

Health care professionals play a key supportive role for people with dementia and their care partners. They can promote early detection and diagnosis and provide ongoing medical care, as well as educate patients about dementia and connect people with the disease and their care partners with community resources that promote quality of life.



Ready to implement dementia friendly practices? Follow the steps:

1

Prepare

- Recognize the signs of dementia.
- Identify champions at the leadership level to sustain the initiative, and on-the-ground, “go-to” resources in clinics or departments.
- Implement a coordinated, person-centered approach for all aspects of dementia care.

2

Learn

- Learn to use dementia friendly communication skills.
- Understand the benefits of early detection and diagnosis.
- Know about tools available to quickly detect cognitive impairment and local services that deal with all stages of disease.
- Provide ongoing dementia education for all staff.

3

Respond

- Assess cognitive health using objective assessments such as the Mini-Cog¹ or Montreal Cognitive Assessment (MoCA)², provide a complete dementia workup, and disclose and document diagnosis.

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Respond (cont.)

- Explain diagnosis and disease process, including possible treatments, what to expect with memory loss and behavior changes, and ideas for staying active and engaged.
- Refer to specialists and resources for counseling, education, and planning.
- Develop a person-centered care plan that maximizes abilities, function, and quality of life; manages medications and chronic disease; provides referrals to services and support; supports care partner needs; addresses home and personal safety and independence (e.g., fall risk, mobility/sensory needs, driving); facilitates advance care, financial, and legal planning; and promotes positive behavioral health.
- Encourage people with dementia and their care partners to connect with others and engage in health and wellness activities.
- Support care partners and recognize and respond to signs of burnout.
- Report suspected abuse, neglect, or financial exploitation.
- Spread practice guidelines to other members of your health care teams and referral networks.

Signs of Dementia³

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

Dementia Friendly Communication Skills^{4,5}

- Slow pace slightly and allow time for person to process and respond.
- Use shorter simple sentences, and ask one question at a time.
- Speak clearly and calmly; be patient and understanding; listen.
- Avoid arguing with or embarrassing the person.
- Treat the person with dignity and respect.
- Be aware of your body language: smile and make eye contact at eye level.
- Seek to understand person's reality or feelings.
- Apologize and redirect to another environment or subject as needed.

Benefits of Early Detection and Diagnosis⁶

- Brings personal relief from better understanding, knowing diagnosis.
- Maximizes time to make decisions and plan for the future.
- Person can access services and support early on.
- Reduces risks.
- Can prevent or reduce future financial costs.
- Improves clinical outcomes and medical management.

Person-Centered Care Planning for Dementia

1. How to maximize abilities, function and quality of life:

- Treat conditions that may worsen symptoms or lead to poor outcomes, including depression and co-existing medical conditions.
- Encourage patient to stop smoking and limit alcohol.
- Recommend occupational and/or physical therapists who can give patients strategies for staying independent as the disease progresses.
- Encourage lifestyle changes that may reduce disease symptoms or slow their progression.
- Encourage routines for regular physical activity and healthy eating.
- Address sensory issues or impairments.
- Encourage socialization and engagement in activities the patient enjoys.

2. Medication therapy and chronic disease management:

- Review and simplify prescribed and over-the-counter medications, including vitamins and herbal remedies; refer to pharmacist as needed.
- Create a medication management plan that educates patient and care partner on medication management aids (pill organizers, dispensers, alarms).
- Recommend that a care partner or health care professional oversee/dispense medications as needed.
- Avoid or minimize anticholinergics, hypnotics (benzodiazepines, zolpidem), H2-receptor antagonists, and antipsychotics.
- Evaluate the medications for over-and

underuse and inappropriate or unsafe prescriptions.

- Reassess the value of any medications, including those being used for cognitive symptoms; consider a slow taper if continued benefit is unclear.

3. Refer patient to services and support:

- Indoor and outdoor chore services, home-delivered meals, transportation, and other assistance as needed.
- See additional resources and Community Based Services and Supports sector guide.

4. Assess and support care partner needs:

- Refer care partners to local resources – such as support groups, respite care, care partner education and training programs, and care partner coaching services – and encourage them to use them.
- Remind care partners to take care of their own health and well-being, including through regular medical checkups.
- Encourage care partners to talk with others about the diagnosis so people can understand a care partner's role and provide support.
- Encourage care partners to ask for help from family and friends.

5. Home and personal safety and independence:

- Refer patient to an occupational and/or physical therapist to address fall risk, recommendations for sensory/mobility aids, home safety and accessibility modifications, and/or driving evaluation.
- Refer patient to driving rehabilitation specialist for clinical and/or in-vehicle evaluation.

- Report an at-risk driver.
- Refer patient to MedicAlert®+ Alzheimer's Association Safe Return®.

6. Facilitate advance care planning and end-of-Life care:

- Discuss care goals, values and preferences with person with dementia and family.
- Encourage patient and family to discuss and document preferences for care early on to prepare for later stages when patient is unable to make decisions.
- Recommend that patient complete a healthcare directive and legal and financial planning and documents, and assign a durable power of attorney.
- Complete POLST (Provider Orders for Life Sustaining Treatment) when appropriate, and routinely re-evaluate and modify plan of care as appropriate.
- Discuss the role of palliative care and hospice in addressing pain and suffering.

7. Promote positive behavioral health:

- Rule out delirium for any acute changes in behavior.
- Describe and categorize the behavior, keeping in mind that behavior is a way to communicate.
- Identify and address unmet needs or reversible conditions.
- Simplify environment – remove clutter, stimuli.
- Support care partner self care, respite, and education on tactics for things like minimizing confrontation and arguing.
- Initiate non-pharmacologic approaches that may reduce symptoms:
 - Plan activities that involve preserved capabilities, interests, repetitive motion.
 - Give the person with dementia “tasks” that match his/her level of competency.
 - Train care partners to communicate, validate, redirect, and re-approach.
 - Reinforce that routine is essential.

- Control the level of stimulation in the person's environment.
- Assess the efficacy of an approach.
- Consider pharmacologic intervention only when non-pharmacologic interventions consistently fail or person is in danger of doing harm to self or others or experiencing intolerable psychiatric suffering.
- There is no FDA-approved medication for Behavioral and Psychological Symptoms of Dementia nor strong scientific evidence to support any particular class of medications. If you use them, document informed consent in medical record and counsel care partners to watch for decreased functional or cognitive status, sedation, falls or delirium.
- Attempt to wean or discontinue medication as soon as possible.
- Monitor target behaviors to evaluate efficacy of medication.

Warning Signs⁷

Signs of inadequate patient support or overburdened care partner:

- Poor medication adherence.
- Weight loss.
- Falls.
- Wandering and being found by neighbors or police.
- Missing appointments.
- Decreased attention to hygiene and grooming.
- Unhelpful visits to urgent care/emergency room.

References

1. **Alzheimer's Association, Mini-Cog**
http://www.alz.org/documents_custom/minicog.pdf
2. **MoCA - Montreal Cognitive Assessment**
<http://www.mocatest.org/>
3. **Alzheimer's Association, Know the 10 Signs**
http://www.alz.org/alzheimers_disease_10_signs_of_alzheimers.asp
4. **Alzheimer's Society, Communicating**
http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=130
5. **Home Instead Business Training, Alzheimer's Friendly Business online course**
<http://www.helpforalzheimersfamilies.com/alzheimers-care-training/alzheimers-friendly-business-training/>
6. **Alzheimer's Disease International, World Alzheimer's Report 2011**
http://www.alz.org/documents_custom/final_world_alz_report_2011_summary.pdf
7. **Lazaroff, A., et al. Using Dementia as the Organizing Principle when Caring for Patients with Dementia and Comorbidities, January 2013, Minnesota Medicine**

Additional Resources

Alzheimer's Association

- **Activity Resources**
http://www.alz.org/library/downloads/search_activities.pdf
- **Caregiver Center**
<http://www.alz.org/care/>
- **Community Resource Finder**
<http://www.communityresourcefinder.org>
- **Dementia and Driving Resource Center**
<http://www.alz.org/driving>
<http://www.alz.org/care/alzheimers-dementia-and-driving.asp>
- **Increasing Disclosure of Dementia Diagnosis**
http://www.alz.org/documents_custom/inbrief_disclosure.pdf
- **Healthcare Professionals and Alzheimer's Resources**
<http://www.alz.org/hcps>
- **Living Well: A Guide for Persons with Mild Cognitive Impairment (MCI) & Early Dementia**
http://alz.org/mnnd/documents/15_ALZ_Living_Well_Workbook_Web.pdf
- **MedicAlert® and Safe Return®**
<http://www.alz.org/care/dementia-medic-alert-safe-return.asp>
- **Online Social Support Community: ALZConnected**
<https://www.alzconnected.org>
- **Residential Care**
<http://www.alz.org/care/alzheimers-dementia-residential-facilities.asp>
- **Respite Care Brochure**
https://www.alz.org/national/documents/brochure_respitcareguide.pdf
- **Safety Center**
<http://www.alz.org/safety>
- **Stages of Alzheimer's**
http://www.alz.org/alzheimers_disease_stages_of_alzheimers.asp
- **Support for People with Dementia**
http://www.alz.org/mnnd/in_my_community_18497.asp
- **Taking Action: A Personal and Practical Guide for**

Persons with Mild Cognitive Impairment (MCI) and Early Alzheimer's Disease

http://alz.org/mnnd/documents/15_ALZ_Taking_Action_Workbook.pdf

- **24/7 Helpline, 1-800-272-3900**
<http://www.alz.org>

Administration on Aging

- **Eldercare Locator**
<http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx>
- **National Center on Elder Abuse**
<http://www.ncea.aoa.gov/>
- **National Family Caregiver Support Program**
http://www.aoa.gov/AoA_programs/HCLTC/Caregiver/index.aspx

The Hartford Financial Services Group

- **Understanding Dementia and Driving**
<http://www.thehartford.com/mature-market-excellence/dementia-driving>
- **At the Crossroads**
<http://www.thehartford.com/sites/thehartford/files/at-the-crossroads-2012.pdf>

National Association of Area Agencies on Aging

- **Healthy Aging**
<http://www.n4a.org/healthyaging>
- **Powerful Tools for Caregivers**
<http://www.powerfultoolsforcaregivers.org/>

National Council on Aging

- **Physical Activity Programs for Older Adults**
<https://www.ncoa.org/healthy-aging/physical-activity/physical-activity-programs-for-older-adults/>
- **2015 Falls Free National Falls Prevention Action Plan**
<https://www.ncoa.org/healthy-aging/falls-prevention/2015-falls-prevention-action-plan/>
- **Adult Day Care Locator and Articles**
<https://www.caring.com/local/adult-day-care>

Others

- **National Wellness Institute – Six Dimensions of Wellness**
<http://c.ymcdn.com/sites/www.nationalwellness.org/resource/resmgr/docs/sixdimensionsfactsheet.pdf>
- **National Institute of Health Senior Health, Healthy Aging**
<http://nihseniorhealth.gov/category/healthyaging.html>
- **Alzheimer's Society, Nutrition**
<http://www.alzheimers.org.uk/Nutrition/>
- **National Hospice and Palliative Care Organization (state by state advanced directive forms)**
<http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289>
- **Gitlin LN, Kales, HC, Lyketsos CG. Nonpharmacologic management of behavioral symptoms in dementia.**

JAMA.2012; 308(19):2020-2029.

http://www.actonalz.org/sites/default/files/documents/Table1_.pdf and http://www.actonalz.org/sites/default/files/documents/Table2_.pdf

- **Validation Therapy**
<http://www.youtube.com/watch?v=CrZXz10FcVM>
https://vvalidation.org/web.php?request=what_is_validation
- **Mayo Clinic, Mild Cognitive Impairment (MCI)**
<http://www.mayoclinic.com/health/mild-cognitive-impairment/DS00553>
- **ACT Provider Practice Tools**
<http://www.actonalz.org/provider-practice-tools>
- **Centers for Disease Control and Prevention, Physical Activity is Essential to Healthy Aging**
http://www.cdc.gov/physicalactivity/basics/older_adults/index.htm
- **American Occupational Therapist Association – Find a Driving Specialist**
http://myaota.aota.org/driver_search/index.aspx
- **National Institute on Aging, Alzheimer's Disease Education and Referral Center, Home Safety for People with Alzheimer's Disease**
<https://www.nia.nih.gov/alzheimers/publication/home-safety-people-alzheimers-disease/introduction>
- **National Alliance for Caregiving**
<http://www.caregiving.org>
- **Caregiver Action Network**
<http://www.caregiveraction.org>
- **AARP Caregiving Resource Center**
http://www.aarp.org/home-family/caregiving/?cmp=RDRCT-CRGVER_APR12_012
- **Wolters Kluwer Uptodate, Delirium: Beyond the Basics**
<http://www.uptodate.com/contents/delirium-beyond-the-basics>
- **American Geriatric Society, BEERS Criteria for Potentially Inappropriate Medication Use in Older Adults**
<https://www.cdphp.com/providers/formulary/~/media/Files/medicare/medicare2015/members/ags-beers-criteria.ashx>
- **Stratis Health, How to Help Your Loved One: Improve Dementia Care by Reducing Unnecessary Antipsychotic Drugs**
<http://www.actonalz.org/pdf/ReduceDrugs.pdf>
- **Health in Aging, A Guide to Geriatric Syndromes: Common and Often Related Medical Conditions in Older Adults**
<http://www.healthinaging.org/resources/resource:guide-to-geriatric-syndromes-part-i/>
- **Hospice Criteria Card (2013)**
http://geriatrics.uthscsa.edu/gerifellowship/documents/updated_08_2013/Hospice%20Card%20%20JSR%20SSR%202013.07.10.pdf
- **POLST (Provider Orders for Life Sustaining Treatment)**
<http://www.polst.org/>

Assessment & Assessment Tools

- **Lawton Instrumental Activities of Daily Living (IADL) Scale**
http://consultgerirn.org/uploads/File/trythis/try_this_23.pdf
- **From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing: Best Practices in Nursing Care to Older Adults general assessment series Issue Number 2, Revised 2012 Editor-in-Chief: Sherry A. Greenberg, PhD(c), MSN, GNP-BC New York University College of Nursing Katz Index of Independence in Activities of Daily Living (ADL)**
http://consultgerirn.org/uploads/File/trythis/try_this_2.pdf
- **Cohen Mansfield Agitation Inventory**
http://www.dementia-assessment.com.au/symptoms/CMAI_Scale.pdf
- **Pain Assessments in Cognitively Impaired Older Adults**
<http://www.geriatricpain.org/Content/Assessment/Impaired/Pages/default.aspx>
- **American Medical Association, Caregiver Self Assessment** http://www.caregiving.org/wp-content/uploads/2010/11/caregiverselfassessment_english.pdf
- **Zarit Burden Interview**
<http://www.healthcare.uiowa.edu/igec/tools/caregivers/burdenInterview.pdf>
- **Patient Health Questionnaire (PHQ-9)**
http://cqaimh.org/pdf/tool_phq9.pdf
- **National Chronic Care Consortium and the Alzheimer's Association Family Questionnaire**
<http://www.actonalz.org/pdf/Family-Questionnaire.pdf>
- **SLUMS St. Louis University Mental Status Examination**
<http://aging.slu.edu/pdfsurveys/mentalstatus.pdf>

Health care is just one important part of the community. Working alongside other sectors, health care professionals can help the whole community become more dementia friendly. Learn more about the process and help your community and others become more dementia friendly at www.dfamerica.org.



Adapted from ACT on Alzheimer's® developed tools and resources.