Dementia Diaries Part 3: Evidence-Based Intervention
Recorded April 21, 2020
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SpeechPathology.com Course #9236
- [Amy] Once again, welcome to our webinar today, Dementia Diaries, Part three, Evidence-based Intervention. Our presenter today is Amber Heape. She is a full-time clinical educator, for a large healthcare corporation, where she has lead multiple interdisciplinary teams and authored corporate clinical programs and trainings. She holds a Doctor of Clinical Science degree in Speech Language Pathology, and a Post-doctoral Certificate in Healthcare Education. Amber is also a graduate of the ASHA Leadership Development program, and is the current State Advocate for Medicare Policy for South Carolina. Amber is a certified Dementia Practitioner, and a certified Montessori Dementia Care Professional. So Amber, we are looking forward to Part three today. I will turn over the floor to you.

- [Amber] Thank you very much, Amy. And thanks guys for joining us today. I will just go ahead and say, you will probably be able to hear it in my voice, today and next week are the two sessions that I get most excited about. Of course, we need the background and the history of the different types of dementias and the different stages. That gives us our foundation. But today's session goes into the evidence-based intervention component. And as practicing clinicians, this is what we do day in and day out. So I get really excited about today's session. And then next week's Part four, is Functional Therapy Activities. And I get very excited about that as well. So I'm looking forward to what all we're going to learn today. These are my disclosures. So as a result of today's course, you as participants should 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; and describe how to compose daily documentation that supports the evidence-based skilled services provided. So I've had this question posed to me before, very early in my career, back when cognitive communication therapy or therapy for patients with a type of dementia, wasn't very widespread. So this is probably 15 years ago or so. And a clinician that I respected very much asked me, well, why should you even treat a patient with
dementia? They can’t learn anything, they’re gonna get worse anywhere. And you
know 15 years ago, I was a different clinician than I am now. I was newly out of a
Masters program, and just in the skilled nursing setting full-time. And so I wasn’t really
sure how to answer that question. But today, how I would answer that question is, well,
let’s say that the patient is going out and they have something going on with their
osteoarthritis. And the patient comes back and they’re not able to walk. Should
physical therapy come in and treat the patient? Well yeah, that would be standard
practice. So if a patient comes into our facilities who’s had a cognitive decline, then
why should we sit back after that period of normal spontaneous recovery, and not
intervene? Well my answer is we should absolutely intervene.

Because people with dementia can learn new things. So Dr. Hopper and Bourgeois and
their colleagues actually did a great systematic review a few years back. And what they
found when they looked at all available researched evidence at that time, regarding
cognitive interventions for patients with dementia, is that they found the patients with
mild to moderate dementia can learn new things. Now that moderate to severe
dementia, there’s less evidence to support them learning new things. However, of
course, we know that we can work on compensatory strategies as well. Memory
techniques were very successful in facilitating recall.

But they also noted that therapy tasks should be functional, and they also noted what I
discussed last week a little bit, how sometimes specific global assessments don’t
show a huge improvement, but when we look at all functional areas and specific tasks
for that patient, that’s when we can actually demonstrate the benefit of our services.
So what is evidence-based practice, and why don't more clinicians use it? I'm gonna
be very transparent and open with you guys. 15 years ago, if you had said the word
evidence-based practice, it would have struck fear in me. Because quite frankly I
thought that evidence-based practice was some unreachable term that researchers
knew about but practicing clinicians really didn’t have access to, unless we wanted to
spend all day every day reading research articles, which I wasn’t comfortable doing. Well my outlook has changed a lot. And that’s actually why I pursued a Doctorate of Clinical Science. Because I wanted to be that go-between, between the academic researchers, and practicing clinicians. And that has become a true passion of mine. Is adding to the evidence base, but bringing it to a level that anyone who’s practicing, at any level of education or experience can understand what these evidence-based practices are. So when you look at evidence-based practice, it’s a triad. It’s not one single item, it’s not just that published research. That is one component of it. External research evidence is one component.

But, you know, what is published as research, may not be gold standard research or it may not be generalized to all the different populations. It may not be applicable to the specific population that we’re addressing at any given point in time. So that’s why that external research evidence is only one part of it. Plus, how would we ever find new treatments if we only depended upon that external research evidence? So that’s why evidence-based practice also looks at clinician expertise, as well as patient and family values. And where those three components meet in the middle, that is true evidence-based practice.

So Douglas and colleagues did a study about six years ago, on why clinicians did not use evidence-based practice, and these really hit home with me because even 10 or 15 years ago, I would have said the same thing. So first of all, there’s not a large amount of high quality double-blinded randomized control trials for every intervention. Those are gold standard. Well, there are so many minute factors and populations that we treat as clinicians, that it’s practically impossible to have, you know, perfect quality evidence out there for every single intervention with general visibility to all the different populations. Also, not enough time to analyze or study what evidence exists. Now if I asked for a show of hands right now, oh there’s over 300 of you live right now, I would say at least 250 of you would probably raise your hand. We lead very busy lives. We
not only have our professional lives, but we have personal lives too. If you’re working in healthcare, you have a nice little thing called productivity that drives your day in many instances. So just the time to search out that available research and then plow through it to see hey, is this really good quality research or is it not? That’s difficult to come by the time for that. Also the inability or lack of knowledge in accessing evidence. So where do you find it? It’s not just a Google search. And we know that research evidence that is peer-reviewed, is much higher quality than just a website that says, hey, you should do this therapy. And then inadequate training or lack of confidence to apply evidence to practice.

But I have great news for you today. ASHA has something called the ASHA Practice Portal. And it is probably one of my favorite resources. If you go on the ASHA website, you can get to that ASHA Practice Portal. There are multiple full-time staff at ASHA, that their only job is to access all of the available research that has been published in specific areas for diagnosis, intervention, et cetera, for all the different types of disorders or deficits that we see as SLPs. So please use this resource. It’s part of what our ASHA dues pay for, is this Practice Portal that really makes it very easy for us to access the evidence-base that’s summarized there for us. So another answer to that question, well, should we even intervene at all?

Well, having no intervention can make that patient end up with excess disability. And we talked about that term last week. That’s disability that we actually force on the resident because we do too much for them. And if we have not fully assessed or intervened to see what strategies may work with that patient, then we don’t have what we need to educate the staff on what the patient can do. Or this simple strategy will help the patient be able to participate in this task. And what that will lead to is staff doing too much for the patient, and then feeling much busier, less time to complete their duties, provide quality care or document. So it’s very important that when we intervene that we get the full picture, and that caregiver education becomes part of our
typical plan. So how do I begin building a cognitive therapy program? About 15 years ago, when I was just coming into skilled nursing long-term care from the school system, what I started seeing was that there were patients who were having dementias because of infection, anesthesia-related decline. Different reversible types, and patients coming in with worsened cases of irreversible dementia, after some type of medical comorbidity. And what I started doing, when I started that therapy program, there had not been an SLP full-time in that facility. So it took a while for all of the staff to see, hey, what she’s doing in there, isn’t just talking to the patient. What she’s doing is actually helping make our jobs easier.

And once you find that core group of people who’s willing to support and help in your cognitive therapy program, you will be surprised at how quickly that program becomes a vital part of your facility. And let me just make one more statement as well. The people who come in contact most with our patients, are typically their CNAs or Certified Nursing Assistants. And anytime I’ve had students working with me, supervising students, one thing that I’d tell them is, the CNA has one of the lowest paid, yet highest workload positions in the entire facility. And, you know, this group, they’re the heart and soul of facilities.

Nursing staff, therapy staff, social work-- We’re all a great part of that team. But therapy, and especially the CNAs staff, come into contact more, spend more time with that patient, than anyone else. So get those CNAs to have some buy-in into your cognitive therapy program. Take the opportunity to celebrate Better Speech and Hearing Month by bringing them all donuts, and having a quick little thank you get-together, where you actually tell them about the things that they can do to help your patients with dementia. So today we’re gonna discuss some of the evidence-based interventions for patients with dementia. And I’ve picked pretty much the most applicable to adult healthcare that I see day in day out. So those are cognitive stimulation, validation or reality orientation approaches, external memory aids or
graphic and written cues, Montessori interventions, the different memory training programs, caregiver counseling education, computer-assisted interventions, environmental modifications, and reminiscence therapy. So we are gonna plow through all of these today. So hold on to your seats. So the first we'll discuss is cognitive stimulation. And I've actually hit on this the first two courses in the series. How we know that 30 minutes a day, six or seven days a week of cognitive stimulation, reduces that patient’s speed of progression. The patients who had that cognitive stimulation were about three times slower to progress into dementia. So like we said last week, with these early mild cognitive impairment, early dementia, phases, stages, cognitive stimulation is something we need to teach the patient, and then have the patient be able to continue on their own, once they're off of our therapy caseload. It's not something that they do with us, and never again.

Just as we tell students, you need to be life-long learners, well, our patients need to be life-long learners of how to continue their cognitive strength as long as possible. So cognitive stimulation not only improves function and wellbeing, but also quality of life. But there's not a lot of research that says, hey, this specific activity is best to do for patients. So what types of activities could be included? Well you could do some memory training, use of mnemonic devices, ROY G. BIV, Kings Play Cards On Faded Green Sheets; those types of memory strategies. Problem-solving. Anything that's multisensory. Smell, taste, touch, sight, sound. Word games and puzzles are great for the patient to be able to do on their own.

As well as social activities. And using external memory aids. Now, what is not beneficial is for the patient to do the same task over and over and over and over every single day. Because they're not activating those different parts of the brain when they do that. So it's important that we teach our patients, hey, I know you love to do word searches. So if you want to do that five or 10 minutes a day, great. But we need to make sure you do some of these other activities as well. I know I've mentioned my
mom on prior courses in this series and she loves Ruzzle on her laptop. And she has one of the brain training apps, that's the free version. And I tell her all the time, mom, you can't do the same task every single day. You need to mix it up. And so some days, she plays Solitaire, some days she does Ruzzle, and other days she does word search, and other days she does crosswords. So there are different things on different days that are going to work different centers of the brain. Our next two evidence-based practices are reality orientation and validation therapy. And in my experience, reality orientation is really beneficial for those higher level patients.

That mild cognitive impairment, that early dementia, if that patient says, "Hey today's Christmas," reality orientation would say, "Well actually, today's date is," and you give the accurate date. So we're actually re-orienting that patient to facts and to current events or surroundings. Then we have our validation therapy approach. And if you want to listen or see a great YouTube video, you want to look at Naomi Feil, her name is right here, F-E-I-L, and Gladys Wilson. Just search that on YouTube, have your tissues handy, but it is a perfect representation of a validation approach. And validation is really for those patients who are in those mid to late stages where, you know, re-orienting them to the day of the week, may not be the most beneficial thing. Especially in those very late stages.

And so Naomi Feil is, I think she's in her 90s now, she's still alive, she's a social worker, and she began this approach that really suggests that every behavior has meaning. That everything a patient does, comes from feelings and their reality to them. And so instead of negating that patient's feelings or reality, what we do instead is validate what they're feeling, regardless of whether it's accurate or factual to us. We acknowledge that the statements they make have feelings behind them. And so we give positive words, positive gestures, that give validation to that patient's feelings, and then we use those to redirect the patient without that traditional reality oriented redirection. So I was in a facility a few weeks ago, and walking past a group of patients who were about to
do some exercise. And there was a lady sitting there sobbing uncontrollably. And I put my hand on her shoulder, because that's an example of positive touch, hand on her shoulder, and introduced myself. And I said, "Why are you crying?" And she looked down on her lap and there was a baby doll on her lap. And she said, "They're going to take my baby." Well a reality orientation approach would have been to say, that's just a baby doll. No one's going to take it, you're fine. Well, telling her that what she thought of as her baby was just a doll, in her late stages of dementia, it's not gonna be a positive experience, and can actually worsen problematic behaviors. So what I did was I said, "Oh, that's your baby. "What is her name?" And she told me her name and I said, "Can I see her face? "She is beautiful, who does she look like?" And she said, "She looks like me."

And I said, "Well she is just beautiful. "I can tell you love her very much, "and you take such good care of her." And she popped up with, "Well they can't take her." And I said, "Oh no, we wouldn't want that. "You take such good care for your baby. "We know you love her. "So let's just ask the nurse to look at her "when she comes to give you your medicine, "and that way, no one will need to take her." And so we re-oriented her. She stopped crying, she started rocking her baby. We actually sang to the baby a little bit. And she was fine after that. Now what was the logic behind that behavior? I don't know her life story.

But I know that she was scared and that she was insecure. And possibly lonely. And that she needed someone to reassure her that it was all going to be okay. And so that's what I did in that situation with the validation approach. Now there is a small amount of research out there that claims that validation isn't useful. But there are lots of investigations, especially outside of the field of SLP, especially in the field of social work, that say it absolutely is useful. And you'll find that with a lot of different evidence-based strategies, that there will be an article somewhere that says, oh no it doesn't work. But then there may be nine that says yes it does. And so we have to
weigh our options and take everything with a grain of salt. So I’ve listed here in your handout, just a few validation techniques that you can use. Of course, I’ve just told you about my recent experience. And if you look up Gladys Wilson and Naomi Feil, you’ll see her use that genuine eye contact, physical touch, as well as observing and matching the patient’s emotion. Next we’re gonna discuss external memory aids. And my favorite external memory aids are graphic and written cues. I had a patient come to me one day in tears. And when I pressed her a little further to find out what was wrong, she said that she’d just gotten off the phone with her son and could not remember her grandchildren’s names to ask about them. So what did we do? We made a family tree with all of the names of her children and grandchildren. I had to make a couple of phone calls and elicit their help.

But we made a graphic cuing piece of, it was just a piece of cardstock, honestly, that we drew and wrote on and laminated and it went in the top drawer of her bedside table. And so she learned that if she was on the phone with one of her children, she could pull out that graphic cue, and trace down and find the names of the children. And you know, I’ve never had Alzheimer’s. I’ve had family members who do. But I can’t imagine being a mother of two teenage daughters and all that that entails, I can’t imagine one day not knowing their names.

And, you know, having something that could help preserve that, would mean the world to me in that situation. And it’s important to note that sometimes even in the later stages, that reading can be preserved. So I’ve given you just a few examples here, of graphic and written cues, and external memory aids. Our next evidence-based practice is Montessori-based intervention. And this is based on Maria Montessori who began her work in the early 1900s. I’m sure many of you have heard of Montessori schools before. And we know that Montessori schools focus a lot on realistic practical learning. And so when you think about Montessori-based interventions, that’s what you think about. Real world, functional, meaningful activities. These activities can be individual or
they can be presented in a therapy group. They should be appropriate, of course, to
the patient’s cognitive level. Another big principle of a Montessori approach is breaking
down a complex task. So if there is, let’s say, a 6-step task, that patient may not be
able to sequence six steps. So we break it down into two steps, and then the next two
steps, and then the final two steps. So that we make that complex task more simple.
And provide the cue and the guidance the patient needs to be successful. In
Montessori interventions, the use of that functional meaningful task really is based on
the premise that muscle memory, things that the body is used to doing, let’s say
hanging up clothes on a clothesline or reaching into the cabinet for a can of soup.
Those are things that people do throughout their lives. And so, you know, that memory,
that muscle memory, can actually be used to help patients with dementia in a
Montessori-based setting.

So meaningful items with familiar materials. You know, we talked last week in the
different stages about how certain stages like that tactile stimulation. So it may need to
be objects for those patients. If the patients are in those very early stages, it may be
pictures or recipes. We have to categorize our materials into, you know, what may be
beneficial for each stage of decline. And we need to use materials that are easily
recognized. And next week, I’m gonna give you guys a lot of activities that include very
personalized occupational or hobby-based activities that can be very personal for the
patients. But the biggest takeaway that I want you to have from Montessori
intervention, is that that functional therapy task is meaningful to the patient and can
also be a positive indicator for quality of life. The next item we’ll talk about is, memory
training programs.

And the first is errorless learning. And in errorless learning, the patient is taught only to
respond correctly. We don’t allow that patient to necessarily be incorrect. We
immediately provide that prompt or cue for correctness, and then we decrease or
remove those prompts once that patient can respond correctly on their own. And
vanishing cues is pretty similar in that, as the patient is more comfortable with that learning, we reduce their reliance on our cues or our prompts. And then spaced retrieval is the final memory training program. And I will tell you, it is my absolute favorite. So spaced retrieval training came about in the late 1980s. Some of you guys may not have been born then, some of you guys may have been out of high school then. I was in middle school in the late '80s. And so this memory training technique came out and it has been a game changer. There is so much data out there that says spaced retrieval training is beneficial. And, you know, I've seen spaced retrieval successfully used to teach dysphagic compensatory strategies.

To teach specific information that the patient needs about their health, et cetera. I've seen patients in my practice who could not remember 30 seconds on evaluation, but with the use of spaced retrieval, we're able to remember those important facts for days on end. And so the basic premise of spaced retrieval is, you give the patient a piece of information. Now it needs to be functional information.

And it should only be one fact or one group of facts at a time. You don't want to work on multiple different facts at the same time. It needs to be all related. Now it can be two or three steps, but it's one piece of major information that is used in that therapy session as you go through the spaced retrieval protocol. So you give this patient a piece of information, and then what you're doing is asking that patient to systematically increase the amount of time that they are able to recall in response to a stimulus question that you will ask. So, an example of that could be, a pertinent one right now could be, you have to wash your hands for 20 seconds with soap and water. Wash your hands for 20 seconds with soap and water. So that's three kind of small pieces of information that's all related into one. And so, I would say that and then I would ask the patient, okay, what are you supposed to remember? Wash your hands for at least 20 seconds with soap and water. The patient gets that right, then we double the time. So we start at 30 seconds, we go to a minute, we go to two minutes. Let's say at two
minutes, that patient gets it wrong. Anytime the patient gets it wrong, we bump back down to the prior interval. So that could look like, 30 seconds is correct, a minute is correct, two minutes, incorrect. So we bump back down to what? A minute. At a minute, correct. Two minutes, correct. Four minutes, correct. Eight minutes, oops got it wrong again. So what do we do? Bump back down to four minutes. And so what we keep doing is increasing, doubling that time interval, every time the patient is successful in recalling that information. And then if they're unsuccessful, we back down. Now, Dr. Cameron Camp has done a lot of research with spaced retrieval. Jennifer Brush and Benigas and Bourgeois, have done a lot of spaced retrieval research as well.

And what Dr. Camp says is that once that spaced retrieval interval reaches 12 minutes, that that information is actually transferred into the long-term memory. So if we're going by that original protocol, 30 seconds, one minute, two minutes, four minutes, eight minutes, 16 minutes. So once we get to that 16, we should be able to stop for the day, and then the next treatment session, we want to go back and ask to see, can they still recall that piece of information that we trained yesterday? Wash your hands for at least 20 seconds with soap and water. I've trained everything from the bingo schedule to a patient’s doctors appointment, to hip precautions, because the patient isn't supposed to lean forward, and was constantly doing that with physical therapy. Or keep the walker right in front of you, while the patient’s ambulating.

Or lock your wheelchair brakes before you sit down. What are you supposed to do before you sit down? Lock your wheelchair brakes. So there's lots of different functional information. So one of the best things you can do is, ask the other therapy staff, hey, what can Ms. Smith learn, that I can assist her with? Next is caregiver education. And there's several different caregiver education models. I kind of have preference for one. But there are lots of different models out there. And we know that when a caregiver is trained and educated, that there are more successful
conversational exchanges with their loved one, and that they have increased improved quality of life. My favorite caregiver education, I like acronyms and mnemonic devices. And so one of my favorite is FOCUSED. So this is face the patient, when you want to speak to them. Orient them to topic. Don't jump from topic to topic. How to unstick communication blocks. Using Yes No questions or choices. How to encourage interaction. And then using very direct short phrases or sentences to maximize conversation. When we're teaching staff to communicate, we can work with the CNAs, like I said. We can work with housekeeping, with the Activities Director, and really educate them on how to approach the patient so that when the housekeeper comes in, the patient doesn't think that, oh no, she's here trying to steal my stuff. Because she knows when she walks in to say, hi Mrs. Smith, I'm here to take your garbage out, is that okay? So you bridge into that topic. Also it's crucial that we don't overlook the non-verbal patient.

That we teach staff that words aren't the only way that a patient can communicate. That they can communicate through eye contact, facial expressions, body language, gesture. As well as touch. That reaffirming pat on the shoulder, the hand squeeze. Or, if a patient's using hostile touch, what could that mean? And really really keeping ourselves open to the fact that it's not just words that we have to look for. I know last week I briefly talked about family counseling and how to ask the family certain questions in interviews.

Another thing that I like to do with families is to explain why we're doing therapy, as well as really involving them in the testing and the goal-making. And also sometimes family members may just need to vent. So you may just have to give them a chance to express how they're feeling, without rushing them along. Another thing you can actually do is ask the family something like, well, what was some activities that your dad needed assistance with before coming here? Or, what time of day did your mom typically eat her big meal of the day? These are things that we need to know because
they’re part of that patient’s normal routine. Like I said, I enjoy using that FOCUS caregiver education model to educate the families on the different types of communication modalities, the different information that I can get from questions, such as, what was your father’s appetite like, what are your goals for your mom’s rehab stay? That’s another great question to ask. And enlisting those family members to be communication partners. So CACIs, Computer-Assisted Cognitive Interventions. CACIs will include things like apps, computer programs, simulated reality tasks. And what these CACIs are used for is to train patients to perform tasks of functional relevance. And when I came out of graduate school, one of the things they used to tell us was, oh don’t use technology with your older patients, they won’t understand it. Well, those of you who work with older patients now, know that they all have cell phones just like we do. There are interventions that have some research out there but it’s really still emerging on what is most effective. If there’s a brain training program, that claims to prevent dementia, they’re lying.

Now are there cognitive stimulation programs that are technology-based that could be used for stimulation? Well yes, absolutely. There’s a lot of technology being used right now as far as iPads and laptops and tablets, Surface Pros, whatever they may be, for our patients to communicate with their families, as well as in clinical practice and tele-practice. But there are computer-esque programs. It’s Never 2 Late is one that I’ve used before. And these computer technology training tasks are very good for patients with dementia, especially mild to moderate dementia. And then you do wanna make sure that your patients with hearing and vision deficits, that you see, are they able to really see the screen or manipulate a touchscreen? And what researches out there says that CACIs are good to generalize to real world tasks. So when we do some simulated tasks, that they do generalize to actual functional tasks. But, specific global standardized test scores of cognition, such as the GDS, may not change simply through the use of CACIs. So what we have to look at is their different skills and abilities. And, you know what, if the patient can fix themselves a sandwich, and they
couldn’t before, that’s a skill but that’s a meaningful skill that that patient may need in order to be able to go home. So we can't lose focus on the specific skills and abilities. So these are some of the examples of some of the programs out there. I've not used all of these programs. I just have tried to pull some of what is available. But please do your own research to make sure that the program that you’re using does have some functional research basis to it. And the use of apps. I'll just tell you, I love using my iPad in therapy. You may have a different type of tablet, that’s fine too. Tactus Therapy has a ton of really good apps and there are free versions. But one of the things we discussed today is spaced retrieval training. And Tactus has an SRT app. It’s a spaced retrieval training app, and guess what it does? It keeps the time for you. So you can actually put the information in, and start the timer, and it will ding when that timeframe is up.

And then it actually allows you to say to the patient, get it correct or incorrect. I call it my Spaced Retrieval for Dummies app. And I need that sometimes. You can also use different games that are online. Now I’ve heard people say, well you should never use a game with a patient. Well my question is, I'm an adult. Do I play games sometimes, absolutely. Do I sometimes play games on my phone a little too much, probably. Sometimes I can get stuck in some of them because I wanna beat my prior success level. But we just need to make sure that the apps that we use with our patients that are adults, are adult-oriented. That they're not something that's too childish. Then we also have environmental modifications. So I’ve listed a few helpful hints here for environmental modifications, and some of the things you can do, such as using a toilet seat that's another color than white, of course. Also when you look at things like your wallpaper, don’t have wallpaper with small print. Because it could look like bugs on the wall. For someone who has that visual deficit that we talked about in Session two, tiny little prints may look like bugs or roaches or very scary things. You know, solid color walls
are pretty good. My daughter used to get very upset at my mom’s house, she had a wallpaper with ivy on it. And one of the pieces of ivy, she said, looked like a person’s face. And what she pointed it out, I could see. But it always scared her as a little girl. She thought it was this little made-up ghost named Sam, that was gonna come and get her. So, you have to be careful with the print on the walls. You need to avoid clutter. You need to avoid loud noises. And what type of loud noises do we have? Bed alarms. Well guys, when you’re in school and the fire alarm goes off, what are you supposed to do? Get up, get out. Take cover, go away. Get from where you are. Well guess what? We do a bed alarm. Could it sound like a fire alarm? Could it trigger a memory that really actually increases the behavior?

Well yes. There are bed alarms out there that you can actually put a voice prompt. Even a voice prompt of, let’s say, the patient’s daughter saying, "Dad, lay back down in bed and push your call button." Hygiene products you have to avoid some, because many could be poisonous as well. And then reminiscence therapy. Reminiscence therapy uses all the different senses to really evoke those positive memories in patients with dementia. It's used to decrease the agitation, stress, and really establish a feeling of comfort and peace in patients with dementia. So the question I often receive is, well how do I choose which approach to use?

Well, I kind of chuckle when I say this, but they call it the practice of medicine for a reason. Because even your physicians don’t always know exactly what treatment is gonna benefit that patient the most, at that given time. So we may think that a specific treatment is going to work with one patient, and it may not. So what we do as practitioners is we use our skilled judgment to say, yes, this is working, or, you know what, no this really isn’t working, I need to try a different approach. So the answer to this question really is, it depends on your patient. And you just really have to know these approaches and be comfortable enough with them, where you begin to kinda get a pretty good idea of the type of patients that seem to do best with each of these
evidence-based approaches. And then we should always look at our desired outcomes, when we're choosing our goals for our patients. So if we have a patient on the GDS five, remember from last week, GDS five is where that patient can no longer live independently at home alone. Well, is that patient going to need medication management? No, the patient's not going back home, they're not going to need that medication management. So that would not be a specific goal that we may necessarily work on. Now if I have a patient who is a GDS five, could I use money management? Some people would say no. But then I have to say, well, what if they want to get a drink or a snack out of the machine? Or what if they go out to the store with activities? Well then, we may need to do a more basic money management, counting out simple bills and coins, with that patient.

You know, if someone is GDS stage six, we may be working on following simple directions and answering simple questions. We're not going to be doing complex problem-solving with a patient who is a GDS level six. So really think about what we learned in Session two, the different deficits in all of the different stages. And say, are the goals I've set for this patient appropriate for the discharge, anticipated discharge location, et cetera? And then once you choose your approach, make your goals, you start your therapy technique, what do you do next? Well, we all know, document. So documentation is something that I talk about day in and day out in my full-time job. And if I've said it once, I've said it 1,000 times.

We must show the skill of our services. So what makes the service we provide, complex to the point where it could not be done by any other professional? Why are we the people that must give this service or this intervention? And then, we have to link those daily notes to our goals, and we have to show a progression. We can't do the same thing over and over and expect a different result. So I've given you some verbs here that are really just characterizing what we do, as therapists every single day. And I've had people say, well, would you use the word assessed, and we're just in a
treatment? Well we're assessing or grading performance every single treatment. If we're not, something's wrong. We may be designing a specific educational plan or a plan for stimulation. We may be evaluating that effectiveness. We may be modeling specific strategies for the patient. So use this list of words as you go through your skill in your documentation. And so what I've done here over the next few slides, is I've given you some examples of what daily notes for some of the different GDS levels may look like. And you'll see that there is a complexity difference at each of these stages, that some of the evidence-based techniques that I use are used in multiple stages, some are not. Of course, I'm not going to read these to you today because I know you can all read. But I wanted you to have some concrete examples of documentation for each of the stages. So I've given you a couple of slides of GDS two or three, a couple of GDS four to five, some GDS six, and GDS seven. And next week, we're going to actually discuss the therapy tasks and activities that we can do as a clinician, and we will bring in that skill documentation to describe those activities and/or tasks. So I hope you will join us then, but I'm going to open up the floor for questions at this point.

- [Amy] Great, thank you so much, Amber. I did wanna let our participants know that if you need to go, you can. You'll get credit for having been here for an hour. But if you have a few minutes to stick around for maybe five minutes' worth of questions, we will tackle some of the questions that have been submitted here. So Amber, I'm seeing a couple of questions about spaced retrieval. And one of these is, when you have an interval with spaced retrieval, are you silent, do you do some other types of tasks, sort of as a distraction? What do you do during the times in between when you're checking their recall?

- [Amber] Yes, absolutely. So what I don't do is throw a bunch of other verbal information at the patient. I may have them working on some type of activity that they enjoy. You know, I've had patients before who liked doing puzzles or crafty-type tasks. So they may do that while we're in between intervals. Or what I've also done is, let's
say they were doing the exercise bike for another discipline. Well they can exercise between our intervals. So I don’t just sit there and look at them. That would be very awkward. You know, they don’t wanna look at my face for that long either. But what I don’t do is throw a bunch of language at them during that time.

- [Amy] Very good, thank you. Now someone else is asking a question about spaced retrieval also, and noting that she works at home. She only sees patients maybe once, one to three times a week. And is that too low of a frequency to work on spaced retrieval? Because she says that some of the research she’s read about spaced retrieval, is based on at least five times per week frequency of therapy.

- [Amber] Well the beauty of this is, if you have patients at home and they have a communication partner, or a family member that’s able to assist, you may be able to train that family member to do some home practice. If your client has the app, then you could actually put the prompt into the app. It will allow you to put that information, type it in. And the patient could do at-home practice as well. So that would be a way you can kind of get those extra attempts in.

- [Amy] Great, thank you. Some is asking about, what is the difference between errorless learning and vanishing cues?

- [Amber] Functionally, there’s not a ton of difference. In errorless learning, they’re not allowed to make errors. In vanishing cues, they may be allowed to make some errors but you’re just pulling the cues back. But functionally, they’re extremely similar.

- [Amy] Thank you. Another question about spaced retrieval and it says, if you are filling those spaced retrieval intervals with tasks like crafts or exercise, then how do you document that? Can you be assessing some type of measures of social engagement or
responsiveness during those types of activities? Or how do you account for that time, I think is what she's getting at.

- [Amber] Yeah, you know you could have them participating in some type of pragmatic activity. They could be doing a sequencing task, or a problem-solving task during those time intervals. And that would still be therapeutic. Like I said, I just wouldn't fill the time with a lot of either written or spoken language because too many words can get jumbled up.

- [Amy] Got it, thank you. Let's try one more question, then we'll need to wrap up here. Do you have any specific recommendations for some of the cognitive stimulation computer programs or any recommendations for higher level patients? The participant is saying she's heard of Lumosity, and Elevate and BrainHQ. And she's wondering if you know of any resources that might help her evaluate the differences between them and the pros and cons of each one.

- [Amber] I've seen one. I can't recall off the top of my head, I did not put that resource together. But I think it's one of the speech therapy blogs, has something similar to that. But I've had experience, I've done, It's Never 2 Late, BrainHQ and Lumosity, are the three that I've had experience with before.

- [Amy] Very good.

- [Amber] But that's not to say that those are better because of that.

- [Amy] Okay, thank you very much. Well I think we better wrap it up here. Thank you to our audience for spending an hour of your time with us. And thanks for your patience when we had those sort of momentary glitches. Amber, thanks for being here so much. We look forward to Part four, a week from today. To our participants, if you're not able
to make it next week for the last piece of this series, it will certainly be available in other formats, recorded formats, after the event, so. Hopefully, we'll see you next week. I hope everybody has a great week, and continue to stay healthy. And be careful out there. Thanks everyone.

- Yes, thank you for joining us.