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Dementia Diaries Part 3: Evidence-Based Intervention

Amber B. Heape, ClinScD, CCC-SLP, CDP, CMDCP

Moderated by:
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Dementia Diaries Part 3: Evidence-Based Intervention
Amber B. Heape, CScD, CCC-SLP, CDP, CMDCP
Presenter Disclosure: Financial: Amber Heape was paid an honorarium by SpeechPathology.com for this presentation. Nonfinancial: Amber serves ASHA as the State Advocate for Medicare Policy for South Carolina. She is a Certified Dementia Practitioner and Certified Montessori Dementia Care Professional.

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Learner Outcomes

As a result of this course, participants will be able to:

- Explain the challenges of evidence-based practice use in practicing clinicians.
- Describe how to evaluate evidence-based treatment approaches for patients with dementia.
- Describe how to compose daily documentation that supports the evidence-based skilled services provided.
Should We Even Treat?

Systematic Review of Existing Literature

Found that:

- Patients with mild and moderate dementia may be able to learn new facts and procedures using cognitive intervention strategies. Less evidence with moderate to severe dementia.
- Memory techniques, specifically Spaced Retrieval, are successful in facilitating recall.
- Therapy tasks should be functional and valid to the patient.
- Some question about the carryover between learned items and overall cognition. Specific tasks and information do not always affect the general cognitive functioning.
- You should consider all areas of the patient (social, educational, cultural, etc.) when determining strategies and considering outcomes.

What is EBP and Why Don’t More Clinicians Use It?

Evidence-Based Practice

- External Research Evidence
- Evidence-Based Practice
- Patient/Family Values
- Clinician Expertise
Why Don’t Clinicians Use EBP?

- Not a huge amount of high-quality evidence for some interventions
- No time to analyze or study what evidence exists
- Inability or lack of knowledge in accessing evidence
- Inadequate training/lack of confidence to apply evidence to practice

(Douglas et.al, 2014)

Having No Intervention May Lead to Excess Disability

- Disability we place on residents by staff providing too much care when the resident may be able to complete parts or entire tasks themselves
- Staff attempts to provide maximum assistance for all residents, thinking it may save time or “just be easier”
- This creates not enough time in the day to:
  - complete assigned duties,
  - provide quality care,
  - document appropriately, and
  - communicate with other staff
How Do I Begin Building a Cognitive Therapy Program

- It all starts with YOU advocating for the patient
- Find supportive staff to make up a “core group” of providers
  And….
  - Teamwork!
  - Education!
  - Functionality!

Evidence-Based Interventions for Patients with Dementia:

- Cognitive Stimulation
- Validation Approach/Reality Orientation Approach
- External Memory Aids/Graphic and written cues
- Montessori-based interventions
- Memory training programs (spaced retrieval training)
- Caregiver training/counseling programs
- Computer-Assisted Cognitive Interventions (CACI’s)
- Environmental Modifications
- Reminiscence Therapy
Cognitive Stimulation

- Improves
  - Cognitive function
  - Well-being
  - Quality of life
- Seems to be most effective for early to mid-stages
- Empirical evidence on specific activities is somewhat limited

Activities for Cognitive Stimulation

- Memory training
- Problem solving
- Use of mnemonic devices
- Multisensory stimulation
- Word games
- Puzzles
- Social activities
- External memory aids
Reality Orientation Therapy vs. Validation Therapy

In my experience…

- ROT-
  - Higher level patients
- Validation Therapy
  - Lower level patients

Validation Therapy

- Introduced by Naomi Feil, a social worker with the geriatric population.
- The basic approach to this therapy is to validate what the person with dementia is saying or feeling, regardless of accuracy or factuality.
- Suggests there is logic behind all behaviors. Therapists focus on understanding the feelings behind statements rather than the accuracy of them.
- The approach teaches that rather than correcting or reorienting the person with dementia, the therapist or caregiver should give positive words or gestures that give validation to the patient’s thoughts and feelings.
- Use conversation to get the patient to do something else without them realizing they are actually redirected.
Validation Techniques

- Listen with empathy
- Ask non-threatening questions
- Allow patient to maintain dignity
- Don’t negate everything the patient says
- Acknowledge feelings behind statements
- Reminiscence
- Paraphrase
- Use physical touch
- Use genuine eye contact
- Observe and match the emotion
- Use ambiguity if you don’t understand the meaning

External Memory Aids: Graphic and Written Cues

- This method of therapy involves providing written factual information and/or familiar photographs to facilitate communication with the client.
  - An example of this would be to make a book of photos of family members with their printed names labeling each person. The client would use these cues to be able to appropriately facilitate communication with family members.

- In a person with Alzheimer’s dementia, the ability to read and recognition memory may be somewhat preserved throughout the main course of the disease. Graphic and written cues capitalize on these residual skills.
Graphic and Written Cues/External Memory Aids

- Activity calendars
- Memo boards
- Memory books/memory wallets
- Appointment cards
- To-do lists

Montessori-based Interventions

- Based on work done by Maria Montessori that began in the 1900s
- Activities of this technique can be used in individual therapy or group therapy sessions.
- Structured, stimulating activities should be appropriate to the patient’s current cognitive level.
- Uses rehabilitation principles including guided repetition, task breakdown, and progressing from simple to complex tasks.
- Principles of dementia interventions such as external cue usage and reliance on implicit memory are used. Shown to be effective in long term, short term care, and independent living.
- Tasks are broken down into hierarchical steps ranging from simple to complex. Extensive cueing and guidance can be provided. Feedback should be given regarding the appropriateness of responses.
- Operates on the premise that muscle memory (procedural memory) is often less damaged in people with dementia
Montessori Intervention Examples

- Use materials familiar to the individual
  - Kitchen objects for word-finding
  - Recipes for a patient who cooks often
- Begin with a simple task and progress to a more difficult task
  - Start with a 3-step sequencing task before progressing toward a 6-step task
- Break activities down into simple steps and focus on one step at a time
- Use materials that are visible and easily recognized
- Use external cues and visual aids to assist with activities
- ALWAYS attempt to use meaningful activities... this adds to quality of life!

Memory Training Programs

- Errorless Learning
  - As each skill is taught, the patient is provided with a prompt or cue immediately to decrease chance of incorrect response.
  - Patient only learns to respond correctly
  - Prompts removed until patient can respond correctly on their own
- Vanishing Cues
  - Similar to errorless learning
  - Reduction of cues as learning progresses
- Spaced Retrieval
Spaced Retrieval Training

- Originated in 1989 as a memory training technique for use with individuals with dementia.
- Patient is given a piece of information. The patient is then asked to recall the information or behavior in response to a stimulus question systematically over time.
- The main goal of the spaced retrieval technique is to teach a single functional piece of information or behavior that can be use in situations of everyday living.
- Examples could be caregiver names, transfer techniques, room number, or other basic ADL facts.
- This technique can be used for multiple pieces of information, but only one fact or behavior should be targeted at a time.

Spaced- Retrieval Training

- For example, information that is quickly forgotten – my room number, where the bathroom is located, who is coming today– is practiced according to a predetermined schedule. The schedule is expanded after successful recall.
- The objective is helping the individual to remember the information for longer and longer periods of time.
- Beginning with a 30-second interval of remembering, individuals might, over time, have the ability to recall specific information for weeks or even months.
- According to Dr. Camp, when the SR interval reaches 12 minutes, the information has been successfully transferred to the resident’s long-term memory.
- With this kind of training, people with cognitive disorders soon learn to find what they are trying to remember, thus minimizing the frustration, anxiety and confusion that can result when important information is not readily available.
- Rather than asking a staff member the answer to her frequent questions, the patient is trained to produce the information herself.
Caregiver Education/Training

- Several different models, that may contribute to
  - More successful conversation exchanges
  - Increased or decreased caregiver burden, depending on situation
  - Improved quality of life for the patient
  - Maintenance of language abilities of the person with dementia
  - Increased caregiver knowledge of dementia and understanding of communication breakdown
  - Increased caregiver satisfaction on communication competency

FOCUSED Caregiver Training

- Designed to be used with family members of people with dementia as well as their caregivers.
- The strategies of the acronym teach caregivers how to effectively communicate with the patient.
- The techniques of the FOCUSED program are:
  - F - Functional and Face-to-face communication
  - O - Orient to topic
  - C - Continuity of Topic (should be concrete - no why?)
  - U - Unstick communication blocks
  - S - Structure the conversation with yes or no questions or choices
  - E - Exchange conversation and encourage interaction
  - D - Direct conversation - use short, simple sentences
Teaching Staff to Communicate

- **Housekeeping** - communicate what they are doing with patient, or wait until patient is out of the room to vacuum, etc.

- **Activities Director** - giving resident limited choices, asking yes/no questions, appropriate activities for each stage of GDS

- **CNA/Nursing Staff** - communicating before procedure/ADL begins, giving choices, asking yes/no questions, waiting for response longer than normal

Teaching Staff to Communicate with the Nonverbal Patient

- Do not misunderstand the non-verbal patient. Many times, they understand what you are saying to them and about them. Be respectful.

- The non-verbal patient may communicate by:
  - **Gestures** - movements with hands or pointing, head nod or shake
  - **Body Language** - the way they sit or stand and move
  - **Facial Expressions** - grimacing (pain), smiling, concern, anger
  - **Eye Contact** - communicating hostility, affection, interest
  - **Touch** - kind touch (reaffirming pat or hand squeeze) vs. hostile touch (angry, wants or needs unmet)
Involving Families

Techniques in Family Counseling:

- Allow the client and family to tell their story
- Enlist the family as collaborators
- Actively involve the family in testing and goal-making procedures when possible. Explain the importance of intervention and how it can benefit the pt.
- Empower the family by asking “What do you need to know now?”
- Listen and respond to the affect of the family. Give them a chance to discuss how they feel in an unhurried, caring atmosphere

Educate families on effective communication

- Modeling
- Support
- Being available for questions
- Problem solving when barriers
CACIs

- Trains patients to perform everyday tasks of functional relevance
- Therapists supplement CACi by providing instructions, redirection, or prompting to facilitate task completion
- Technologies used with many patients in community or assisted living settings!
- Research is still emerging on exactly which interventions are most effective
- Candidates for CACIs:
  - Patients with episodic memory impairments resulting from dementia, but relatively spared motor learning skills (procedural memory)
  - Individuals with mild to moderate dementia and the ability to attend and participate in sessions
  - Patients with hearing and vision within normal limits with adaptive equipment and hand-eye coordination to manipulate touch-screen or keyboard

CACIs

- Gain and retention of trained skills
- Generalizability to real world tasks
- Decreased time and assistance needed to perform tasks
- Retention of information, even after therapy ends
- Little change in standardized test scores of overall cognition, yet possible change in skills and abilities
- Great for patients with MCI (Gates et.al, 2019)
- Improved social health, social participation
Examples of CACIs

- It’s Never Too Late
- MULTITASK (large graphic library)
- BrainHQ
- Cognifit
- Brain Fitness Program
- Lumosity
- MindSparke
- Dakim Brain Fitness
- Happy Neuron
- Braingle
- Brain Age Concentration Training
- Queendom
- Elevate
- Peak
- Fit Brains

***These programs are examples and have not been verified***

Apps for Ipad/Ipod

- Tactus Therapy Solutions Apps (Free versions)
  - Language Lite
  - Visual Attn Lite
  - SRT
  - Category Lite
  - Conversation Lite
- Scrabble
- Sodoku
- Memory!
- Just Say It!
- Sandwich Maker
- Unblock Me
- Ruzzle
- Brain Challenge HD
- Chain of Thought
- Fit Brains Trainer
- Word Warp
- Describe It
- déjà vu
- iMazing
- Conversation Starters- iTopics
- TherAppy Apps
- Story Creator
- MakeChange
- Answer Yes/No
- Text Twist
- Clockface Test
Environmental Modifications

- **Plants** - make sure non-toxic
- **Temperature** - anticipate patient’s needs (they may not be able to tell you they are too cold or too hot)
- **Hallways** - med carts, linen carts, food carts should all be on one side of the hallway
- **Color** - use calming colors (not glossy, red, orange, etc.) Lavender, light blue, light green
- **Homelike environment** - fill walls with photos, memories, use quilts or bedspreads.
- **Lighting** - use soft lighting, drapes, blinds
- **Toilet seat** - other color that white
- **Dining room** - create homelike environment (tablecloths, contrasting placemats, soft music, china cabinet)
- **Courtyard** - wandering paths, benches to rest on, planters at different heights, bird feeders, secure environment

Environment - What Not to Do!

- **Wallpaper**
- **Clutter**
- **Noise**
- **Alarms**
- **Lighting**
- **Hygiene products**
- **Shiny floors**
Reminiscence Therapy

- Uses all senses (sight, smell, sound, touch, taste) to evoke positive memories in patients with dementia
- Long-term memories may be preserved into late stages
- Used to decrease stress, agitation, and minimize challenging behaviors
- Re-establishes meaning in memories

How do I choose which approach to use?
Consider the Desired Outcomes When Choosing Therapy

- Would we expect a patient on GDS 5 to work on medication management?
- What should we do if a patient presents on a much lower GDS than prior level of function due to acute condition?
- Can a patient progress beyond their prior level of function?
- Can a patient with dementia learn?

Once you choose your approach and employ that therapy technique, what do you do next?

- DOCUMENT!
Daily Notes Should…

- Justify billing codes being used
- Demonstrate the skilled interventions of the therapist
- Must be linked to a goal
- Demonstrate medical necessity
- Demonstrate progression

Documenting Daily Therapy Activities

- ALWAYS remember that your daily notes should convey why it was necessary to have this activity facilitated by a therapist!
- Documentation should include the SKILL of that therapist.
- What did YOU do?

- Analyzed
- Assessed
- Decision Making
- Demonstrated
- Developed
- Designed
- Educated
- Evaluated
- Facilitated
- Graded

- Incorporated
- Implemented
- Inhibited
- Instructed
- Modeled
- Progressed
- Provided
- Reviewed
- Selected
- Trained
GDS 2/3

- Facilitated Montessori-based activity of executive functioning skills to improve patient’s ability to organize and self-administer medications properly at return home. Spaced Retrieval Training successful at 30 seconds, 1 minute, 2 minutes (x2). Patient struggled with memory skills over 2 minutes.
- Instructed patient in recall of safe transfer sequence with 7/7 acc and verbal cueing. Pt responded to safety questions regarding safe transfer sequence with accuracy in 3/4 trials(75%). Pt recalled walking sequence x 4 steps with difficulty recalling need to step first on weaker leg, right leg. Rehearsal technique used to improve recall of 4 steps in walking sequence with 4 rehearsals with errorless learning.
- Guided patient in completing sequencing pattern for transfer in 5/7 attempts with verbal cueing. Pt sequenced pattern for walking in 3/4 acc after multiple rehearsals and demonstration for improving comprehension. Pt recalled pattern with self-correction up to 5 min delay with 2/4 acc. Pt problem solved in structured task of Tangram completion with timely completion and mod assist necessary on 1/4 tasks, min assist provided on 3/4 tasks.
- Reinforced use of spaced retrieval strategy for increased recall of functional information. Pt recalled 4/4 functional information items at intervals of 30 seconds, 1 minute, 2 minutes, 4 minutes, 8 minutes, and to ¾ items at 16 minutes with min verbal cueing provided by SLP utilizing spaced retrieval strategy.

GDS 2/3

- ST graded recall of functional information in order to increase communication competence and safe integration within the environment. Pt demonstrated accuracy on 18/20 trials of functional information presented in lists of 5 items. ST assessed safety awareness and identification of potentially hazardous situations in order to increase safe interaction within the environment. Pt demonstrated accuracy of 10/10 trials independently of hazard recognition.
- ST graded recall of functional information in order to increase safe interaction within the environment. Pt demonstrated accuracy on 7 out of 10 trials given minimal verbal cues of information presented verbally with visual aid assistance. ST instructed patient and daughter on ways to maintain cognitive stimulation and activity when at home which includes, but is not limited to reading, word searches, cross words and puzzles. Daughter verbalized understanding and patient agreed to continue.
- Incorporated computer-assisted cognitive interventions to increase short-term recall skills. Instructed patient in use of personal device to increase cognitive stimulation upon discharge home this week. Patient demonstrated ability to access programs for intervention and ability to actively utilize 4/5 identified applications. Recommended 30 minutes of cognitive-stimulating activities per day upon discharge home (including computer-assisted interventions) in order to maintain gains made during plan of care.
GDS 4/5

- ST facilitated delayed recall of novel information in order to increase safe interaction within the environment. Pt demonstrated accuracy on 7/10 trials given moderate verbal cues of ST selected items. ST graded 3 step sequencing of cognitive tasks in order to increase safe interaction within the environment. Pt demonstrated accuracy on 4/5 trials given minimal verbal cues for sorting and sequencing of 3 step ADL activities.

- Instructed patient in completion of Montessori-based task for sequencing ADLs. Chunking strategy used to maximize patient success. Computer-Assisted cognitive intervention task presented for patient word-finding skills. Patient presents with 15/20 correct, which is an improvement from the 10/20 correct last recording period.

- Skilled treatment provided bedside with patient oriented to person, roommate (by name), and confused to location/situation. Pt reoriented easily with visual/written cues. Pt reviewed information related to orientation to place/situation, and safety in personal room, then responded to wh- questions with 4/9 acc (44%). Rehearsal and rephrasing used to relay info regarding use of call button in a variety of situations; pt verbalized understanding. Pt demonstrated use of the button, and CNA responded in role play situation x1 rehearsal. Pt verbalized understanding.

- Pt oriented via written cues and responded to orientation questions without success. Pt difficult to redirect from environmental distractions this day. Pt problem solving during daily task of meal setup, with increased cueing necessary for scanning immediate environment for cues, and obtaining assistance from staff. Staff education initiated with x2 CNA regarding need to consistently orient pt to call light, leave it in plain view d/t memory difficulty; verbalized understanding. Staff verbalizes that pt has not used the call light. Repeated role playing with CNA staff to model response to call light with pt demonstrating use of button.

- ST educated pt on safety instruments within the facility in order to increase level of safety and decrease risk of fall. Pt verbalized understanding and demonstrated use of call light. ST instructed pt on compensatory strategies to improve recall which includes but is not limited to chunking, lists and categorizations. Pt verbalized understanding of recall of compensatory strategies. ST graded recall of functional information in order to increase safe interaction within the environment. Pt demonstrated recall of 3/5 items independently but improved to 5/5 given moderate semantic cues.

- Instructed Pt in strategies for increased sequencing skills to facilitate increased participation and safety during ADL completion. Pt utilized problem solving skills to completed 4 step sequencing tasks using ADL pictures with 4/10 trials with mod verbal and visual cueing provided by SLP.
GDS 6

- Developed graphic cues for patient due to perseveration of “where am I?”
  Patient was able to utilize graphic cue in 2/5 attempts. Errorless learning approach utilized to redirect patient in simple communication tasks with staff. Instructed CNA staff on effective communication with patient: i.e. using short sentences, yes/no questions instead of open-ended ones. Staff verbalize compliance.

- Guided pt in completion of convergent naming task with 0/6 acc; max cueing. Oriented x 1, difficulty with facility orientation. Pt responded to wh- questions regarding wants/needs in 3/6 attempts

- Patient seen in am for skilled speech therapy services. Treatment focused on verbal expression at the word level. Training provided for use of open-ended phrase and sentence completion to produce accurate words. Patient able to imitate correct words; however, unable to spontaneously generate words. Poor comprehension and inaccurate word responses.

Patient sitting up in geri-chair. Treatment focused on verbal expression training to improve ability to express wants and needs and to communicate effectively. Names of objects modeled for the patient with patient able to imitate ¼ trials. Unable to spontaneously produce name of words. Auditory comprehension tasks addressed identification of objects in a field of 2 yet 0% accuracy. During treatment patient noted to have marked difference in cognition. Vitals taken with O2 saturation at 88% on 2L of oxygen and heart rate at 114. Therapy discontinued and patient care transferred to nursing.

- Facilitated bedside treatment, with patient presenting with increased alertness. Patient presented with eye contact, followed visual stimuli of “yes” and “no” cards in 4/10 attempts using eye gaze. Patient used head nods, “yes” in 5/10 attempts given visual and verbal cues and “no” in 2/10 attempts given verbal, visual and tactile cues to respond to questions related to things within his visual field, orientation to environment, pain and body temperature.
Assessed patient’s nonverbal communication of wants/needs and pain. CNA present for the assessment and provided input on patient’s usual patterns. Patient judged to grimace when in pain, and grasps nearby objects or people when she is in need of something. Attempted use of communication board for hungry, thirsty, and bathroom scenarios. Patient was resistive today, so strategy will be attempted again tomorrow. Patient reacted positively to music stimuli, and calmed when instrumental music was provided.

In the next module…

- Functional Therapy!