OCTOBER 19, 2012
10 A.M. – 12 P.M.

THE 2012 STATEWIDE
Alzheimer’s Disease
& Related Dementias
WEBINAR

Hosted by
the Florida Department
of Elder Affairs
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NORMAL BRAIN AGING vs. NOT SO NORMAL....?

Normal brain aging is NOT a disease. As we approach our 40’s, all of our body systems begin to slow down and the tissues lose some of their elasticity. We usually begin to notice things we ‘used’ to do so well. By the time we are approaching our 60’s we may wish to have more spices in our foods, or need eyeglasses, or want to wear socks to bed or call our daughter by our wife’s name. Normal brain aging!

Have you had temporary forgetfulness with later recall ability? You are 52, and cooking dinner for the spouse coming home about 6pm. When you sit down to eat, you realize that you have forgotten to pop the biscuits into the oven. You are busy talking with your golf partners and forget to write down the scores from the last hole; but notice at the next tee, and can recall the scores. You can’t locate the exact row where you parked the car at the mall until you think about it more and use the ‘button’ to make the alarm sound two rows away. Normal brain aging!

NOT SO NORMAL.... Your golf partners have begun to take turns keeping score; teasing you about talking too much or forgetting too often. Perhaps you’ve taken the can of biscuits out of the refrigerator and later find them in the cupboard with the cereal; and similar things have occurred recently. You are searching for your parked car at the mall, where you are sure you parked it outside the entrance to Macy’s – however you parked outside of Sears – and this has happened a couple of times in the last few months.

The person retains the ability to reason & solve the problems of everyday living. You remember that you need to get gas in the car. You remember how to get to the Publix store that is between your home and your sisters.

NOT SO NORMAL.... The car has run out of gas 4 times this year while you were trying to go somewhere, and you are surprised each time. You are driving to visit your sister, who lives 5 miles away, and you forget where you were going – again this month.

Someone may forget part of an experience but not the whole experience. Your husband cannot recall the names of the couple you met and went on a number of shore-trips with on a cruise taken for your 20th wedding anniversary last year. He does seem to remember most of the rest of the cruise details that you remember. Normal brain aging! (Or perhaps, he does not choose to retain that information, unlike you?)

NOT SO NORMAL... You are telling your wife about speaking with her sister Pam, in Publix today about her son’s wedding last week, and she asks you...’who is Pam again?’ You ask your husband if he would like to go back to the Ale House for the lobster dinner special he liked so much last Friday, and he says – ‘We went out to eat last week?’

People recognize dangerous and unsafe situations. You take the time to unplug the curling iron before you leave the bathroom in the morning. You unplug the jig-saw before changing the blade.

NOT SO NORMAL.... You are in the garage putting at cleaning the workbench, and hear the tea kettle whistling away in the kitchen for longer than a minute. You did not put it on to boil. Your wife is sitting in the living room looking out the window at the birdfeeder and says ‘the cardinal is not coming back’, when you ask her if she hears the kettle whistling, she says ‘if you wanted some tea, why didn’t you tell me, I would have made some for us’?
There is a modest decline in the ability to learn NEW things. Imagine the trauma of replacing your cell phone, computer, electric range, dishwasher or clothes washer - and being forced to learn how to operate a new model. It takes us longer, but we can become adept with the new equipment. Normal brain aging!

NOT SO NORMAL.... You downsized from a house to an apartment a year ago; when coming home from Publix, you still find yourself turning down your ‘old’ street – and you get lost for long periods of time getting to Publix.

A slight decline in the ability to retrieve information from our brain is expected. We hesitate & take a bit longer to recall the name of the movie star in the movie we are watching on TV. But, we do remember it in a few minutes. Normal brain aging!

NOT SO NORMAL... After living in the same house for 20 years, you have found yourself wondering how to drive to the church on Sunday. Your husband says: ‘This is the fifth Sunday in a row that you have asked me which way to turn to get to church. I knew I should have driven today.’

Perhaps some difficulty with complex tasks will emerge as we age. However, if given adequate time we are able to complete the task. A good cook for 20 years, your husband can make Sunday morning brunch better than anyone else, and does so for your domino-playing group once a month. Eggs (any way), waffles, bacon, juice, pancakes, quiche, coffee, mimosa and many other items made up his special brunches. But, sometimes you must make a last-minute trip to the store to get something he has forgotten to pick up. Normal aging process!

NOT SO NORMAL.... Over the last year your husband has done things like: burned the oatmeal, served nearly raw eggs, warmed up the grapefruit juice and served it in mugs, put dominos into the pancake batter and dumped tea bags into the coffee maker. He laughs it off and tells you he is just overwhelmed at work worrying about his retirement date coming up.

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TOP 10 SIGNS OF DEMENTIA

What is DEMENTIA...???

Dementia is a group of signs & symptoms that are characteristic to the contributing disease or disorder that causes them to appear. When two or more of a person’s cognitive functions have been impaired by that disease or disorder to the point that the behaviors interfere with a person’s daily living activities, that person is said to have – “dementia, due to _ _ _ _ _ _ _”.

Dementia is NOT due to normal aging, NOT a diagnosis, and NOT a disease. It could be caused by a manageable condition, or caused by a non-reversible problem. The top ten signs of dementia listed below are not arranged in any particular order.

- Progressive short-term memory loss
- Confusion of time & place
- Difficulty with familiar tasks
- Misplaced objects
- Problems with abstract thinking
- Poor judgment & problem solving ability
- Lack of initiative & motivation
- Personality changes
- Mood changes, increased anxiety
- Language difficulties

What do I need to know about DEMENTIA...???

Review each of the signs above and visualize the behaviors that someone would be exhibiting that would demonstrate that sign of dementia. Now apply that behavior in the ordinary tasks we all need to perform in our daily lives. Is it possible to exist alone, in safety & good health, for very long?

Imagine YOURSELF with these risks: Burning one’s self trying to cook, not being able to take prescribed medications correctly, inability to clean one’s body, being abused physically or emotionally by someone else, inability to recognize friends & family members, neglect from others, inability to distinguish between toothpaste and hair cream, becoming lost in familiar places, exploitation, driving accidents, financial scams, feeling constantly confused, inability to pay utility bills, sleeping or lethargy for days, inability to initiate contact with friends & family, and so on.

Whatever the cause for dementia in a person, a team of dementia-specifically trained professionals should evaluate and treat the disease or disorder with everything available to maintain the patient’s functioning and dignity. The person suffering from the dementia symptoms requires access to services and assistance to maintain their lives in a safe and healthy manner. Community services are available to people suffering from dementia symptoms and provide the education needed to understand and help. Research in a telephone book or on the internet, and newspaper can be very helpful. Contact local and state governmental agencies, religious groups and others who can assist, or know where to find assistance.

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DEMENTIA, ALZHEIMER’S AND RELATED DISEASES OVERVIEW

What is Dementia?
Dementia is the loss of at least two intellectual functions (such as thinking, remembering and reasoning) severe enough to interfere with a person’s daily functioning. It is not a disease in itself, but rather a group of symptoms that may accompany certain diseases or physical conditions. It is not a normal part of aging. The cause and rate of progression of dementia symptoms vary. Conditions which may cause or mimic dementia include depression, brain tumors, nutritional deficiencies, head injuries, hydrocephalus, infections (AIDS, meningitis), drug reactions and thyroid problems. It is imperative that anyone experiencing memory deficits or confusion undergo a thorough diagnostic work up. This requires examination by a physician experienced in dementia-related issues, appropriate imaging procedures, and detailed laboratory testing. The examination should include a reevaluation of all medications. The results of the total evaluation will determine the types of care the patient needs!

Alzheimer’s Disease
Alzheimer’s is the most common of the dementia disorders. Alzheimer’s disease is a progressive, degenerative disease that attacks the actual brain cells, and results in impaired memory, thinking and behavior. Symptoms include gradual memory loss, decline in ability to perform routing tasks, disorientation in time and space, impairment of judgment, personality change, difficulty in learning, and loss of language and communication skills. As with all dementias, the rate of progression in Alzheimer’s patients varies from person to person. From the onset of symptoms, the life span of an Alzheimer’s victim can range anywhere from 8 to 20 years. The disease eventually leaves its victims unable to care for themselves. While a definite diagnosis is possible only through the examination of brain tissue, usually done at autopsy, it is important for a person suffering from any symptoms of dementia to undergo a thorough clinical examination. New tests, including PET scan with enhanced radiotracers and laboratory tests on CSF (cerebrospinal fluid) may now enable physicians to identify the probability earlier in the disease. Approximately 20% of suspected Alzheimer’s cases prove to be a medical condition other than Alzheimer’s, and those are sometimes treatable.

Vascular Dementia
Vascular dementia is a deterioration of mental capabilities caused by multiple brain attacks (strokes or infarcts). The onset of symptoms may be relatively sudden as many small strokes can occur before dementia symptoms are actually noticed. These strokes may damage areas of the brain responsible for a specific function as well as produce generalized symptoms of dementia. As a result, vascular dementia may appear similar to Alzheimer’s. It is not reversible or curable, but recognition of an underlying condition (high blood pressure, carotid artery stenosis, coronary artery disease) often leads to a specific treatment that may modify the impairment. Vascular dementia is usually diagnosed through neurological examination and brain scanning techniques. Computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI) can identify impaired areas in the brain. Ultrasound examinations of the carotid arteries and cardiac/cerebral arteriograms are also useful.

Parkinson’s Disease
Parkinson’s disease is a progressive disorder of the central nervous system, which affects more than one million Americans. Individuals with Parkinson’s lack the substance dopamine, which is important for control of muscle activity. It is often characterized by tremors, stiffness in limbs and joints, speech impediments and difficulty in initiating physical movement. Late in the course of the disease, some patients develop dementia.
Conversely, some Alzheimer’s patients develop symptoms of PD. Medications such as Levodopa, which converts into dopamine once inside the brain, and Depreylnl, which prevents degeneration of dopamine-containing neurons, are used to improve diminished symptoms or reduce the physical motor system issues, but do not correct the actual mental changes that occur.

**Huntington’s Disease**

Huntington’s disease is an inherited, degenerative brain disease. It affects the mind and then the body. The disease symptoms usually begin during mid-life. Symptoms are characterized by sharp intellectual decline, and spastic irregular and involuntary movements of the limbs or facial muscles. Other symptoms include personality changes, memory disturbances, slurred speech, impaired judgment and psychiatric problems. Diagnosis of Huntington’s includes an evaluation of family medical history, recognition of typical movement disorders and CAT brain scanning. Genetic testing is currently available; a genetic marker linked to Huntington’s has been identified on chromosome 4. There is no treatment available to stop the progression of the disease, but the movement disorders and psychiatric symptoms may be helped by drug therapy.

**Creutzfeldt-Jakob Disease**

Creutzfeldt-Jakob disease is a rare, fatal brain infection caused by a transmissible organism, called a prion. Early symptoms include failing memory, changes in behavior, and lack of coordination. The disease progresses rapidly; mental deterioration becomes pronounced, involuntary movements (especially muscle jerks) appear, and the patient may become blind, develop weakness in the arms or legs, and ultimately lapse into a coma. Death is usually caused by other (pneumonia, urinary tract) infections in the bedridden, unconscious patient. A definitive diagnosis is obtained through an examination of brain tissue, usually at autopsy.

**Frontal Temporal Lobe (Picks Disease)**

Picks disease is usually difficult to diagnose as it is often confused with having a psychosis. Eliminating the other possible disorders can help focus on FTD. Disturbances in personality, behavior and orientation may precede and initially be more severe than memory defects which is why it is often called “Alzheimer’s in Reverse”. The patient may be well aware of their abnormal behaviors and develop severe depression. A definitive diagnosis is usually obtained at autopsy.

**Depression**

Depression is a psychiatric disorder marked by continuing/severe sadness, inactivity, difficulty in thinking and concentration, feelings of hopelessness, and sometimes - suicidal tendencies. Many severely depressed patients will have some mental deficits including poor concentration and attention. When dementia and depression are present together, intellectual deterioration may be exaggerated. Depression, whether present alone, or in combination with dementia, can often be diminished with proper treatment.

**Diffuse Lewy Body Disease**

Diffuse Lewy Body disease is another degenerative brain disorder, and is tied with vascular disease as second most common cause of dementia disorders. Lewy bodies are small round inclusions that are found within neuron cells. These Lewy bodies are found in both Parkinson disease and Alzheimer’s disease. Symptoms include cognitive impairments, fluctuations in level of alertness, visual hallucinations, severe motor defects, reduced facial expression (immobile, mask-like face), shuffling gate, tremors, rigidity, unsteady gate and balance. Falling is a major safety concern.

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The Four A's Of Alzheimer's

Characteristic Patient Dementia Symptoms

- Impaired comprehension and/or expression of verbal or nonverbal language
- AMNESIA

- Partial or total inability to recall past experiences, people, facts, or events
- AGNOSIA

- Inability to perform previously learned purposeful motor skills
- APRAXIA

- Inability to use one or more senses to identify surroundings

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Alzheimer’s disease is staged according to the manifestation of symptoms that mark the patient’s deteriorating condition. The chart below indicates characteristic symptoms during the early, middle, and late stages of the disease.

<table>
<thead>
<tr>
<th>Memory</th>
<th>Early Stage</th>
<th>Middle Stage</th>
<th>Late Stage</th>
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<tbody>
<tr>
<td>• Short-term memory loss</td>
<td>• Unawareness of all recent events</td>
<td>• Total memory loss of recent and distant events</td>
<td></td>
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<tr>
<td>• Difficulty remembering names, words, or thoughts</td>
<td>• Ability to recall distant past intact</td>
<td>• Inability to recognize self in mirror</td>
<td></td>
</tr>
<tr>
<td>• Misplacing familiar items, such as eyeglasses or keys</td>
<td>• PLUS: Any/all Early Stage symptoms</td>
<td>• PLUS: Any/all previous symptoms</td>
<td></td>
</tr>
<tr>
<td>• Forgetting telephone messages</td>
<td>• PLUS: Any/all previous symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Missing appointments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Getting lost on familiar trips</td>
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<table>
<thead>
<tr>
<th>Language</th>
<th>Early Stage</th>
<th>Middle Stage</th>
<th>Late Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Decreased communication</td>
<td>• Continual use of repeated words or phrases</td>
<td>• Significantly reduced vocabulary</td>
<td></td>
</tr>
<tr>
<td>• Unaffected speech</td>
<td>• Slowed speech with pauses and interruptions</td>
<td>• Inability to read</td>
<td></td>
</tr>
<tr>
<td>• Reduced vocabulary</td>
<td>• Inability to complete sentences or continual need to revise speech</td>
<td>• Need for repeated instructions/cues</td>
<td></td>
</tr>
<tr>
<td>• Difficulty in finding appropriate words</td>
<td>• PLUS: Any/all Early Stage symptoms</td>
<td>• Severely limited vocabulary (use of one or two words) or inability to speak</td>
<td></td>
</tr>
<tr>
<td>• Making irrelevancies</td>
<td>• PLUS: Any/all previous symptoms</td>
<td>• Repetition of words or sentences without understanding their meaning</td>
<td></td>
</tr>
<tr>
<td>• Decreased verbal communication</td>
<td></td>
<td>• Total loss of comprehension</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• PLUS: Any/all previous symptoms</td>
<td></td>
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<table>
<thead>
<tr>
<th>Mood and Behavior</th>
<th>Early Stage</th>
<th>Middle Stage</th>
<th>Late Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mood swings</td>
<td>• Frequent mood swings</td>
<td>• Frequent agitation</td>
<td></td>
</tr>
<tr>
<td>• Withdrawal or depression</td>
<td>• Increased self-absorption/insensitivity</td>
<td>• Obliviousness to others/environment</td>
<td></td>
</tr>
<tr>
<td>• Easy distractibility</td>
<td>• Little display of warmth</td>
<td>• Inability to recognize caregiver</td>
<td></td>
</tr>
<tr>
<td>• Need to seek out familiar people and surroundings</td>
<td>• Need to pace or wander</td>
<td>• PLUS: Any/all previous symptoms</td>
<td></td>
</tr>
<tr>
<td>• Less initiation and spontaneity</td>
<td>• Increased agitation, suspicion, hallucinations, and delusions</td>
<td></td>
<td></td>
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<tr>
<td>• Denial of forgetfulness and confusion</td>
<td>• Sleep disturbances</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• PLUS: Any/all Early Stage symptoms</td>
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### Coordination and Motor Skills
- Good control over coordination and motor skills
- Slowed reaction time
- Possible inability to perform vital vehicle operation skills

### Cognitive Skills
- Increasing difficulty handling finances (such as paying bills, balancing checkbooks, or making change)
- Beginning difficulty performing complex but familiar tasks (such as playing bridge or golf, video games, cellphone)
- Inability to work

### Self-care
- Ability to complete activities of daily living with little or no assistance
- Beginning of difficulties in prioritizing activities appropriately

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COMMUNICATION and ALZHEIMER’S DISEASE

Communication: Is the way information is shared or ideas exchanged. All plants and animals communicate; within their own species and with other species. When a human conveys a message, they expect a response. Verbal & non-verbal methods of communication are valid and important, especially for humans.

The senses play a vital role in human communication. If sight or hearing are declining or defective our ability to perceive our surroundings is adversely affected. When a patient with a dementia disorder also suffers from sensory deficits, the combination can be overwhelming for them and trigger negative behaviors.

Summer months in Florida can be a time of increased need to be able to communicate effectively with Alzheimer’s patients. Our patients very often have the instincts that warn of approaching storms, as well as the reactions to their arthritis-affected joints and sinus’ telling them of weather changes. These indicators and the frequent rain storms, with much thunder & lightening, can be very upsetting to our patients. Hurricane and tropical storm events can be even more distressing for the patient (and the caregiver)! Many of them simply do not have the brain neurons to be able to understand and cope with what they are feeling during these events.

How Alzheimer’s Initially Interferes with the Patient’s Communication

- Brain unable to process lengthy sentences and concepts.
- Unable to remember the right words to express their feelings.
- May substitute or actually make-up words to describe familiar objects or people.
- Totally forget what they were trying to communicate.
- Speak a verbal ‘salad’ of tones, vowels and words.
- Express frustration or anxiety by cursing or using offensive words.
- Speak less often.
- Rely on nonverbal, facial, and hand gestures.
- Lack of either verbal or non-verbal communication attempts or responses.
- Revert to primary language (which may not be English!).
- Unable to comprehend written words or pictures.
- Inability to physically write words.
- Sensory perceptions become distorted and/or diminished.

General Communication Tips

- Treat the person as an adult. Although the patient with dementia may be confused, they deserve to be treated with respect.
- Modify the environment. Calm & quiet is best. Temperature comfortable? Lighting too bright?
- Allow the patient to make those choices for which they are able. Maintain patient independence as much as possible.
- Simplify instructions. Short phrases. One direction at a time. Use their first name.
- Do not expect the patient to be able to provide correct answers to detailed questions.
- Never try to reason or argue with a patient. Their brain cannot change.
- Be sensitive to picking up their feelings. Learn to read their gestures & behaviors for clues to their feelings.
Steer clear of negative phrases. “Let’s go over here.” – not – “I have already told you that you can’t go there.”

Provide encouragement & positive reinforcement. Imagine not knowing who or where you were. Wouldn’t you need encouragement also?

Demonstrate patience. Give the patient time to respond to what you have communicated. Count to 10 slowly in your mind. If the patient has not indicated a response to your communication by then – you may need to repeat it, only more precisely, with fewer words.

Do not scold or use sarcastic voice tones. The patient does not have the brain capacity to intentionally make you frustrated. However, they may be able to use instinct to detect your true feelings and react to what they perceive.

Avoid surprising the person. Approach from the front. Only speak after their eyes recognize your presence, or you use gentle touch to contact them.

Be sure to hug, kiss and touch the patient as much as they can tolerate. Contact deprivation may influence negative behaviors in the patient.

Establish a familiar routine/schedule. Schedules are your friend. They help both you & the patient to feel focused and in control by accomplishing the tasks on it. Tasks not accomplished can be re-scheduled, again & again!

Make the environment as positive as possible. Gloomy surroundings will be recognized instinctively by the patient.

Reduce noise and overly bright light.
Play soothing music at a low volume.
Keep a nightlight on. If the shadows do not adversely affect the patient.
Use your face/body language as a reinforcement to verbal communication.
Keep patient’s favorite ‘calming’ items available. A doll, blanket, token, stuffed animal or cloth.
Sing to the patient. Any tune that is happy and not too fast in tempo. Lullaby’s, nursery rhymes show tunes.

Sit down near to them. If they are seated on the floor, you should be too!
Promote a nap/rest period in place of the focus on stimulus.
Redirect patient to acceptable activity. Offer a favorite food (ice cream?) or activity (pet the dog?).

Telephone Communication Tips

If at all possible, avoid speaking on the telephone with a patient displaying dementia symptoms except for short greetings.

Be aware of the time ‘lag’ in cell phone voice transmissions. Older ears don’t process cell phone transmissions as acutely as younger ears, and adding dementia to that interaction really increases the confusion in brain processing.

Important information should not be relayed to an Alzheimer’s patient via telephone.

The patient may not be able to connect a telephone conversation with making or keeping a future appointment.

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PACING/EXIT-SEEKING/SUNDOWNING BEHAVIORS

**Pacing** can be defined as a continual or ceaseless ambulation/physical propelling movement for which the brain’s cognitive deficits prevent the patient from discontinuing. **Exit-seeking** seems to involve a patient in very resourceful and energetic actions to allow them to continue on a continuing important mission in another place that their impaired brain perceives is very important. Patients with Frontal-Temporal Lobe Disease are the dementia disorder patients that most commonly demonstrate pacing and exit-seeking behaviors. **Sundowning Syndrome** is a condition in which agitation, increased activity and irritability may be demonstrated by a patient during late afternoon hours and after the sun sets; many dementia disorder patients experience this syndrome.

The patient does not choose to exhibit these behaviors, and their brain cannot learn to stop them. The degeneration of the brain’s neurons is the cause of the behavior. Medications provided to reduce pacing/exit-seeking may produce lethargy, impair their senses and increase the risk of falling – but cannot stop the deteriorating brain from the need to cause the behavior.

**Pacing** is not always an undesirable behavior in the early stages of the disorder. In a safe environment it can be a stimulating and therapeutic source of healthy, pleasurable activity, exercise, and entertainment which can occupy the patient for hours at a time. Often, the physical exercise of pacing enhances the patient’s ability to rest/sleep at night. The caloric intake needs of the patient must be balanced with their energy output to maintain their optimal physical condition.

**Indoors** can be the safest type of pacing behavior for the patient. They could be walking in cyclical patterns through the house/facility, or following a caregiver around as they perform their daily activities of living. Setting up safety barriers and having alert staff tend to be a care routine in a facility; in the home, a sole caregiver will need to be innovative, watchful, and obtain respite from 24/7 duties.

Safety **outdoors** can be challenging for all types of patient movements until all aspects of escape are addressed. In south Florida, the outdoors contains many wonderful benefits and therapeutic values for the patient and caregiver alike: stimulation, diversity, sunshine, fresh air, trees, pets, even quiet. Many facilities have secure enclosed patio areas that these patients can enjoy; wander guard devices on the patient that alarm if they are near an exit; and, areas of the building that are locked & require a code to enter. Making a typical home nearly escape-proof is possible, but is a complicated, time-consuming and usually expensive task for a caregiver who is already trying to cope with the other impacts of the disease on their family life.

Safety issues become even more complicated for **nocturnal** movement by the patient, and are very challenging to address adequately. In a facility, care is taken to assure this patient does not awaken/bother others who are trying to sleep. However, pacing the hallways is usually a quiet & solitary activity for these patients – and staff should be on duty 24/7 to adequately supervise the patient.

**Sundowning**, however, presents behaviors of agitation & irritability that some medications may assist to relieve in the patient. Dementia trained healthcare practitioner’s can be of vital assistance in prescribing for and monitoring such drugs. In the home setting, this nocturnal activity is especially disheartening to family caregivers who are torn between their own vital need for rest/sleep, and the terrifying thought of the patient being unsupervised at night.

Patients who display the behaviors of pacing, sundowning and exit-seeking are the primary reason that family caregivers seek placement in long-term care facilities as they cannot effectively cope with these issues for very long before the very real symptoms of physical fatigue, exhaustion and stress develop and impair their caregiving and their own health.
SUCCESSFUL STRATEGIES

**Never leave the patient unsupervised.** This includes: at home, the doctor’s office, restaurant, grocery store, house driveway, in a car, a facility without wander-guard systems, etc.

**Identification** - Make sure the patient has identification on them at all times. Laundry labels in clothing and shoes; shoe tags; ID bracelet; electronic monitoring device; GPS type monitoring device; implanted electronic chips; Safe Return jewelry; money belt with identification instead of money; flash drive bracelet and so on.

**Distraction** – Use conversation, food, favorite juice or a change in activity to redirect them.

**Toileting** – Always try this strategy. Many dementia disorder patients are not aware of their body’s signals to ‘go’. Most of them will respond if you take them to the right place & assist. If it has been 1-2 hours since they were last toileted (or ate/drank something) – try it!

**Medication Check** – If a new drug (or changed dose) has been recently implemented, this could be a trigger for the brain to exhibit a behavior. Consider all medications: over-the-counter, herbal, illegal and supplements.

**Intake** – Is the patient hungry or thirsty? Offer favorites, not just anything available.

**Environmental triggers** – Reduce stimuli like loud music, the TV, vocal dog or children that might spark an unwanted behavior.

**Camouflage** – Doors & windows that look like something else (bookshelf or wall) can be very effective deterrents.

**Locks** – Simple slide bolts in high or low locations (many dementia disorder patients do not seem able to recognize or reach these-check your patient first). Dutch door with locking handles. Key operated slide bolts.

**Soft Alarms** - Bells on clothing or doors; simple motion sensors; beaded doorway curtains.

**Signs** – Simple words or pictures/drawings can be effective in the early stage to identify particular items or locations of things; perhaps to warn the patient away with a ‘STOP’ sign.

**Walk with the Patient** – The exercise could benefit both of you & allow memories to connect.

**Safety Plan** – Keep current photo and notations of height, weight, eye & hair color available. Tell neighbors & friends of the patient’s diagnosis & behaviors; make sure they have your telephone number. Have essential names & phone numbers of healthcare providers, friends & family.

**Remove Cues** – Essential errand/work items such as coats, hat, shoes, keys, purse, wallet and glasses that the person will not go out without picking up. Don’t put them on the table by the door! Substitute a set of keys that won’t operate anything.

**Dementia Specific Respite** – An adult day facility can provide appropriate stimulation, therapeutic activities, nourishment and socialization for the patient – and relief time for the caregiver. Arranging for a week of dementia-specific facility care for the patient could allow the caregiver to attend a significant family event or have minor surgery or catch up on rest or........!

Adapted from: The Complete Guide to Alzheimer’s Proofing Your Home by Mark L. Warner, Purdue Publications

Providing good care for the dementia disorder patient does not mean that the caregiver must perform each task themselves. It is vital to remember that other’s can often perform the tasks and allow the caregiver to be able to have the time & energy to interact with the patient without the stress of believing they must be responsible for and do everything themselves.

*We provide a safety net around our patients and caregivers every day.*

*Alzheimer’s Community Care*
There are GENERAL GUIDELINES for working with patients who have dementia symptoms. These strategies are not strictly specific for each of the behaviors with which they are listed. If one strategy does not work, try something else until the patient is calmer and the unwanted behavior has stopped or been changed for the better.

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<tr>
<th>Behavior/Response</th>
<th>Definition</th>
<th>Strategy</th>
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| 1. Exit Seeking/Wandering/Pacing | - Exit Seeking – continually trying to leave care area/facility/building  
- Pacing - movement with or without a purpose or goal | - distraction  
- safe area to pace  
- monitor fatigue  
- NEVER leave patient unattended  
- identification on patient  
- disguise & lock exits  
- remove travel cues  
- locator device on patient |
| 2. Rummaging/Pillaging/Hoarding | - searching, looking at, touching, holding, moving items from one place to another  
- retaining multiple items with or without purpose | - name on personal items  
- use “straightening up” as an activity  
- replace one item with another  
- set special areas or boxes for rummaging/hoarding  
- remove excess items periodically  
- do not question or argue |
| 3. Anxiety/Agitation | - disturbed, troubled state of fear, anger, in response to stimulation; demonstrated by inappropriate verbal, vocal, or physical activity | - avoid frequent changes, crowds, or loud noises  
- avoid anything that can be overwhelming  
- remove person from the stressful situation  
- speak quietly and validate |
| 4. Catastrophic Reaction | - exaggerated or over-reaction to an incident; demonstrated by sudden mood change, uncontrolled crying, agitation, restlessness, anger, with or without violence | - anticipate stressors  
- use positive statements  
- distraction/diversion  
- failure-free activities  
- respond to the emotion, not action  
- use planned exercise to reduce stress |
| 5. Combativeness/Aggression | - physical striking out (hitting, pinching, biting, etc) due to fear, anger, misinterpretations, or challenges | - respond, distract (use singing) to avoid further aggression  
- move and speak slowly, remind them who you are; do not threaten  
- develop a pre-planned system of response |
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| **6. Sundowning** | increased behaviors (pacing, confusion, restlessness, yelling, etc.) that occur mid-to late afternoon and evening; possibly due to physical and emotional exhaustion or dehydration | simplify approaches and environment  
encourage fluids until 7 pm  
schedule soothing bedtime ritual  
plan evening calm-down activity  
provide security and protection  
evaluate medications, lighting  
avoid restraints if possible |
| **7. Screaming, yelling, calling** | expressions of fear, or losing control | distract, divert (use music, sing)  
provide repetitive task (mating socks)  
use touch, if appropriate |
| **8. Repeated movements** | using hands or fingers to take apart or pull at things or hitting or wiping surfaces, or chewing, clapping, etc. | distract, divert attention  
engage in singing  
provide an object to hold (ball, stuffed animal, etc.)  
box of varied tactile objects |
| **9. Layering or removing clothes** | dressing/undressing of clothes in inappropriate layers, places or times | gently assist them to put on a robe or clothes  
if in public, do not argue; distract & cover significant body parts  
substitute appropriate for inappropriate clothing |
| **10. Sexually explicit behavior** | inappropriate language, public exposure, offensive and/or misunderstood gestures | remain calm; don’t overreact, argue, or scold  
ignore language and behavior, distract or divert  
assist to a private space |
| **11. Demanding or accusing** | wants everything done immediately or done for him/her; can’t remember where possessions are | use caring, calm voice  
assist to find missing items  
use food or tasks to distract |
| **12. Hallucinations & Delusions** | hallucinations: sensory experiences (hearing, seeing, tasting, smelling, feeling) not experienced by anyone else; delusions: persistent incorrect beliefs (‘You’re not my daughter) | check hearing, vision, hearing aids, glasses  
modify environment to eliminate causes  
if harmless, let go and distract with tasks  
remember that it is real to them  
don’t take it personally |
| **13. Withdrawal & apathy** | sadness or depression to surroundings and people | avoid problem situations  
encourage positive situations  
reassure them that you are there to help  
do not force participation  
gentle touch – if appropriate |

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