LOST IN TIME

CAN YOU DETECT THE SIGNS OF DEMENTIA IN THE ELDERLY?

Have you ever forgotten your car keys or misplaced your glasses? Everyone experiences these memory lapses from time to time. In most instances, it's merely a case of absent-mindedness. But forgetfulness may be one of the indicators of something more severe for elderly people, namely dementia.

For many health care workers, family members, physicians and researchers, dementia is poorly understood. Dementia is neither a disease nor a diagnosis; it's a term for a collection of symptoms. Due to its nature of inconsistent symptoms among people, management is always a complex issue.

Clinicians do know that dementia is a progressive impairment of orientation, memory, judgment and other aspects of intellectual functioning. Characterized by generalized cerebral atrophy, dementia can be more prominent in the frontal occipital temporal regions of the brain. Histologically, it's characterized by neurofibrillary tangles and senile plaques.

Working with Clients who have dementia can be difficult, particularly in cases of severe dementia. Many of these residents can't even follow commands or make eye contact. Nevertheless, you must still conduct an evaluation to determine impairment levels, then teach coping skills and strategies to compensate for mental deficiencies. This evaluation allows you to establish a

performance baseline for later comparison, identify specific traits or behavior patterns and gather data to design a treatment plan. This process should include the following steps:

- ***Testing:*** *Standardized tests are a valuable resource for gathering data.* The success of standardized tests, however, depends on the type of instrument you choose and a client's level of cognitive ability. Options include, Kohlman's evaluation of living skills (KELS), functional assessment staging (FAST) and Allen's cognitive level (ACL) test. KELS and FAST focus on determining a patient's functional ability and disability, based on cognitive function. Allen's cognitive level also can be used to classify functional stages of the patient. Another test--the global deterioration scale--helps determine the level of impairment. It's useful to measure future impairment and give caregivers an idea what to expect as the disease progresses. If a client can participate or follow directions to complete standardized tests, consider similar options. For instance, the mini-mental test is a short verbal questionnaire that determines quantitative measures of cognitive performance. To obtain information and identify functional deficits, you also can ask informal questions, interview caregivers or review medical records.
- ***Observation:*** *Observe the patient to obtain vital clues about cognitive function.* Can a resident recognize simple objects, such as a toothbrush or spoon? Does he know his immediate living environment and potential hazards? Does he know his body parts? (In late stages of dementia residents don't). Questions or criteria should progress from simple to complex activities. For example, see if a person remembers his room number first before asking if he can recall a longer series of figures in a telephone number.
- ***Record review:*** Records from other clinicians or former care facilities are important resources to determine functional or cognitive impairments. Let's say documentation indicates that the patient was agitated when it was time for breakfast. Before labeling the patient as having behavioral problems, examine life-long habits as documented in medical records. Maybe the resident isn't an early riser or only likes coffee in the morning. He may not be exhibiting problem behavior; he's just not

interested in breakfast and is irritable in the morning. After a complete evaluation, you'll have a better understanding of the resident's abilities and potential to handle functional tasks and activities of daily living. Of these tasks and ADL's, self-care is particularly difficult with residents who have dementia. Nevertheless, strategies--as the following scenarios illustrate--can help caregivers manage the problem.

Problem 1: A resident can't attend to dressing tasks. The inability to initiate or tend to the task is a common symptom in people with middle-to-late-stage dementia. At these stages, the client's cognitive ability to process the information is impaired or lost. Sometimes, the ability to process the information only partially exists, and the resident doesn't understand an activity's benefit. Moreover, fear may underlie some of the behavior. For example, the resident may be afraid of falling when he tries to put on clothes.

Solution: Simplify the closet. Hang only a few pairs of clothes and limit choices. Too many choices frustrate the client. Be familiar with a resident's dressing habits and styles. For instance, if someone loves to wear suspenders, he may not remember to connect pants and a shirt to wear the suspenders. Handle the problem by making sure the suspenders are always attached to the pants before he puts them on. Talk to the family or other caregivers about dressing style and favorite items, such as ties, coats or jewelry. In addition, don't tell the client that his choice is wrong, which could cause anger or irritation. Instead, respond diplomatically by saying, "I think this shirt would look nice on you."

Problem 2: The resident can't participate in bathing. Some residents don't understand the need to bathe. In addition, some may be afraid of the water. Others may feel embarrassed and may, therefore, say they've already showered.

Solution: Lifelong habits that rely on time play an important role. If a client lived on a farm and was an early riser, it will be difficult or impossible to persuade him to shower at 11 a.m. Design the patient's schedule so he can bathe early in the morning. If embarrassment is an issue with bed bath, start by washing the face, then both arms. Go slowly and don't rush the resident. And never insist that the patient undress. Make the shower warm and comparable to home bathing. If fear of hot water persists, try using a warm towel or wash

cloth. Don't direct a hand-held shower or take the resident under the shower, which can heighten anxiety or fear. To soothe the patient, consider signing a favorite old-time song during bath activities.

Problem 3. The resident refuses to participate in mouth care. Some residents may have lost the ability to understand the importance of personal hygiene.

Solution: Break down the task into small components. Start by opening the toothpaste and apply it to the toothbrush. If the resident doesn't recognize the items, use general labels such as "toothbrush," not brand names. With dementia, the brain can recognize general terms, but can't connect the concept of a brand name with a product. If the patient still rejects the mouth care, you can use mouthwash or swabs for hygienic purposes.

Problem 4: The resident has difficulty attending to eating tasks. He has problems initiating the tasks of scooping food or picking up a glass, secondary to impaired strength and motor control.

Solution: Make sure residents haven't been under-stimulated or overstimulated before mealtime. If overstimulated mentally or physically, a resident may not be able to initiate the task of eating, either because he's exhausted or he thinks he's already eaten. And if under-stimulated, the patient might think it's still morning, even though it's time to eat lunch. As a result, he'll refuse to eat. If the client still comprehends the importance of money, you can provide tokens to create the impression that he's paying for the meal. This exchange allows the resident to feel as if he has some control. But don't offer too many choices of foods, it will only create confusion. However, a facility should change the menu periodically to keep patients interested in mealtime. Boredom can set in if patients eat the same foods everyday. Introduce finger food if the client has trouble using utensils. In addition, try to maintain uniformity at the dinner table by placing residents with similar abilities together. And creating a pleasant atmosphere--such as the smell of barbecue wafting through the air--stimulates the desire to eat.

Caring for older adults with dementia is a complex task for health care clinicians and caregivers. By applying these successful coping strategies, however, you may be able to lessen the complexity of care.

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