitivity to light and sounds.
• Apathy and depression.
• Wandering and rambling speech.
• Tremor.

Typically, the elder will suddenly appear more confused than usual and, depending on their speech ability, will ask for things to be repeated several times. They will start to slip in and out of consciousness, and, in the periods of lucidity, they will neither unusually quiet and withdrawn or more active than normal.

Some elders may become aggressive against nursing staff, and attempt to climb over bedrails, or to remove catheters, drains, and tubes.

Others may have suicidal thoughts.

Avoid the use of drugs
Once delirium has been recognized, attempts to diagnose the underlying cause should be made without delay.

An elder with delirium is at increased risk of falls, pressure sores, and incontinence, so quick diagnosis and treatment is strongly advised.

Symptoms need to be treated promptly and adequately.

But, for this, most experts recommend that drugs be used only when everything else has failed, since medications like benzodiazepines and antipsychotics may actually worsen delirium.

Furthermore, several studies indicate that, although cognitively impaired persons are more vulnerable to delirium, they are also more likely to benefit from appropriate non-drug interventions.

Non-drug approaches
In elders with dementia, the recommended intervention is a non-drug approach that maximizes caregiver support.

This minimizes the use of medications and, instead, emphasizes caregiver attention that includes adequate hydration, and attending to sensory needs, such as vision and hearing impairment, explains Fick.

In particular, “environmental interventions such as providing a regular routine, orientation objects (clocks, calendars, photos), adjusting lighting, providing familiar caregivers, reducing restraints use, and simplifying the environment, may decrease delirium in person with dementia.”

Help with reorientation
In fact, providing constant visual and verbal clues to keep the elder in touch with reality—an approach known as Reality Orientation (RO)—is now considered by experts worldwide as the preferred alternative to drugs for an effective management of the symptoms of delirium.

The following suggestions from Dr. David Meagher, from the Department of Clinical Research of Crichton Hospital, Scotland, can help family caregivers, and hospital or nursing home staff, to orientate the cognitively impaired elders with delirium:
• Place clocks and calendars within the person’s view.
• Give frequent reminders of the time of the day, day of the week, month, and year.
• Remind the elder of the names of staff and relatives, and of the name of the hospital or nursing home.
• Provide the person with familiar objects from home, including family pictures.
• If possible, ensure that care is provided by the same member of staff.
For the orientation approach to be successful, it’s essential to communicate clearly with the elder using short, simple sentences and repeating things whenever necessary—and provide reassurance, affection, and comfort.

Importantly, the person’s sight and hearing should be checked and corrected with glasses and hearing aids.

Sleep patterns should be maintained or restored. Other caregiver interventions, that research has shown to be effective in treating delirium, include:
- A daily exercise program.
- Reducing noise from things like beepers and telephones, in order to help them with sleeping.
- Daily cognitive stimulation activities for those elders with Alzheimer’s.
- For those elders who have sensory impairments, providing devices such as visual aids, larger size push-button phones, and sound amplifiers.

Provide a good therapeutic environment
According to guidelines from various experts, good management of delirium should also be directed at improving and simplifying the environment. This can be achieved by:
- Providing adequate lighting during the day.
- Leaving the night-light on during the night.
- Ensuring exposure to natural light, even if only through a window.
- Eliminating excessive, or sudden, noise.
- Removing potentially harmful objects.
- Ensuring that the room is adequately warm.
- Research shows that it’s also essential that, whenever possible, the elder with delirium remains active.

In particular, “ambulatory patients should walk three times each day,” says Meagher, while “non-ambulatory patients should undergo a full range of movements for 15 minutes three times each day.”

Restraints should be avoided, since they may cause harm and injuries, and have not been proved to be effective in improving the symptoms of delirium.

Note: you should always be very compassionate and understanding for those elders who have delirium.

This can be an extremely difficult, often frightening, time for them, and may indicate that other serious diseases are present, as well.

So they need all the compassionate, friendly, understanding caregiving that you can give them. Greet them each day with a smile and kind words. That can help them a lot. END

Non-drug interventions are recommended for delirium, including:
- Provide good lighting, day and night
- Eliminate excessive and sudden noise.
- Provide exercise.
- Conduct cognitive stimulation activities.
- Give them plenty of exercise.
- Provide familiar caregivers.
- Provide familiar objects.
- Check eyesight and hearing.

End of Life: Helping with Comfort and Care
A new booklet on end-of-life care is available from the National Institute on Aging. End of Life: Helping with Comfort and Care is written and designed to help caregivers and families make the period just before the death of an older person as comfortable as possible for everyone involved. The booklet provides an overview of issues faced by caregivers and families, such as:
- providing comfort for the dying person
- making health care decisions
- actions to take right after the person dies
- ways to handle grief

The booklet is based on research, augmented by suggestions from practitioners with expertise in helping individuals and families through this difficult time.

The booklet can help readers better understand what is happening and give them a framework for making care decisions.

End of Life: Helping with Comfort and Care is available online at www.nia.nih.gov/HealthInformation/Publications/end-of-life.htm. You can also call the ADEAR Center at 1-800-438-4380.

(Quiz p. 26)
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Visit BetterDiabetesCare at www.BetterDiabetesCare.nih.gov, share the site with colleagues, and click on the CE link to learn more and to begin earning credits!


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www.ndep.nih.gov
Helping your elders get their financial situation in order

Elders with Alzheimer’s need to get their financial, and other personal affairs in order, before the disease advances to the stage whereby they cannot make these decisions on their own.

The National Institute on Aging’s Alzheimer’s Disease Education and Referral Center (ADEAR) has a brochure available with suggestions on how the elder can proceed to get their financial situation in order.

The title of the brochure is: Legal and Financial Planning for People with Alzheimer’s Disease. For your information, we’ve reproduced key sections of the brochure here.

You can download the complete brochure, free, by logging onto the ADEAR Internet site at: www.nia.nih.gov/Alzheimer’s.

Many people are unprepared to deal with the legal and financial consequences of a serious illness such as Alzheimer’s disease (AD).

Legal and medical experts encourage people recently diagnosed with a serious illness — particularly one that is expected to cause declining mental and physical health — to examine and update their financial and health care arrangements as soon as possible.

Basic legal and financial instruments, such as a will, a living trust, and advance directives, are available to ensure that the person’s late-stage or end-of-life health care and financial decisions are carried out.

When possible, advance planning should take place soon after a diagnosis of early-stage AD while the person can participate in discussions.

People with early-stage AD are often capable of understanding many aspects and consequences of legal decision making.

However, legal and medical experts say that many forms of planning can help the person and his or her family even if the person is diagnosed with later-stage AD.

Use a lawyer

There are good reasons to retain the services of a lawyer when preparing advance planning documents. For example, a lawyer can help interpret different State laws and suggest ways to ensure that the patient’s and family’s wishes are carried out.

It’s important to understand that laws vary by state, and changes in situation — for instance, a divorce, re-location, or death in the family — can influence how documents are prepared and subsequently maintained.

Advance Directives for Health Care

Advance directives for health care are documents that communicate the health care wishes of a person with AD. These decisions are then carried out after the person no longer can make decisions.

In most cases, these documents must be prepared while the person is legally able to execute them.

A Living Will records a person’s wishes for medical treatment near the end of life. It may do the following:

• specify the extent of life-sustaining treatment and major health care the person wants
• help a terminal patient die with dignity
• protect the physician or hospital from liability for carrying out the patient’s instructions
• specify how much discretion the person gives to his or her proxy (discussed in the next item) about end-of-life decisions

A Durable Power of Attorney for Health Care appoints a designated person, sometimes called an agent or proxy, to make health care decisions when the person with AD no longer can do so. Depending on State laws and the person’s preferences, the proxy might be authorized to:

• refuse or agree to treatments
• change health care providers
• remove the patient from an institution
• decide about making organ donations
• decide about starting or continuing life support (if not specified in a living will)
• decide whether the person with AD will end life at home or in a facility
• have access to medical records

A Do Not Resuscitate (DNR) Order instructs health care professionals not to perform cardiopulmonary resuscitation if a person’s heart stops or if he or she stops breathing. A DNR order is signed by a doctor and put in a person’s medical chart.

Advance Directives for Financial and Estate Management

Advance directives for financial and estate management must be created while the person with AD still can make these decisions (sometimes referred to as “having legal capacity” to make decisions). These directives may include some or all of the following:

A Will, which indicates how a person’s assets and estate will be distributed upon death. It also can specify:
• arrangements for care of minors
• gifts
• trusts to manage the estate
• funeral and/or burial arrangements

Medical and legal experts say that the newly diagnosed person with AD and his or her family should move quickly to make or update a will and secure the estate.

A Durable Power of Attorney for Finances names someone to make financial decisions when the person with AD no longer can. It can help people with AD and their families avoid court actions that may take away control of financial affairs.

A Living Trust provides instructions about the person’s estate and appoints someone, often referred to as the trustee, to hold title to property and funds for the beneficiaries. The trustee follows these instructions after the person no longer can manage his or her affairs.

A living trust can:
• include a wide range of property
• provide a detailed plan for property disposition
• avoid the expense and delay of probate (in which the courts establish the validity of a will)
• state how property should be distributed when the last beneficiary dies and whether the trust should continue to benefit others

Who Can Help?

Health care providers cannot act as legal or financial advisors, but they can encourage planning discussions between patients and their families.

Qualified clinicians can also guide patients, families, the care team, attorneys, and judges regarding the patient’s ability to make decisions.

Advice to elders: Steps for getting your affairs in order

• Gather everything you can about your income, property, investments, insurance, and savings.
• Put copies of legal documents and other important papers in one place.
  You could set up a file, put everything in a desk or dresser drawer, or just list the information and location of papers in a notebook.
  If your papers are in a bank safe deposit box, keep copies in a file at home. Check regularly to see if there’s anything new to add.
• Tell a trusted family member or friend where you put your important papers.
  You don’t need to tell this friend or family member your personal business, but someone should know where you keep your papers in case of emergency.
  If you don’t have a relative or friend you trust, ask a lawyer to help.

Resources for Low-Income Families

Families who cannot afford a lawyer still can do advance planning. The following resources can help:
• Samples of basic health planning documents can be downloaded from State government websites.
• Area Agency on Aging officials may provide legal advice or help.

Other possible sources of legal assistance and referral include:

National Institute on Aging Information Center
P.O. Box 8057
Gaithersburg, MD 20898-8057
800-222-2225 (toll-free)
800-222-4225 (TTY/toll-free)
www.nia.nih.gov/HealthInformation
www.nia.nih.gov/Espanol

National Academy of Elder Law Attorneys
1604 North Country Club Road
Tucson, AZ 85716
520-881-4005
www.naela.org

State legal aid offices
State bar association
Local nonprofit agencies
Foundations
Social service agencies
Inservice quiz:
Delirium

Nursing objectives:
1. To understand the differences between dementia and delirium.
2. To recognize the symptoms of delirium, and how they’re different from dementia.
3. To learn about treatments to improve delirium that frontline caregivers can do.
4. To understand why it’s important to report symptoms of delirium early.

1. True, False. Since delirium is a part of dementia, it does not get treated in those who have Alzheimer’s.
2. True, False. Frontline caregivers are often the ones who can first detect the subtle signs of delirium in their elders.
3. What are some of the symptoms of delirium? (Check all that apply.)
   a. Disorganized thought and speech
   b. Unable to pay attention.
   c. Disorientation.
   d. Behavioral disturbances.
4. What are some of the causes of delirium? (Check all that apply.)
   a. Diabetes.
   b. Cancer
   c. Dehydration
   d. Head injury.
   e. Kidney disease.
5. True, False. Non-drug interventions are the most successful in treating delirium.
6. True, False. Delirium is a very serious situation for an elder, and can result in increased cognitive decline, and even an early death.
7. True, False. You’ll want to avoid exercising elders with delirium, because it may make their confusion even worse.
8. True, False. Providing the elder with familiar objects from home, including family pictures has been proven to help improve delirium.
9. True, False. Providing good lighting during both day and night can help improve delirium in many elders.
10. True, False. Daily cognitive stimulation activities can reduce delirium in those elders who also have Alzheimer’s disease.

(Answers p. 15)

Name ______________________________ Date________________ Score_____________
Upcoming topics for 2009:

Jan: Resident rights: The latest legal update, basic Dos & Don’ts
Feb: Maintaining a good quality-of-life for elders: What the regulations say; why it’s important, how to maintain a good quality-of-life for your elders, more.
March: Personal care skills. Why good personal care is important, factors that make for good personal care; personal care for Alzheimer’s elders; Dos and Don’ts.
April: Domestic violence: It’s everyone’s problem. Signs, symptoms, how to help.
May: Problem behaviors: Some basic tips on how to successfully deal with them; ideas for preventing; more.
June: Infection control, including the deadly MRSA. Includes the latest Federal recommendations.
July: Emergency procedures: Fire, storm, medical (such as Heimlich maneuver.)
August: Basics of safe lifting and transporting.
Sept: Successfully coping with problem behaviors: the latest research and recommendations.
Oct: Techniques for successfully communicating with elders who have Alzheimer’s.
   The latest research and recommendations.
Nov: Providing good oral care, and why it’s important.
Dec: Preventing pressure ulcers: An update on the latest research and recommendations that are working, including new information from the CMS Quality Initiative pressure ulcer reduction program and education.

Plus, a big bonus for educators: a free Internet Educational Library for you... to provide you with additional training materials, such as PowerPoint slides, MS Word slides and teacher’s discussion notes, handouts, etc... available online free to subscribers, to make their teaching job easier!
A person-centered behavioral therapy program proven to significantly reduce depression... and problem behaviors... in your elders

An easy-to-understand 88-page educational manual that provides non-mental health caregivers with step-by-step instructions for treating and managing depression among elderly patients.

Depression is a serious problem in the elderly. Research shows that up to 30-45% of elders in nursing homes can be depressed. Depression can substantially reduce the elder’s quality of life, and result in increased problem behaviors, worsening health problems, and more. But it’s often not diagnosed or treated effectively, so it remains an ongoing problem with many elders.

Depression can, however, be effectively treated with simple... and fun... behavioral therapy programs that most any trained caregiver can conduct!

One of the pioneers in developing this effective therapy is Dr. Peter A. Lichtenberg, professor of psychology, psychiatry, and behavioral neuroscience at Wayne State University, Detroit, Michigan. He and his research colleagues have developed an innovative, and effective, behavioral therapy program that has been proven in research studies to significantly reduce depression in elders.

Their program can be conducted by most any trained activity director, therapist, or CNA.

This 88-page manual contains information, questionnaires and other tools that will allow you to conduct an effective, individualized, person-centered, behavioral therapy program in your facility.

Plus, there’s another benefit. The manual contains a special person-centered program called “Pleasant Activities” which can also help reduce certain problem behaviors, such as anxiety, agitation, and aggression, in Alzheimer’s residents, as well.

Included is a handy questionnaire to identify which Pleasant Activities each resident is personally interested in.

This tool is ideal for determining specific person-centered activities to enhance the Activities of Daily Living for each resident, which the new CMS Activities Guidelines recommend.

Chapters include:

- Procedures for Assessment and Treatment of Depression
- Basic Elements of Behavioral Treatment
- Developing Rapport with the Patient
- Assessing the Patient’s Mood
- Combining Controlled Breathing and Visual Imagery
- Integrating Pleasant Events into the Session
- Use of Positive Reinforcement Strategies
- And more.

This manual will assist you in:

✓ Understanding the scope of depression in the geriatric medical population.

✓ Facilitating early identification of the depressed geriatric patient.

✓ Providing a well-standardized and effective means of assisting your elders in improving their moods.

✓ Developing person-centered programs that work for both depression and problem behaviors.

Only $36 with free shipping!

A great value, considering its importance to your elders’ quality of life!


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ALZHEIMER’S CARE GUIDE (ISSN 10705112/USPS 010 268) is published bi-monthly for $65 per year by Freiberg Press Inc., PO Box 612, Cedar Falls, IA 50613. Periodicals postage paid at Cedar Falls, IA. POSTMASTER: Send address changes to Alzheimer’s Care Guide, PO Box 612, Cedar Falls, IA 50613. Ph: 319-553-0642 Fax: 319-553-0644

Email: admin@care4elders.com; Internet: www.care4elders.com

INTERNATIONAL ORDERS: $65 per year in Canada, $85 elsewhere. The words "U.S. Funds" must appear on the check.

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Editor/publisher: Bill Freiberg.

Note: Because of varying regulations, differing medical opinions, the fact that individual elders may respond differently, varying research results, errors, and so on, always check with medical personnel before undertaking the advice and programs in this newsletter.