

If you are viewing this course as a recorded course after the live webinar, you can use the scroll bar at the bottom of the player window to pause and navigate the course.

This handout is for reference only. It may not include content identical to the powerpoint. Any links included in the handout are current at the time of the live webinar, but are subject to change and may not be current at a later date.

ALZHEIMER'S 101: A OVERVIEW FOR HEALTHCARE PROFESSIONALS

Megan L. Malone, M.A. CCC-SLP

Jenny Loehr, M.A. CCC-SLP

Presented for Speechpathology.com

OBJECTIVES

By the end of this course, participants will be able to:

- describe strategies to communicate with patients with Alzheimer's disease and related disorders, throughout progression of the disease.
- describe methods to manage behavioral challenges related to Alzheimers disease/dementia.
- list current interventions and methods used with patients with Alzheimers/dementia to promote independence and improve participation in activities of daily living.
- describe methods/strategies to help support families/caregivers of persons with Alzheimers disease/dementia..

DISCLOSURES

- The presenters of this course are the authors of the treatment manual, “Here’s How to Treat Dementia” (2013), published by Plural Publishing.

ACKNOWLEDGEMENTS

- Information shared in this presentation is provided through the work of various organizations & professionals:
 - Menorah Park Center for Senior Living/Myers Research Institute, Beachwood, OH
 - State of New York, Department of Aging
 - Hearthstone Alzheimer’s Care, Woburn, MA.
 - Northern Speech Services
 - National Institute on Aging
 - Retirement Research Foundation
 - National Alzheimer’s Association

PART I: UNDERSTANDING DEMENTIA & ALZHEIMER'S DISEASE

- Dementia & Alzheimer's Defined & Demographics
- Causes
- Symptoms
- Physical Considerations
- Memory Overview

PART I: DEMENTIA/ALZHEIMER'S DEFINED & DEMOGRAPHICS

QUESTION TO CONSIDER:

“ON A SCALE OF 1 TO 10,
HOW WOULD YOU RATE
YOUR LEVEL OF
KNOWLEDGE OF
ALZHEIMER’S &
DEMENTIA?”

QUESTION TO CONSIDER:

“WHAT DO YOU CONSIDER
YOUR CURRENT ROLE TO
BE IN WORKING WITH
PERSONS WITH
ALZHEIMER’S/DEMENTIA?”

DEMENTIA DEFINED

- Dementia is not a specific disease
- Dementia is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain.
 - This includes Alzheimer's Disease
- Diagnosis is made if two or more brain functions such as memory and language skills are significantly impaired without loss of consciousness.

RESEARCH TELLS US...

- Dementia is the loss of mental functions involving thinking, memory, reasoning, and language to such an extent that it interferes with a person's daily living.
- Dementia is a group of symptoms that can include:
 - **Language disturbances** (e.g., aphasia, dysphasia, anomia)
 - **Problematic behaviors** (e.g., repetitive questioning, wandering)
 - **Difficulties with activities of daily living** (e.g., dressing, personal grooming)
 - **Personality disorders** (e.g., disengagement, aggressive behaviors)

Loehr & Malone, 2013

ALZHEIMER'S DEFINED

According to the Alzheimer's Association (2017)(1):

- Alzheimer's is a type of dementia that causes problems with memory, thinking and behavior.
- Symptoms usually develop slowly and get worse over time, becoming severe enough to interfere with daily tasks.
- Alzheimer's is the most common form of dementia
 - Accounts for 50-80% of dementia cases

ALZHEIMER'S DEFINED (CONTINUED)

- Alzheimer's is not a normal part of aging
 - Age is a risk factor, but up to 5% of cases have onset as early as 40's and 50's (early onset)
- Alzheimer's is a progressive disease
- There is no current cure, but treatments of the symptoms of Alzheimer's exist and research is ongoing.

DEMOGRAPHICS OF ALZHEIMER'S & DEMENTIA

- More than 5 million people are living with Alzheimer's
- Alzheimer's is the 6th leading cause of death in the U.S.
- 1 in 10 people age 65 and older has Alzheimer's dementia
- Almost 2/3 of persons with Alzheimer's are women
 - Women in their 60s are about twice as likely to develop Alzheimer's during the rest of their lives as they are to develop breast cancer.

• (Alzheimer's Association, 2017) (1)

DEMOGRAPHICS OF ALZHEIMER'S & DEMENTIA (ALZHEIMER'S ASSOCIATION, 2017)(1)

- Persons with fewer years of education are at a higher risk for developing dementia
 - Due to better health care access & stronger compensation skills
- Alzheimer's in the U.S. primarily affects white, non-Hispanics
- Older African Americans & Hispanics are more likely to develop Alzheimer's & other dementias
 - Genetic risk factors (high blood pressure & diabetes)
 - More common for diagnosis to be missed in these populations

DEMOGRAPHICS OF ALZHEIMER'S & DEMENTIA (ALZHEIMER'S ASSOCIATION, 2017)(1)

• Caregivers

- Approximately 2/3 of Alzheimer's & dementia caregivers are women
- More than 15 million Americans provide unpaid caregiving to persons with dementia
- Alzheimer's and dementia caregivers had \$9.3 billion in additional health care costs of their own in 2013.
 - Report high levels of stress & depression is common

\$259 billion

- “Total payments in 2017 for all individuals with Alzheimer's or other dementias are estimated at \$259 billion.”
- “Medicare and Medicaid are expected to cover \$175 billion, or 67 percent, of the total health care and long-term care payments for people with Alzheimer's or other dementias. Out-of-pocket spending is expected to be \$56 billion.”

(Alzheimer's Association, 2017)(1)

PART I: CAUSES

CAUSES

- Dementia is a set of symptoms caused by changes in the brain...it is not a diagnosis that stands by itself
- These changes are a result of nerve cell damage affecting communication in the brain
- Some of the causes can be reversible...but most are permanent

COMMON CAUSES OF DEMENTIA

- Alzheimer's disease
- Vascular Dementia
- Lewy body Dementia
- Frontal Temporal Dementia
- Alcohol related dementia
- Normal Pressure Hydrocephalus
- Parkinson's Disease

(Alzheimer's Association; 2014)

COMMON CAUSES OF DEMENTIA

- Alzheimer's disease
 - Gradual progressive disease
 - Development of plaques and tangles in the brain
 - Disruption in the communication in the brain
 - Atrophy of the brain
 - Hallmark symptoms are memory loss and confusion.

COMMON CAUSES OF DEMENTIA

- Vascular Dementia
 - Slow progressing
 - Stroke related dementia
 - Impaired blood flow to the brain causing cell death.
 - Memory loss, poor judgment and language related dysfunction.

COMMON CAUSES OF DEMENTIA

- Lewy Body Dementia
 - Rapid progressing disease
 - Development of proteins in the brain causing a disruption in neural communication
 - Physical symptoms are similar to Parkinson's disease (rigid muscle tone, flat affect, shuffling gait)
 - Hallmark cognitive symptom is visual disturbances and hallucinations

COMMON CAUSES OF DEMENTIA

- Frontal Temporal Dementia
 - Not as common as other dementias
 - Quickly progressing with a rapid onset of symptoms
 - Development of Pick bodies in the brain
 - Behavioral changes, mood alterations, poor social skills, very impulsive

COMMON CAUSES OF DEMENTIA

- Alcohol related dementia
 - Commonly called Korsakoffs dementia
 - Rapid onset and slow progressing
 - Atrophy of the brain due to alcohol
 - Symptoms can often improve with removal of alcohol
 - Poor judgment, reasoning, memory loss

COMMON CAUSES OF DEMENTIA

- **Normal Pressure Hydrocephalus**
 - Fluid accumulation around the brain and spinal cord
 - Symptoms are sudden
 - Increased falls, problems with balance, increased need to urinate, increased confusion
 - Can be reversed if identified early
 - Treatment is the placement of a shunt to drain fluid from the brain

COMMON CAUSES OF DEMENTIA

- **Parkinson's Disease**
 - Usually occurs in the later years of the person with Parkinson's disease
 - Gradual development of confusion and memory loss

Common Causes of Dementia

•Mild Cognitive Impairment

- 15-20 percent of adults 65 and older may have MCI
- Amnesic MCI: Primarily affects memory
- Non-amnesic MCI: Affects other areas of cognition
- Individuals with MCI are more likely to develop Alzheimer's disease than those without.
- Individuals with MCI have twice as many hospital stays as other older adults

OTHER CONDITIONS CAUSING DEMENTIA

- Nutritional deficiencies
- Infections
- Subdural hematomas
- Poisoning
- Anoxia
- Brain Tumors
- Metabolic changes
- Vitamin B12 deficiency
- Chronic Alcohol Abuse
- Depression

(Loehr & Malone 2013)

QUESTION TO CONSIDER:

“IF THERE WERE A TEST
THAT COULD TELL YOU
THAT YOU WERE GOING TO
DEVELOP ALZHEIMER’S
DISEASE, WOULD YOU
WANT TO KNOW THE
RESULTS?”

**PART I:
SYMPTOMS**

SYMPTOMS

- Memory Impairment that disrupts daily life
- Challenges in planning or problem solving
- Difficulty completing familiar tasks
- Confusion with time or place
- Trouble understanding visual images and spatial relationships
- New problems with words in speaking or writing
- Poor judgment
- Withdrawal from work, family or social activities
- Changes in mood and personality
- Misplacing things and losing the ability to retrace steps

(Alzheimer's Association; 2014)

PART I: PHYSICAL CONSIDERATIO NS

PHYSICAL CONSIDERATIONS

- Swallow dysfunction
- Malnutrition
- Dehydration
- Gum/Dental Disease
- Infection
- Gait Dysfunction
- Heart disease
- Sleep disturbance
- Depression

PART I: MEMORY OVERVIEW

MISTAKEN BELIEFS ABOUT DEMENTIA

- Individuals with dementia cannot learn or remember information
- Best way to care for persons with dementia is to make them comfortable, accept their idiosyncrasies, and be patient with them

MEMORY

- Memory is dependent on organizing incoming information (attention) and highly developed encoding skills.
- Memory is critical to our ability to acquire language, develop high level thinking, and effectively make decisions.

MEMORY STAGES

- 1. Encoding/Acquisition
 - Early processing of material to be learned
 - Examples: Repetition, verbal rehearsal, organizing in a meaningful way (mnemonics (Every Good Boy Does Fine, acronyms (USA)))
- 2. Consolidation
 - Transfer of recently encoding information into permanent storage
 - Can take a few minutes or days to complete; recent info is more vulnerable for loss than past info; can be interfered with by brain trauma

(Patient Education Center, 2017)

MEMORY STAGES (CONTINUED)

- 3. Storage
 - Refers to the way information is held in memory for future use
 - Quality of encoding (organization, meaningfulness) increases the quality of storage
 - Easier to recall information that has been rehearsed multiple times
- 4. Retrieval
 - Pulling information from long term memory
 - Repeated retrieval strengthens memories
 - Schemas make information easier to recall
 - Mental representations based on experiences (restaurant, doctor's office)

(Patient Education Center, 2017)

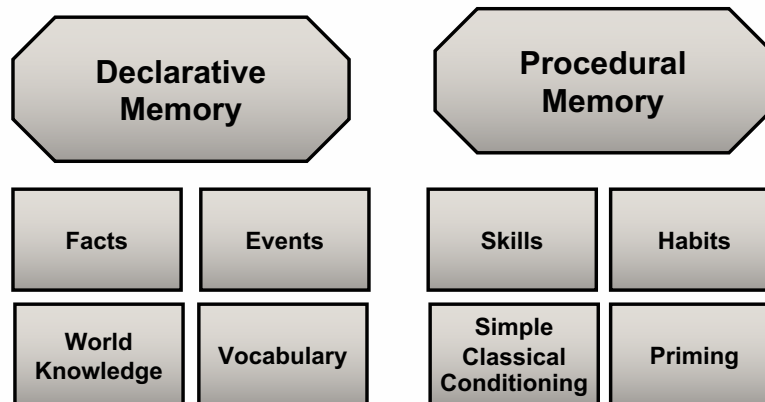
MEMORY STAGES

- Encoding, Storage and Retrieval are interactive processes
- The ability of one process affects the quality of another
 - Good encoding makes for good retrieval later on
- Deficit in one stage can lead to a deficit in another

MEMORY DEFINITIONS

- Working Memory, Short Term Memory:
 - Ability to use information as it's being processed (remembering phone number)
 - Primarily affected first with Alzheimer's and other dementias
- Long Term Memory:
 - Information from short term memory that is retained permanently
 - Declarative and Procedural Memory
 - Long Term Memory can be affected by dementia in both storing information and retrieving it.

LEARNING & MEMORY IN DEMENTIA: MODEL OF MEMORY (SQUIRE, 1994)



CIRCUMVENT THE DEFICITS

- Persons with dementia do have weaknesses in the areas of learning and memory **BUT** a number of strengths exist as well.
 - Ability to learn procedures
 - Ability to read
- Research has shown that the learning of information and its retention depends heavily on how it is presented.
- **KEY: Be aware of the weaknesses but FOCUS ON THE STRENGTHS!!!**

PART II: INTERVENTIONS FOR ALZHEIMER'S & DEMENTIA

- DEMENTIA STAGING
- TREATMENT TRENDS (BEHAVIORAL) & EXAMPLES
- ADDRESSING ADLs
- COUNSELING & EDUCATION

QUESTION TO CONSIDER:

“HAVE YOU EVER MET AN
ELDERLY PERSON WHO
WASN'T DEMENTED? DID
THAT SEEM STRANGE TO
YOU? IF SO, WHY?”

PART II: DEMENTIA STAGING

Dementia Staging

- Early Stage
 - Overlooked as a normal part of aging
 - Short term memory deficits
 - Misplacing or losing objects
 - Frequent but not constant disorientation
 - Mood changes including aggression, agitation, paranoia and defensiveness
 - Social isolation
 - Denial

Dementia Staging

- Middle Stage
 - Increased forgetfulness
 - Trouble recalling names of spouse, family members and friends
 - Poor hygiene habits
 - Increased dependence on family members
 - Increased incidence of falls
 - Speech/language deficits more prominent
 - Repetitive questioning
 - Incontinence

Dementia Staging

- Late Stage
 - Dependent upon caregivers for all basic needs
 - Needs help with feeding
 - Limited communication
 - Swallow trouble
 - Unsafe mobility
 - Inappropriate and unpredictable behaviors

(Alzheimer's Association, 2017 (2); Reisberg et al., 2011)

PART II: TREATMENT TRENDS & EXAMPLES

BEHAVIORAL/NON-PHARMACOLOGIC TREATMENTS

WHAT WE SEE IN MANY FACILITIES...

- Caregivers in facilities (nurses, rehab therapists, activities professionals, nursing assistants) tend to base their interventions on abilities/skills found in declarative memory
- This leads the person with dementia to experience:
 - failure in given tasks
 - a reduction in self-esteem,
 - a reluctance to take an active role in facility programs and in their own lives

QUESTION TO CONSIDER:

**“WHAT ARE SOME
TREATMENTS/STRATEGIES
YOU HAVE SEEN USED WITH
PERSONS WITH DEMENTIA?”**

**THE SPACED RETRIEVAL
TECHNIQUE**

- Spaced Retrieval (SR)
 - Technique used to help persons with cognitive impairments recall important information over progressively longer intervals of time.
 - First used to address face-name learning in non-impaired individuals
 - Has been used successfully with patients with Alzheimer’s Disease, Traumatic Brain Injury, Parkinson’s Disease, and Dementia related to HIV (Bourgeois et. al, 2001; Camp, et. al, 2008; Neundorfer, et. al, 2004; Malone et. al, 2007)
 - Is an effective tool that therapists can use to help clients reach their goals in rehab therapy and is billable and reimbursable.
 - Takes advantage of the procedural memory system and is success-based.

MONTESSORI-BASED DEMENTIA PROGRAMMING

- Montessori-Based Programming
 - Programming method that use Montessori educational principles to provide constructive engagement, meaningful activity, and practice of skills to older adults.
 - Uses principles from the Montessori classroom to help older adults maintain independence and learn new skills.
 - Camp and other researchers have documented the use of this programming method with persons with Alzheimer's Disease and have found that it increases overall participation in activities, as well as rates high in staff satisfaction (Camp, 2002; Skrajner, 2007).
 - Therapists can use these methods to address goals in treatment.
 - Facility staff and patient families can use these methods also.

VALIDATION THERAPY

- Process of communicating with a disoriented elderly person by validating and respecting their feelings in whatever time/place that is real to them, even if it doesn't match our reality. (Vanderslott, 1994)
- Direct contrast to Reality Orientation
- Goal is to understand the meaning behind a person's behavior & validate their beliefs

REMINISCENCE THERAPY

- Focuses on facilitating the patient with dementia to remember experiences in his/her life and assisting in that person sharing those memories with others (Grasel, Wiltfang & Kornhuber, 2003)
- Frequently done in groups in facility settings
- Promotes social interaction, conveying positive emotions, & promoting self-awareness (Hodgson & Schweitzer, 1999)

VISUAL & GRAPHIC CUES

- Used as a way for persons with dementia to compensate for memory deficits
- Can include use of visual cues on index cards, message boards to list a person's schedule or important reminders
- Includes use of Memory Books (Bourgeois, 1992)
 - Uses meaningful pictures and short clear sentences describing the pictures



CONVERSATIONAL APPROACHES

- Asking questions that incorporate choice
 - “Would you like spaghetti or pot roast for dinner?” instead of “What would you like for dinner?”
- Asking questions that can be answer easily with a yes/no response
- Asking questions that tap into a person’s opinion or feelings rather than recall of information
 - “How do you feel about the food here?” rather than “What did you have for breakfast today?”

(Hinckley, Bourgeois, & Hickey, 2011)

COMMUNICATION STRATEGIES

- | | |
|---|---|
| <ul style="list-style-type: none"> • Look at the person directly when talking to them. • Give the person time to respond. Try not to finish sentences for the person. • Speak slowly and clearly • Keep statements, questions, and commands short and simple • Try not to correct or argue with the person. Find meaning in what the person is saying. | <ul style="list-style-type: none"> • Use visual supports when needed • Approach the person from the front and get on his/her level if they are sitting or in a wheelchair so they can see you. • Avoid talking down to the person. Even if he/she is not verbal, they may be able to understand you. Treat the person as a person. |
|---|---|

(Alzheimer’s Association, 2017 (3))

PART II: COUNSELING & EDUCATION

COUNSELING AND EDUCATION

- For the family member...
 - Start immediately
 - A little at a time
 - Keep it simple
 - Allow time

COUNSELING AND EDUCATION

- For the person with dementia...
 - Always try to include the patient
 - Never assume they don't understand
 - Chose the appropriate time for discussion
 - Grief needs to happen

5 STAGES OF GRIEF

- Denial: A coping mechanism that helps someone deal with the situation
- Anger: Can manifest itself in many ways. The caregiver may be the target of this anger.
- Bargaining: Family members may be looking for a cure or magic fix for the dementia.
- Depression: Increased overt expression of sadness
- Acceptance: Sometimes with acceptance comes a calm and relaxed relationship between loved ones.

(Kubler-Ross, 1969)

QUESTION TO CONSIDER:

“HAVE YOU EVER HAD TO
INTERACT WITH SOMEONE WHO
WAS GRIEVING?
HOW WAS THAT EXPERIENCE FOR
YOU?”

**PART III:
ADDITIONAL
CONSIDERATIONS**

- BEHAVIORAL ISSUES
- DRUGS & SUPPLEMENTS
- HOLISTIC APPROACH

PART III: BEHAVIORAL ISSUES

QUESTION TO CONSIDER:

“WHAT ARE SOME COMMON
BEHAVIOR ISSUES YOU
ASSOCIATE WITH SOMEONE
WHO HAS
ALZHEIMER’S/DEMENTIA?”

RESEARCH TELLS US...

- Problematic Behaviors can stem from unmet needs in the areas of:
 - **Physiology** (undiagnosed/untreated pain)
 - **Safety** (fear of being hurt)
 - **Love and Belonging** (fear of being abandoned)
 - **Self-actualization** (lack of having a meaningful role in the community)

(Camp, Cohen-Mansfield, & Capezuti, 2002)

FINDING THE “WHY”

- To effectively address a problematic behavior and develop an appropriate course of action, we need to ask

“Why did the person with dementia demonstrate this behavior?”

- Keep in mind...Behavior is *never random*.

FINDING THE “WHY”

- Brainstorm all possible reasons for behavior
 - Physiologic
 - Environmental
 - Lack of meaningful engagement
 - Personal (need for attention, social contact, reassurance, etc.)
- “Who Owns the Problem?”
- Ask person directly!

Behavior Brainstorming Worksheet

Patient: _____

Challenging Behavior: _____

Possible Reasons for Behavior (list all possible ideas):

Possible Unmet Needs (Circle Any Applicable & List Why):

Physiologic _____ Love & Belonging _____

Safety _____ Self-Actualization _____

Possible Contributory Factors (Circle All that Apply):

Environment _____ Need for Reassurance _____ Other _____

Routine (or lack of) _____ Need for Social Interaction _____

Need for Attention _____ Other Residents/Triggers _____

Times When Behavior Typically Occurs (“Is there a pattern?”) _____

Times When Behavior is Not Occurring _____

Patient Aware of Behavior? Y / N _____

Patient’s Response to Questions about Behavior: _____

Previous Responses/Strategies to Reduce Behavior: _____

Possible New Strategies to Try to Reduce Behavior (List Staff Responsible for Implementation & Date to Reassess):

Rehabilitation Referral Needed: Y / N (PT OT SLP) _____

Name of Staff Obtaining Referral: _____

Loehr & Malone,
2013

CIRCUMVENT THE DEFICITS

- Maximize remaining abilities to overcome challenges & develop appropriate interventions
- Find individual strengths for each resident and build on them
 - Observe resident
 - Ask family & staff
 - Provide opportunities
 - Engage in activities/Provide roles

CHALLENGING BEHAVIORS ASSOCIATED WITH DEMENTIA

1. Aggression
2. Anxiety/Agitation
3. Confusion
4. Repetition
5. Suspicion
6. Wandering/Getting Lost
7. Trouble

https://www.alz.org/national/documents/brochure_behaviors.pdf

_____(Alzheimer's Association, 2015)

Teach the Caregiver How to Respond

- Listen to the frustration
- Provide reassurance
- Involve the person in activities
- Modify the environment
- Find outlets for the person's energy
- Check yourself

CHALLENGING BEHAVIOR BRAINSTORM

1. Repetitive Question Asking

What strategies have you used or seen
work for this common challenging
behavior??

Case Studies:
“How Do I Help with Activities of
Daily Living (ADLs)?”

QUESTION TO CONSIDER:

“WHAT ARE SOME
WAYS YOU’VE
ADAPTED ADLs TO
HELP A PERSON WITH
DEMENTIA?”

ADL CASE STUDY

- 79 year-old female residing at a long term care facility
- Diagnoses include recent hip fracture, dementia, type 2 diabetes, COPD, high blood pressure
- Needs assistance in recalling her hip precautions (high fall risk), using adaptive equipment correctly in the shower and while getting dressed, and participating in ADLs in bathroom, like brushing her teeth.

ADL Case Study

What should we work on first?

- Prioritize!
 - Safety issues should be addressed first
 1. Reducing Fall Risk/Recalling Hip Precautions
 2. Use of adaptive equipment
 3. Participation in ADLs
- Ask “Why?”
 - understand underlying reason for person’s difficulty with skill
 - “Why are they forgetting their hip precautions?”; “What are they forgetting to do that puts them at a risk for falling?”

ADL Case Study

- Brainstorm Solutions and Try Them Out!
 - Capitalize on strengths and remaining abilities
 - Reading, Repetition, Simple Sequences (Task Breakdown), Procedural Memory, Demonstration of Skill, Reduced Verbalization
 - Involve the patient in the process
 - Ask them for their opinion/feedback
 - Know that you may need to try several ideas out in order to discover a solution that works for the person's individual needs

If at first you don't succeed, try, try again!!!

ADL Case Study



- Hip Precautions/Fall Risk
 - ASK WHY?
 - Make sure patient understands the precautions and what they mean.
 - Write down precautions and place in easy to see places
 - Repeat precautions often with patient and ask them to repeat them back to you to insure repetition and learning
 - Provide positive reinforcement when the patient is demonstrating use of the precautions
 - Teach new strategies to insure safety using intervention, like Spaced Retrieval method
 - Q: "Where should you keep your feet to help your hip heal?"
 - R: "On the footrests"

ADL Case Study

- Use of Adaptive Equipment
 - ASK WHY?
 - Breakdown steps of using equipment (e.g teach how to use sock aid or how to use hand held shower or long handled sponge) and practice before bath or getting dressed
 - Use visual supports (pictures or written instructions)
 - Demonstrate then have patient imitate (“Watch me. You try.”)



ADL Case Study

- ADLs in bathroom
 - ASK WHY?
 - Breakdown steps of sequences
 - Use visual supports (pictures/written steps)
 - Demonstrate, then imitate
 - Reduce distractions (clutter on counter)
 - Follow established routines (find out typical way the person used to perform tasks; set up items needed for task in logical order from left to right)
- 1. Put toothpaste on toothbrush.**
 - 2. Brush teeth**
 - 3. Put toothbrush under water to rinse off**
 - 4. Put toothbrush in toothbrush holder**

PART III: DRUGS & SUPPLEMENTS

QUESTION TO CONSIDER:

“DO YOU THINK THAT
EATING RIGHT, GETTING
REST AND EXERCISE CAN
HAVE AN IMPACT ON
BRAIN HEALTH?”

DRUGS AND SUPPLEMENTS

- Two types of drugs:
 - Cholinesterase inhibitors
 - NMDA receptor antagonists

NON-PHARMACOLOGICAL INTERVENTION

- Coconut oil
- Coenzyme Q10
- Gingko Biloba
- Huperzine A
- Omega 3 Fatty Acids
- Exercise
- Cognitive exercises

PART III: HOLISTIC APPROACH

HOLISTIC APPROACH

- Best approach to care of persons with dementia includes support from multiple sources working together
- **EVERY** staff member of a facility is a part of the dementia care team
 - Can Include:
 - Physician, RN, Social worker, dietician, PT, OT, SLP, CNAs, Activity/recreational therapists
- Team members can work together to develop interventions, counsel and educate patients & families, etc.

• Loehr & Malone, 2013

QUESTION TO CONSIDER:

“HOW DO YOU VIEW
YOUR ROLE IN WORKING
WITH PERSONS WITH
ALZHEIMER’S/DEMENTIA
NOW?”

QUESTION TO CONSIDER:

“ON A SCALE OF 1 TO 10,
HOW WOULD YOU NOW
RATE YOUR LEVEL OF
KNOWLEDGE OF
ALZHEIMER’S &
DEMENTIA?”

THANK YOU!

MEGANMALONE1025@GMAIL.COM

JENNYLOEHR65@GMAIL.COM

REFERENCES

- Alzheimer's Association (2014a). "What is Alzheimer's?" Retrieved from http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp
- Alzheimer's Association (2015). "Behaviors: How to Respond When Dementia Causes Unpredictable Behaviors. Retrieved from https://www.alz.org/national/documents/brochure_behaviors.pdf
- Alzheimer's Association (2017)(1). "2017 Alzheimer's Disease Facts and Figures." Retrieved from <http://www.alz.org/facts/>
- Alzheimer's Association (2017)(2). "Stages of Alzheimer's". Retrieved from http://www.alz.org/alzheimers_disease_stages_of_alzheimers.asp
- Alzheimer's Association (2017)(3). "Communication and Alzheimer's". Retrieved from <https://www.alz.org/care/dementia-communication-tips.asp>
- Bourgeois, M. (1992). Evaluating memory wallets in conversations with patients with dementia. *Journal of Speech and Hearing Research*, 35, 1344-1357.

REFERENCES

- Bourgeois, M., Camp, C., Rose, M., White, B., Malone, M., Carr, J., & Rovine, M. (2003) A comparison of training strategies to enhance use of external aids by persons with dementia. *Journal of Communication Disorders*, 36, 361-379.
- Camp, C., Cohen-Mansfield, J, Capezuti, E. (2002). Use of nonpharmacologic interventions in nursing home residents with dementia. *Psychiatric Services*, 53 (11), 1397-401.
- Camp, C., Cohen-Mansfield-J., & Capezuti, E. (2002). Use of nonpharmacologic interventions amongst nursing home residents with dementia. *Psychiatric Services*, 53(11).
- Camp, C. J., & Malone, M. L. (2008) Mise en œuvre d'interventions de récupération espacée auprès de personnes atteintes de la maladie d'Alzheimer. *Cahiers de la Fondation Médéric Alzheimer*, number 3.
- Grasel, E., Wiltfang, J., & Kornhuber, J. (2003). Non-drug therapies for dementia: An overview of the current situation with regard to proof of effectiveness. *Dementia and Geriatric Cognitive Disorders*, 15(3), 115-125.
- Hendrie, H.C. (1998). Epidemiology of dementia and Alzheimer's disease. *American Journal of Geriatric Psychiatry*, 6, S3-S18.

REFERENCES

- Hinckley, J., Bourgeois, M., & Hickey, E. (2011). Treatments that work for both aphasia and dementia. Presented at the annual convention of the American Speech-Language-Hearing Association, San Diego, CA.
- Hodgson, B., & Schweitzer, P. (1999). *Reminiscing with people with dementia: A handbook*. London. UK: Age Exchange.
- Kubler-Ross, E. (1969). *On death and dying*. New York, NY: Touchstone.
- Loehr, J. & Malone, M. (2013). *Here's how to treat dementia*. San Diego, CA: Plural Publishing
- Malone, ML, Skrajner, MJ, Camp, CJ, Neundorfer M, Gorzelle, GJ: Research In Practice II: Spaced-Retrieval, A Memory Intervention. *Alzheimer's Care Quarterly*. (2007); 8(1): 65-74.
- Neundorfer, M., Camp, C., Lee, M., Skrajner, M., Malone, M., & Carr, J. (2004). Compensating for cognitive deficits in persons aged 50 and over with HIV/AIDS: A Pilot Study of Cognitive Intervention. *Midlife and Older Adults and HIV*, 79-97.

REFERENCES

- Patient Education Center (2017). "How We Remember: Three Stages of Memory". Retrieved from <http://www.patienteducationcenter.org/articles/how-we-remember-3-stages-memory/>
- Reisberg, B., Imran, J.A., Khan, S., Monteiro, I., Torossian, C., Ferris, S., Wegiel, J. (2011). Staging dementia. *Principles and Practice of Geriatric Psychiatry*, 3, 162-168
- Skrajner, MJ, Malone, ML, Camp, CJ, McGowan, A, Gorzelle, GJ: Research in practice I: Montessori-Based Dementia Programming® (MBDP). *Alzheimer's Care Quarterly*. (2007); 8 (1): 53-64.
- Squire, L. (1994). Declarative and nondeclarative memory: multiple brain systems supporting learning and memory. In: Schacter, DL, Tulving, E, eds. *Memory Systems*. Cambridge, MA: MIT Press; 203-232.
- Vanderslott, J. (1994). A positive exercise in damage limitation: Management of aggression in elderly confused people. *Professional Nurse*, 10(3), 150-152.