Systems & Staging with Dementia

Empowering Therapists to Provide Responsible and Reimbursable Care
Written and Presented by:
Erin Browning Ball, MA, CCC/SLP

Â April 14, 2015
Today’s Goals

• Neurological Review - family friendly
• Differentiating symptoms and type of dementia
• STAGING-DEVELOPMENT OF PLANS
• Cognitive linguistics & communication to increase outcomes
• Behaviors
• Documentation
• Ethics
“I have lost myself”

Auguste Deter (1850-1906).
Brain Function & Dementia

- It is a BRAIN based problem. Symptoms are only what we treat.

- It is NOT the person, it is their BRAIN.
Typical vs Nonneurotypical
Brain Comparison

Top: Normal Brain
Bottom: Brain with Dementia
Brain Differences

Left: Alzheimer’s Disease
Right: Normal
Comparing

Normal Brain

Brain with Dementia
Cortical vs Limbic Function
Alzheimer’s Disease

Images courtesy of the National Institute on Aging/National Institutes of Health
Cortical Degeneration

- Temporal lobe
- Hippocampus formation
- Frontal lobe
- Corpus callosum
Motor Control

- Basal ganglia
- Substantia nigra
- Cerebellum
- Brain Stem
Aging Brain

- Deterioration occurs with age
- 5-10% of mass lost
- Memory decline
- Chemical changes
Brain with Dementia

- Cortical degeneration increased
- Slowed metabolic function
Retrogenesis

- Reisberg’s theory
- Predictable pattern of brain deterioration
- Progression of symptoms inverse to development.
- Later learned functions go away first, and earlier learned functions stay in tact longer.
- Evidenced in motor function and cognitive function.
- What is the neurological basis for this?
- What is the impact across disciplines in the continuum of care?
Robert and Karen Patterson

This interview is provided courtesy of StoryCorps, a national nonprofit organization which records and collects stories of everyday people.

www.storycorps.org
Frontal Lobe Function

- Attention
- Initiation
- Inhibition
- Persistence
- Volition
- Production of Speech (Broca’s area)
- Executive function
- Multitasking
- Judgment
- Abstract thinking
- Mental Flexibility
- Problem Solving
Frontal Lobe Deteriorates &
We See Changes With

- Making decisions
- Finding alternate solutions
- Shifting train of thought
- Finishing tasks
- Beginning tasks
- Interacting appropriately
- Understanding abstract concepts
Temporal Lobe Function

- Short Term Memory
- Long term Memory
- Learning information
- Comprehension of Language (Wernicke’s area)
Temporal Lobe Deteriorates
We See Changes With

- Understanding complex language
- Recalling personal information
- Remembering functional information
- Learning new things
Occipital Lobe Function

- Visual recognition
- Visual perception
Occipital Lobe Deteriorates
We See Changes With

- Recognizing people
- Recognizing things
Limbic Region

- Emotional
- All or nothing
- Regulated by frontal lobes
Limbic Filters Deteriorate & We See Changes With

Å Reactions to stimuli
Å Levels of aggression
Å Emotional lability
Cerebellum & Brain Stem Deteriorate We See Changes

- Sustained attention/effort
- Mental speed
- Procedural memory required for ADLS
- Balance/Gait
- Dyskinesia
- Basic motor functions
Neuroplasticity & Degenerative Conditions
QUIET PLEASE

I'M FORMING NEURAL PATHWAYS
Using the brain to make gains

- **Frontal Lobe**
  - Basic functions as well as higher level skills

- **Temporal Lobe**
  - Memory and language

- **Cerebellum**
  - Procedural Memory

- **Occipital Lobe**
  - Visual perceptual changes

- **Parietal Lobe**
  - Sensory processing and integration

- **Limbic System**
  - Emotional component
Specific Types of Dementia
Alzheimer’s Disease

- Progressive
- Plaques and Tangles
- Death of Nerve Cells
- Memory Changes 1st signs
- Decision Making Impaired
- New Learning Impaired
- Slow Development of Symptomology
Vascular Dementia (MID)

- Multiple infarcts interrupt blood flow to brain
- Thromboembolism
- Arteriosclerosis
- TIA
- Sudden onset/sudden change of function
- Attentional and executive function impairments
- Need to treat risk factors
Parkinson’s Disease

- Genetic and environmental
- Risk factors: exposure to pesticides, insecticides, head trauma
- Loss of smell
- Tremors
- Rigidity
- Bradykinesia
- Parkinsonian gait
- 20% will develop dementia
Lewy Body Dementia

- Ball of protein deposits found in cortex
- Fluctuations in cognitive functioning
- Alertness and attention extremely variable
- Hallucinations (mostly visual)
- Parkinsonism
Creutzfeldt-Jakob Disease

- Human Prion disease
- Classic vs. Variant
- Transmittable spongiform encephalopathy
- Mad cow disease
- Chronic wasting disease
- Onset to death 6 mo-1 year
- As of 2005, deaths in US 300 people
Creutzfeldt-Jakob disease deaths and age-adjusted death rate, United States, 1979-2010*

Images courtesy of the Centers for Disease Control & Prevention
Frontotemporal Dementia

- Gradual personality changes early on
- Most common cause of dementia in people under age of 60
- Behavioral, language, or motor symptoms
- Executive function
Brain Comparison

Normal

FTD
Korsakoff’s Syndrome

- Associated with chronic alcoholism
- Thiamine (Vitamin B1) deficiency
- Poor nutrition & decreased absorption of vitamins in stomach
- Wernicke’s encephalopathy is a precursor
- Memory loss, mainly short term
- Difficulty learning new skills
- Double vision, eyelid drooping
- Apathy
- Repetitive talking with confabulations
AIDS

- Mental slowing
- Can often sustain conversation, but upon clinical interview deficits seen
- Decreased coordination of voluntary movements
- Depression
Differentiation

- Symptoms as related to systems and structures
- Involve a team of professionals
Tests, Screens, Informal Assessments Based on Diagnosis
Neurocognitive Disorders (NCD) & DSM V

- Mild NCD
- Major NCD
- Delirium

- NIH backed article in April 2011
- Diagnostic criteria to be broadened.
  - Presymptomatic (biomarkers, for research at this point)
  - Mild Cognitive Impairment, but pre-dementia
  - Dementia
Practicality of Diagnosis

- Mini Mental State Examination (MMSE)
- Saint Louis University Mental Status Exam (SLUMS)
- Mini-Cog

- Functional Assessment Staging Test (FAST)
- Brief Cognitive Rating Scale (BCRS)
Despite our screening tool or assessment

Â We want to look for FUNCTIONAL ability and caregiver reports as well.

Â Ask the RIGHT questions.

Â It is a continuum.
OT

• The Montreal Cognitive Assessment (MoCA)
• Blessed Dementia Scale
• Clock Drawing Test
• Mini Cog
MOCA

http://www.mocatest.org/
http://www.strokecenter.org

Android App
Clock Drawing Test

No dementia

Clock-drawing test score = 15/15
(Mini-Mental State Examination score = 30/30)

Alzheimer disease

Clock-drawing test score = 11/15
(Mini-Mental State Examination score = 21/30)
- Numbers 1 to 12 incorrect (-1 point)
- Hour and minute target incorrect (-2 points)
- Numbers in incorrect position (-1 point)

Scoring the clock drawing
The clock drawing can be scored using the criteria described by Freedman and colleagues.21
Fifteen items are used to evaluate the drawing and 1 point is given for each item that is present. The following criteria are used — the shape of the circle is acceptable; it is not too small, overdrawn or repeated; only numbers 1 to 12 are present; all numbers are in Arabic numerals; the numbers are in the correct order; the paper is not rotated while drawing the numbers; the numbers are in the correct position; all numbers are inside the contour; the clock has a centre where the hands meet; the clock has 2 hands; the target number for the hour hand is indicated; the target number for minutes is indicated; the minute hand is longer than the hour hand; no superfluous markings are present; the hands are joined or are within 1.27 cm of each other.

Editor's Note: The original list that appears in the print version has been replaced with the above information.

Alzheimer disease

Clock-drawing test score = 8/15
(Mini-Mental State Examination score = 25/30)
- Numbers in incorrect position (-1 point)
- Hour and minute targets incorrect (-2 points)
- Clock has only 1 hand (-4 points)

Suspected frontotemporal dementia

Clock-drawing test score = 3/15
(Mini-Mental State Examination score = 25/30)
- No contour (-2 points)
- Superfluous markings (-1 point)
- Hour and minute targets incorrect (-2 points)
- Numbers in incorrect order / incorrect position / outside contour (-3 points)
- Clock has no centre or hands / hands not joined / length of hour and minute hands cannot be compared (-4 points)
SLP

• Functional Linguistic Communication Inventory (FLCI)
• Arizona Battery for Communication Disorders of Dementia (ABCD)
• RIPA-G
• Cognitive Linguistic Quick Test (CLQT)
ABCD
RIPA-G
CLQT
Staging of Dementia

Global Deterioration Scale
Modified from Global Deterioration Scale, Reisberg, 1982.
How to use this Staging System

- Provide a baseline
- Provide families with information
- Guide POC
- Dictates treatment goals, activities, and recommendations including discharge guidelines
- Stay 2 stages ahead of the game.
Bob & JoAnn Chew

This interview is provided courtesy of StoryCorps, a national nonprofit organization which records and collects stories of everyday people

www.storycorps.org
GDS stage 1
No cognitive decline

- Normal
- No complaints of memory loss
- No evidence of memory loss in the interview
GDS Stage 2
Very Mild Cognitive Decline
GDS Stage 2
Cognitive and Communication

- Forgetfulness
- Patient & possibly close family complaining of memory deficits.
- Subjective
- No objective impairment of memory displayed
- Beginning to forget names of objects
- Beginning to forget where items have been placed
- Patient demonstrates awareness of and concern with deficits.
GDS Stage
2 ADLs & IADLs

- No objective impairment
- Difficulty in highly challenging situations.
- Decreased concentration in cognitively demanding situations.
GDS Stage 3
Mild Cognitive Decline
GDS Stage 3
Cognitive and Communication

- Obvious impairment beginning
- Co-workers & family becoming aware of deficits
- Word finding problems
- Patient loses and misplaces items frequently
- Lack of recently read material and increased time to process written material.
- Objective Impairment when intensely interviewed.
- Obvious deficits with attention during structured tasks.
- Working memory impairments
- Decreased delayed recall
- Higher level thinking impairments
- Denial presents as avoidance with complex tasks
GDS Stage 3
ADLs & IADLs

- Issues with multi-tasking, planning for future events, and difficulty in demanding situations.
- Easily able to learn and implement compensations
GDS Stage 4
Very Early Dementia
GDS Stage 4
Cognitive & Communication

- Poor knowledge of current and recent events.
- Deficits with recall of personal history details.
- Attention impairments
- Still oriented to time and person.
- Concrete thinking and communicating
- Recognize familiar people.
- Word finding deficits
- Thinking and communications become egocentric
GDS Stage 4
ADLs & IADLs

• ADLs still intact especially when familiar
• Highly dependent upon environmental cues
• Difficulty traveling, problem solving in the home, & handling finances.
• Needs support to stay at home (at least once daily)
• Able to navigate familiar environment, but will require new routine with new environments
• Rigidity with routines
GDS Stage 4
Behavioral Changes

- Denial
- Hyper-focus
- Difficulty regulating emotions
- Anxiety
- Anger
- Depression
GDS Stage 5
Early Dementia
GDS Stage 5
Cognitive & Communication

- Impairments are obvious in structured setting and conversation.
- Sequencing deficits, task must have visible results
- Procedural memory still intact
- Episodic memory often still intact with particular events
- Cannot consistently provide personal info.
- Frequent disorientation to time and place.
- Decreased direction following out of context
- Use of pronouns and understanding of pronouns deficient.
- Able to answer y/n, 2 choice, and concrete questions
- Able to read & write simple words & possibly familiar phrases
- Problem solving and insight significantly decreased.
GDS Stage 5
ADLs & IADLs

• Can still feed self and toilet with simplification, modification, and if familiar
• Difficulty with decision making process behind these ADLS.
• Difficulty with initiation of these basic ADLS
• Can learn up to 3 step sequences when results are predictable
• Does not anticipate or attempt to solve problems
• Can complete routine and familiar tasks
• Understands when task is complete if visible results
• Sleep wake cycle is deficient
GDS Stage 5
Behavioral Changes

• Fear
• Paranoia
• Impatient
• Anxiety increases when alone
• Looking for “what’s next” or “where now”
GDS Stage 6
Middle Dementia
GDS Stage 6
Cognitive & Communication

- Unaware of recent events and experiences.
- Forgets the name of caregiver or spouse at times.
- Disoriented to time and place.
GDS Stage 6
ADLs & IADLs

Â Needs assistance with ADLS, cognitive and physical.
Â Incontinence
Â Can complete mechanics of toileting if routine
Â Difficulty sitting for entire meal
Â Possibly still self feeding.
Â Difficulty with recognition and use of everyday objects
Â Dressing sequencing is poor
Â Beginning to experience deficits in procedural memory and the physical completion of ADLS
GDS Stage 6
Behavioral Changes

- Change in personality
- Delusions and hallucinations become more common
- Anxiety, agitation, violent episodes, loss of volition, depression
- No personal boundaries
- Lack of expression of discomfort can cause behavior change
GDS Stage 7
Late Dementia
GDS Stage 7
Cognitive & Communication

- Late Dementia
- Automatics actions only
- No functional verbal communication
- May respond to stimulus if multiple senses targeted (not just auditory)
- May change facial expressions or use movements, pinching, hitting, etc to communicate
- Possible use of repetitive words, yelling, grunting, moaning
GDS Stage 7
ADLs & IADLs

• Completely Incontinent
• Physical dependence for all ADLs
• Function of swallow declining
GDS Stage 7
Behavioral Changes

May pinch, hit, or kick.
Physical & Sensory Changes Associated with Cognitive Decline
GDS Stage 1
Physical & Sensory

Å No objective physical or sensory impairments.
GDS Stage 2
Physical & Sensory

Å No objective physical or sensory impairments.
GDS Stage 3
Physical & Sensory

May experience loss of strength.
May experience loss of lean muscle mass.
GDS Stage 4
Physical & Sensory

- Ambulating
- Safety Issues mostly when in challenging situations, and reasoning impaired.
- Able to scan visually
- Visual cues in environment recognized when highly visible
- Attention interfering with safety
- Decreased ability for eyes to adjust to light change quickly
GDS Stage 5  
Physical & Sensory

Â Still ambulating

Â Vision declining, 12-14 inches in front of the patient is best

Â Occipital & parietal changes beginning; seeing motion deficient, dimensions are difficult to distinguish & objects appear flat, high contrast color is most effective, deficits manifest as perceptual

Â Hypothalamus Damage, patient begins to display difficulty with temperature regulation

Â Fine motor manipulation becoming increasingly impaired.
GDS Stage 6
Physical & Sensory

- Poor motor initiation or motor sequencing with basic ADLS
- Sensory changes in vision, tactile,
- Fall risk significantly increased
GDS Stage 7
Physical & Sensory

- Dependent will all functional mobility
- Risk for skin breakdown, contractures, and dysphagia increases
- Response to sensory stimuli decreased
Weight Loss

• Involuntary Weight Loss in age 65 & older
• Present in 50-60% of nursing home residents
• 13% of ambulatory patients
• Nearly doubling adipose and losing 5-15% of non fat mass
• Sarcopenia
Normal Pressure Hydrocephalus

- Ventricular volume
- Subarachnoid space
- Responsible for no more than 5% of dementia cases
- Dx by MRI
Teaching the Family and Caregivers
You are responsible for teaching the caregiver too

• Be aware of learning styles
• Education level and understanding
• Denial
Staging Related to Education

- Early Stages: 2-4
- Mid Stages: 5&6
- Late Stages: 7
Working with Age Associated Memory Deficits
Cognitive Aging

Aging is associated with progressive losses in function across multiple systems, including sensation, cognition, memory, motor control, and affect.

Reduced brain activity due to behavioral change, from a loss in brain function driven by aging brain machinery, or more likely from both.
Is there any hope?

- Brain Plasticity
  - How neural pathway formation can be our best friend?

- Sensory & Motor Activity
Considering other factors

- Loss of growth hormone production
- Menopause
- Andropause
- Metabolic Changes
- Medications
Mood & Behavior Changes
Aggressive Behaviors

- Biting
- Hitting
- Outbursts
- Combativeness

- Medical complication
- Pain
- Changes in environment
- Lack of communication
Catastrophic Reactions

- Highly emotionally charged
- Patient may cry, yell, curse, hit, flail
- Uncontrolled reaction

- Person feels overwhelmed
- Patient feels challenged not supported
Eating Difficulties

- May refuse to eat
- May eat too quickly or eat too much
- Eat non-food items
- Expression of control
- Medical condition
- Dental problem
- Swallowing
- Motor control
- Change in sensation
Wandering & Sleeplessness

- May wander and get lost
- If in a facility may wander into dangerous areas
- Unable to fall asleep
- Unable to stay asleep
- Patient is confused
- Routine is changed
- May be anxious
- Pain
- Attention is impaired
- Hungry
- Tired
Hoarding

- Patient begins to collect items
- Items are “hidden” on person or in his/her space
- Agitation can occur if challenged

- Typically not the aggressive person unless hoarded objects are taken
- Compulsive
- Difficult to distract
- Afraid of not having enough
- Don’t want to be wasteful
Yelling

• Patient yells and screams
• May be for a request, real words
• Just making noise

• Overstimulation
• Understimulation
• Attention
• Pain
• Hunger
• Anxiety
Guidelines for Behavioral Interventions

• American Geriatrics Society & American Association for Geriatric Psychiatry

• Careful assessment of potential causes for agitation, aggression, & depression is essential.

• Environmental or behavioral techniques should be employed before pharmacological intervention.

• If these attempts fail after 30 days, or the person is a threat to themselves or others then medications can be used under medical supervision & should be reassessed every 3 months.
ALWAYS CONSIDER

Â Basic Physiological Needs First

Â Eating
Â Drinking
Â Sleeping
Â Toileting

Â Movement & Breathing
Strategies to Intervene & Improve Outcome Achievement
Strengthen Strengths

“My Mother or Father Shouldn’t Suffer”

- Meaningful
- Multisensory
- Functional
- Successful
- Stimulating of cognition
Maximizing Effectiveness with Difficult Patients: Stage by Stage
Ken Morganstern interviewed by his daughters

www.storycorps.org
Effective Communication is Key

- Understanding
- Expressing
- Cognitive Component

- Without Effective Client/Clinician Communication, Outcomes will be limited
Understanding

- Increased time to process language
- Lack of response to conversation
- Decreased ability to answer questions
- Decreased ability to follow directions
- Decreased response to verbal stimuli
- Increased success with concrete language
Expressing

- Decreased word finding, non-specific speech
- Breakdown in syntax
- Length of utterance
- Neologisms

- Use of common phrases “fillers”
- Length of time for word retrieval
- Naming / paraphasias
Reading

- Level of complexity impacts performance (even as specific as number of syllables)
- Familiarity of words

- May not always be able to get content, words are read but are they comprehended?

- Low vision
- Reading often remains intact and can be used to your advantage
Attention

• Selective
• Divided
• Sustained
Organization

- Categorization-Sorting

- Sequencing

- May do better if they have a model, someone paralleling the desired sequence
Reasoning

• Divergent Thinking

• Convergent Thinking
Memory

- Procedural Memory (motor, will stay intact longest)
- Semantic Memory (retrieval is decreased, hippocampus)
- Episodic Memory (autobiographical)
- Working Memory
Safety Awareness

Â An in depth view is especially important for documentation and reimbursement.

Â Beyond basic “awareness” look at the symptom of decline in cognitive processes

Â Look at which process or processes are the contributors to decreased safety
Using EBP to increase “learning”

Å Spaced Retrieval

Å What is it?
Å How does this apply to ALL disciplines?

Å Basic Methodology
Å Reference & Support to Make it Work
GDS Stage 3

What is reasonable for intervention and outcome?
SLP Stage 3

- Category naming, circumlocution to increase word finding and rehearse fact recall.
- Note taking, summarizing, outlining & list making skills to increase comprehension& recall
- Social communication strategies, patient initiating topic.
- Have patient & caregiver identify most successful communication environments.
SLP Stage 3

- Teach strategies of highlighting, note taking, outlining, & listing to increase recall of information.
- Begin use of planner/calendar for appointment keeping and memory logging.
- Problem solving tasks, providing multiple solutions to a given problem.
- Establish compensatory systems to increase problem solving (phone lists, med organizers, etc).
- Have patient identify most successful environment for attention, make modifications, and increase use.
- Family/caregiver training to aid in carryover
OT Stage 3

- Development & use of compensatory systems for IADLs.
- Work towards independence with ADL routine, initiation and completion
- Teach independence with splint schedule & precautions
- Light housekeeping and simple meal prep with cueing system for initiation
OT Stage 3

- Teach independence with weight bearing precautions during transfers & ADLs
- Ensure independence with grooming routine and appropriate clothing selections.
- Independent with self pacing during ADLs & IADLs
- Establish compensatory systems to increase problem solving, memorization of emergency routines
PT Stage 3

- May or may not need assistive device, but teach concept.
- Independent with exercise program with rehearsal and written instruction
- Ambulation with uneven surfaces, negotiating doorways, thresholds, 12-15 stairs with handrails
- Work to improve Berg Balance score to >41, through functional task and exercise training
PT Stage 3

- Increase TUG score to <10, through functional task and exercise training
- Independent knowledge and use of precautions
- Increase safety with ambulate and navigation around obstacles independent or mod I
- Independent with energy conservation techniques
- Independent with O2 tank management
GDS Stage 4

What is reasonable for intervention and outcome?
SLP Stage 4

• Category strategies, using related topics to a specific person or event to increase initiation and maintenance of communication/memory
• Identify a communication partner/event and implement “chat schedule”
• Independent request of repetition of directions or need for more information
• Orientation and long term recall
• Communication initiation and pragmatics being on topic
SLP Stage 4

- Log of days events to increase recent functional information recall
- Teach new sequences overtly and practice with written and verbal compensations.
- Circumlocution and a series of “wh” questions to increase word finding, visual cueing.
- Verbal problem solving with rehearsal
- Establish written communication routine.
- Pull written/visual info from their environment and modify environment for success
OT Stage 4

- UB self care and dressing with mod I
- LB self care and dressing mod I or supervision
- Increase UB strength through progressive resistive strengthening exercise routine
- Work towards independence with self pacing
- Work towards fair-good activity tolerance
OT Stage 4

- Navigating the immediate environment using compensation
- Increased leisure activity with use of calendar/schedule
- Provide structure cueing system with ADL routine
- Fine motor control for dressing tasks
PT Stage 4

- Increase strength with progressive resistive strengthening exercise routine.
- Improve static and dynamic balance
- TUG score 12-15, want good mobility here and implement assistive device
- Mod I with functional transfers, negotiation of doorways, obstacles, stairs, teach overt routines/strategies
PT Stage 4

- Ambulation of 500 ft. consistently (assessing what is reasonable for the patient’s environment)
- Independent with when provided education and cueing system
- Independent with symptoms of orthostatic hypotension and isometric leg exercise prior to standing with cueing system
- Decreasing pain & decreasing edema through intervention of e-stim, exercise, etc
GDS Stage 5

What is reasonable for intervention and outcome?
SLP Stage 5

- Increase attention to social/functional task, conversation 10-15 minutes
- Improve question answering, open ended familiar, 2 choices, yes/no
- Teach staff paring of gestural language with verbal direction.
- Teach caregivers the most successful level of question and provide written list
- Visual and environmental information to increase orientation to immediate environment.
SLP Stage 5

- Address orientation to daily routine, simplify written cues into simple short lists
- Teach use guest registry for the patient, will often decrease anxiety if they can read what family member have written.
- Develop/use memory book or life box to increase recall and communication
- Direction following 1&2 steps
- Address cognitive organization
OT Stage 5

- UB/LB dressing with mod assist and cues required
- Work towards self pacing with min cues
- UB/LB bathing with mod assist, min-mod if still in familiar environment
- Self feeding 75% of meal with modifications/simplifications
- Improve continence with schedule, simplification of toileting, and prompted voiding
- Visibility of toilets to increase independent toileting
OT Stage 5

- Complete toileting hygiene with min A or verbal cueing
- Address dynamic sitting balance to increase ADL
- Improve use of AE in specific contexts (75-80% of the time)
- Transfers with bedrails/grab bars for increased stability, can teach independence with this
- Development of RNP, FMP, caregiver training
PT Stage 5

- Ambulation of 300 ft with assistive device (depending on environment)
- Ambulation while carrying objects to decrease falls during wandering
- Work towards increasing functional balance with TUG of 16-19
- Address standing tolerance and static balance
PT Stage 5

- Set-up assist, or possibly teach routine for safe transfers
- Work towards increasing consistent use of assistive devices in specific contexts (75-80%)
- Development of RNP, FMP, caregiver training for LE ROM, LE strength, ambulation
GDS Stage 6

What is reasonable for intervention and outcome?
SLP Stage 6

Â Attention to task social and functional task for 5-10 minutes
Â Modify memory aids, room, etc to include written form of own name pics of recalled items, previous address.
Â Yes/No question approach for choice making and question answering. Also, relate questions to “the now”.
Â Patient using simple words/phrases/gestures to communicate
Â Train staff to pair a gesture with a direction, or object to indicate use.
SLP Stage 6

- Teach staff specific and individualized ways to initiate communication with the patient who has significant communication impairments (gestures, eye contact, touch).
- Provide communication partner and schedule in conjunction with activities.
- Identify patterns in paraphasias and train caregivers to anticipate specific to the patient.
- Sequencing of functional activities repetitive and routine
- Cognitive feeding, initiation, pulling food from utensils, lip closure, sensory
OT Stage 6

- Develop and train strategies for fair balance using grab bar during toileting
- Posture in wheelchair 2-4 hours depending upon patient need
- Increase productive use of time/meaningful activity
- Provide sensory stimulation to regulate system which can interfere with ADLS & agitation.
- RNP, FMP, and caregiver training programs completed
OT Stage 6

- Address patient active participation without outbursts during bathing routine
- UB/LB dressing with max A
- Standing with fair + dynamic standing balance at sink for oral care & grooming
- Feeding self with mod A, utensil loading or handheld food items
- Increase AROM needed for functional tasks
PT Stage 6

- Address sit to stand with stand-by assist or min assist with grab bars, from wheelchair to walker
- Increase strength for transfers, LE exercise, will need direct instruction, program with concrete goals; functional is most successful, quad strength with sit to stand
- Ambulate 30-100 ft depending upon patient, will need assist and device or handheld assist
PT Stage 6

- Decrease edema with supine rest breaks adequate position and train staff
- Work on bed mobility with assist and bed rails
- Tolerance to wheelchair sitting with reduced pain
- RNP, FMP, and caregiver training programs completed
GDS Stage 7

What is reasonable for intervention and outcome?
SLP Stage 7

- Increasing attention to task with environmental modification for improve feeding success
- Bolus control, swallow initiation, reduce clinical indicators of aspiration with compensatory techniques and modifications
- Making simple choices with a visual presentation of items
- Improving compliance with antibacterial oral care program
- Work on increasing amount of PO intake with strategies implemented
- Accept presentation of food and drink
OT Stage 7

- Increase positioning with upright posture for PO intake, bed and chair
- Decrease signs of discomfort with chair positioning 2-3 hours per day
- Decrease loss of PROM or skin integrity compromise with splinting program
- Improving compliance with bathing, dressing, nail care
- Bed mobility, roll side to side with max A
- Address decreasing negative behaviors that indicate agitation my providing sensory stimulus program
PT Stage 7

Look at decreasing contracture risk, improved ankle dorsiflexion ROM, Hip abduction ROM, reduced knee flexor tone
Decrease pain with lumbar rotation ROM, teaching effective methods for Hoyer lift use
Address improve lower extremity positioning
Wound care
LE splinting
Sensory Challenges

Å Hypersensitive
Å Hyopsensitive
Incorporating Sensory Needs into Care Plan & Treatment

Therapeutic Techniques to Maximize Alertness & Arousal
What senses do we target?

- Tactile
- Proprioceptive
- Vestibular
- Visual
- Auditory
- Olfactory
- Gustatory
Tactile

Â Touching
Â Pressure, vibration, movement, temperature, pain, itching
Â Looking at varying textures for the patient to touch in functional activities.
Â Use of massage, lotions, baths.
Â Building things, sanding, discrimination of objects, parts during building.
Â Cooking activities, touching ingredients, rolling dough, washing dishes.
Proprioceptive

- Body position
- Increased proprioceptive input will be calming/organizing.
- Work, push, pull (wheelchairs, wiping surfaces, exercise groups)
- Quilts, heavy blankets
- Lifting, loading
- Walking
- Cooking activities, rolling, weight of pots and pans.
- Orally, increased proprioceptive input with sucking through straw, thick substances, hard candy, gum
Vestibular

- Balance and Movement
- Repetitive movements to stimulate vestibular system will calm
- Rocking chairs, glider, porch swings
- Games that challenge movement, baseball, bowling
- Dancing
Auditory & Visual

- Watch things that are naturally calming or stimulating. Fish tanks, wildlife, picture books, words searches, simple visual discrim tasks, will calm. Television (especially current programming), bright cluttered visual stimuli, lights and flashing will alert or arouse.

- Listen to music that is calming, steady paced, in contrast to quick loud music which will alert. Natural sounds such as traffic horns, sirens, alarms will be alerting.
Olfactory & Gustatory

Â Calming: Foods with thick, smooth textures, chewy, warm, hard candy, gum, taffy, pudding, yogurt. Scents such as vanilla, apples, bananas, butter, lavender, pine, aftershave, soap.

Â Alerting: Food that are cold & crunchy. Ice, pickles, chips, dry cereal, popcorn, rice cakes, nuts, cucumbers, raw carrots. Scents such as basil, coffee, chocolate, garlic, onion, oregano, vinegar, citrus.
Out of the Box Treatment

Å Lab
Stephanie Cook and Loretta Dranoff

This interview is provided courtesy of StoryCorps, a national nonprofit organization which records and collects stories of everyday people.

http://www.storycorps.org/
Lou

- Legally blind, severe hearing loss, dementia Alz type, divorced, 1 child, in the navy, worked in shoe factory
- Currently lives in nursing home, 3 years here
- Has a slight history of hiding or throwing things away
- Moderate cognitive decline, GDS Stage 4
- Currently hoarding spoons.
- Encouraging other residents to do the same
- Hiding under bed, in drawers
- Confabulates stories of the spoons
- Independent ambulator, fall risk

‘Patient responded favorably to XXXXXXXX’
Ron

- Mixed dementia, recent admission to the nursing home, moderately severe cognitive decline, GDS Stage 5
- Was a high school teacher and basketball coach, married with children, family involved.
- After 1 week he began dressing and undressing repeatedly
- Inside-out, backwards clothing, multiple layers
- Getting other residents’ clothing, not gender specific
- Going into other people’s rooms
- Balance deficits, fall before coming to the Alz unit
Eileen

- Recent pelvic fracture and broken finger on dominant hand
- Poor tolerance to weight bearing
- Not using walker
- Stage 6
- Hypersensitive to stimulus
- Concrete communication and thinking
- Combative with bathing
- Complaining of pain
- Poor PO intake
George

- Contractures
- Yells frequently, up to 3 hours a day, repetitive words, perseverates
- Poor swallowing safety
- Low vision
Coding

- Dementia as a medical diagnosis changes recipe.

- Not just with coding but more importantly with documentation to support the codes.
Goal Setting

Long Term
Å Where will you end up?
Å What stage dictates the outcome.
Å Ensure each short term goal correlates with a long term outcome
Å Make them reasonable

Short Term
Å Achievable by the time you write the next progress note
Å Undershoot progress
Å It’s better to upgrade than to extend the goal
All goals will have the following

- Who will do it
- What will they do
- Under what circumstances will it be done
- How is it measured
- How does it functionally impact life
Daily Notes and 10 Visit Progress

- 3rd Party Payor needs to know what treatment is, not just the progress of the patient

- What is your SKILLED role

- Discuss negative outcomes avoided as a result of therapy as well as the positive outcomes achieved
Progress

What is it??
How to document it??
According to CMS

"Dementia is the general loss of cognitive abilities, including an impairment of memory, and may include one or more of the following: aphasia, apraxia, agnosia, or disturbed planning, organizing, and abstract thinking abilities...Throughout the course of their disease, patients with dementia may benefit from pharmacologic, physical, occupational, speech-language, and other therapies."
Diagnose, Do, Document

Â Proper diagnosis must be in place to support the treatment

Â The way we provide the treatment “doing”. Must be modified to suit the individual.

Â Documentation must reflect our modifications based on diagnosis.
Therapeutic Responsibilities at End of Life
Difficult Decisions & Ethical Concerns

- Education vs Coercion
- Swallow Function
- Physical Function
- Quality of Life
“Treatment”

- Consultative Service
- Few Sessions
- Comfort/Pain
- Safety
Questions & Comments
Anna Wise

www.storycorps.org
Let’s Problem Solve Your Toughest Cases