Medical Complications of Moderate to Severe Dementia

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Home Health Curriculum

Provision of effective care and supportive services to persons living with moderate to severe impairment from ADRD and their caregivers.

G O A L	Home Health clinicians to train caregivers on how to identify, prevent, and manage the medical issues associated with dementia, before they become more serious and result in the use of unplanned medical services.	

Important Goal Reminders:

1. Improve the care and wellbeing of PWD and help them remain in their home
2. Reduce hospitalizations and ED visits
3. Increase caregiver knowledge, self-confidence with caregiving, decrease stress

Outline

- Home Health interdisciplinary scope of practice

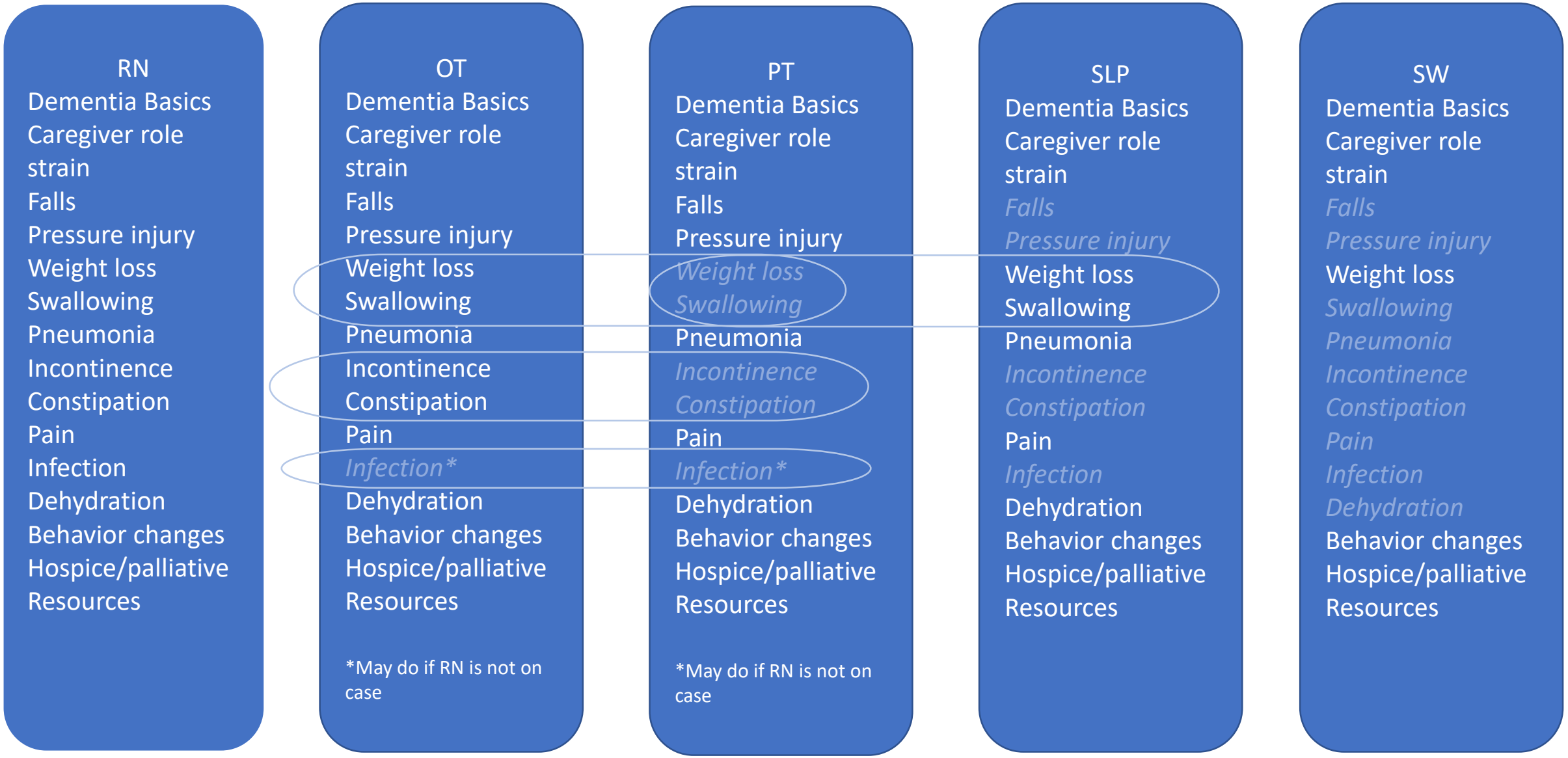
- Program:
  - Dementia basics
  - Caregiver basics
  - BPSD
  - Communication Changes
  - Falls
  - Infections
  - Pneumonia
  - Dysphagia
  - Weight Loss
  - Dehydration
  - Incontinence
  - Constipation
  - Pressure Injury
  - Pain
  - Palliative and Hospice Care
  - Resources

- Questions

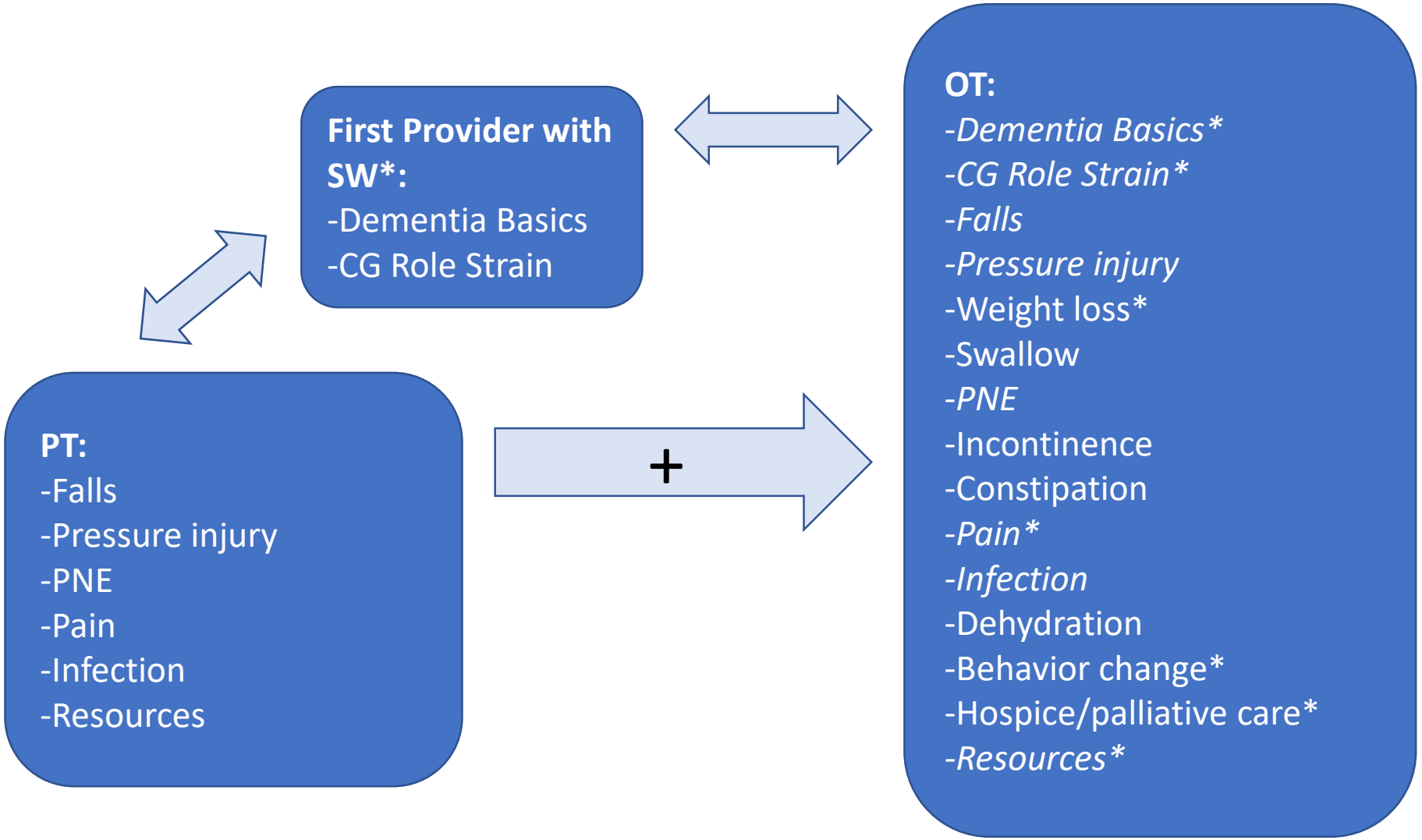
Referral flow guidelines

- First provider always teams with SW to do *Dementia Basics* and *Role Strain* at first program visit (after evaluation/enrollment visit)
- Refer to other services any time you feel the caregiver has a need outside your POC or scope. Communicate with this provider on modules you'd like them to cover.

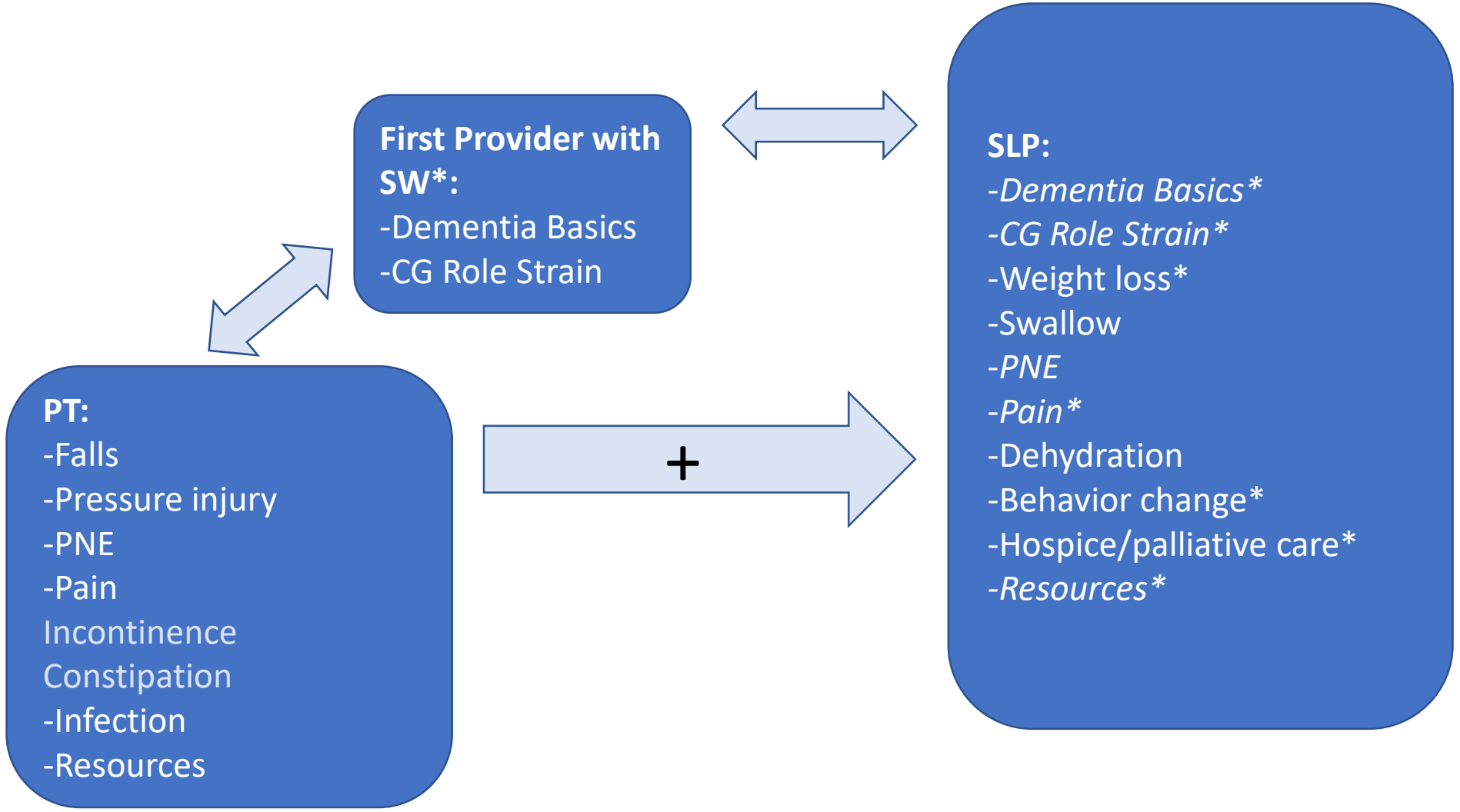
WAI Home Health Caregiver Curriculum – Comparison of scope of practice



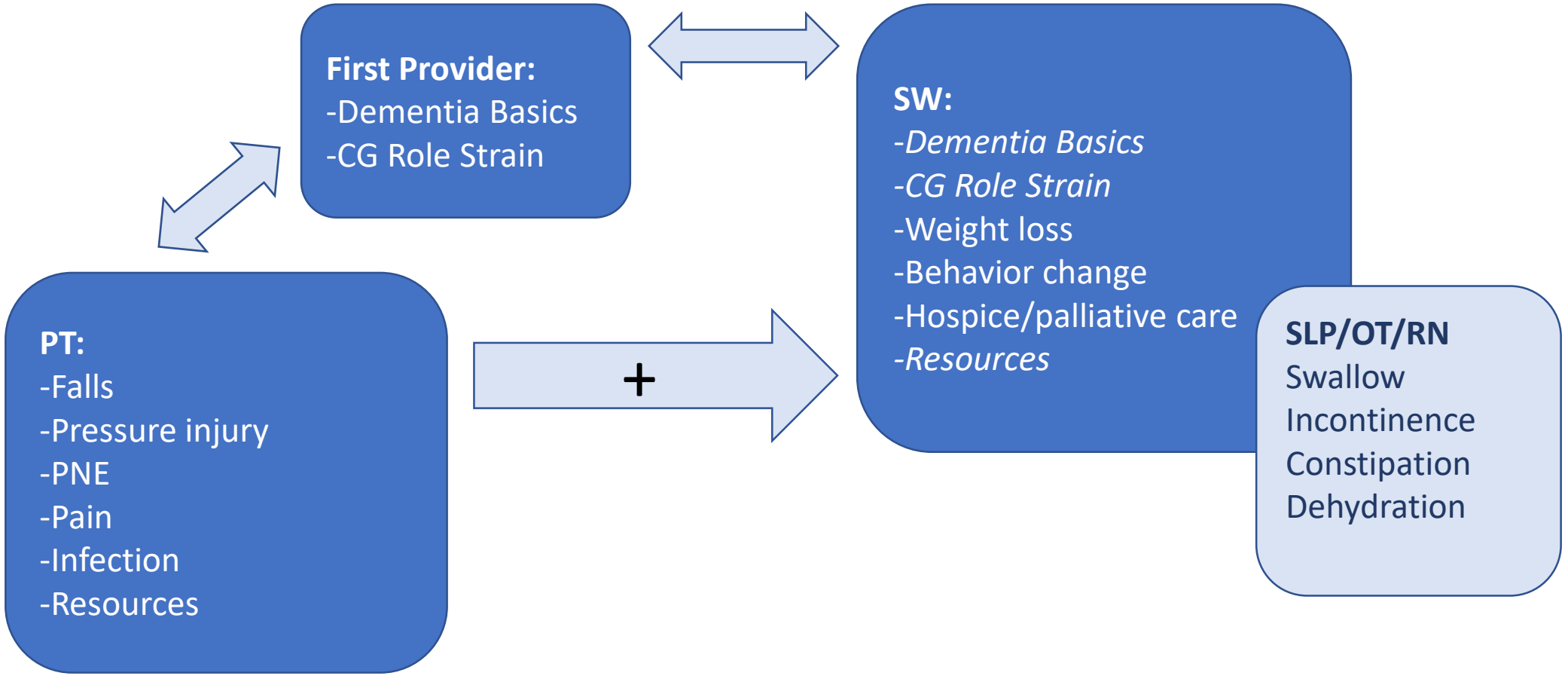
Clinical referral flows: PT+OT+SW referrals



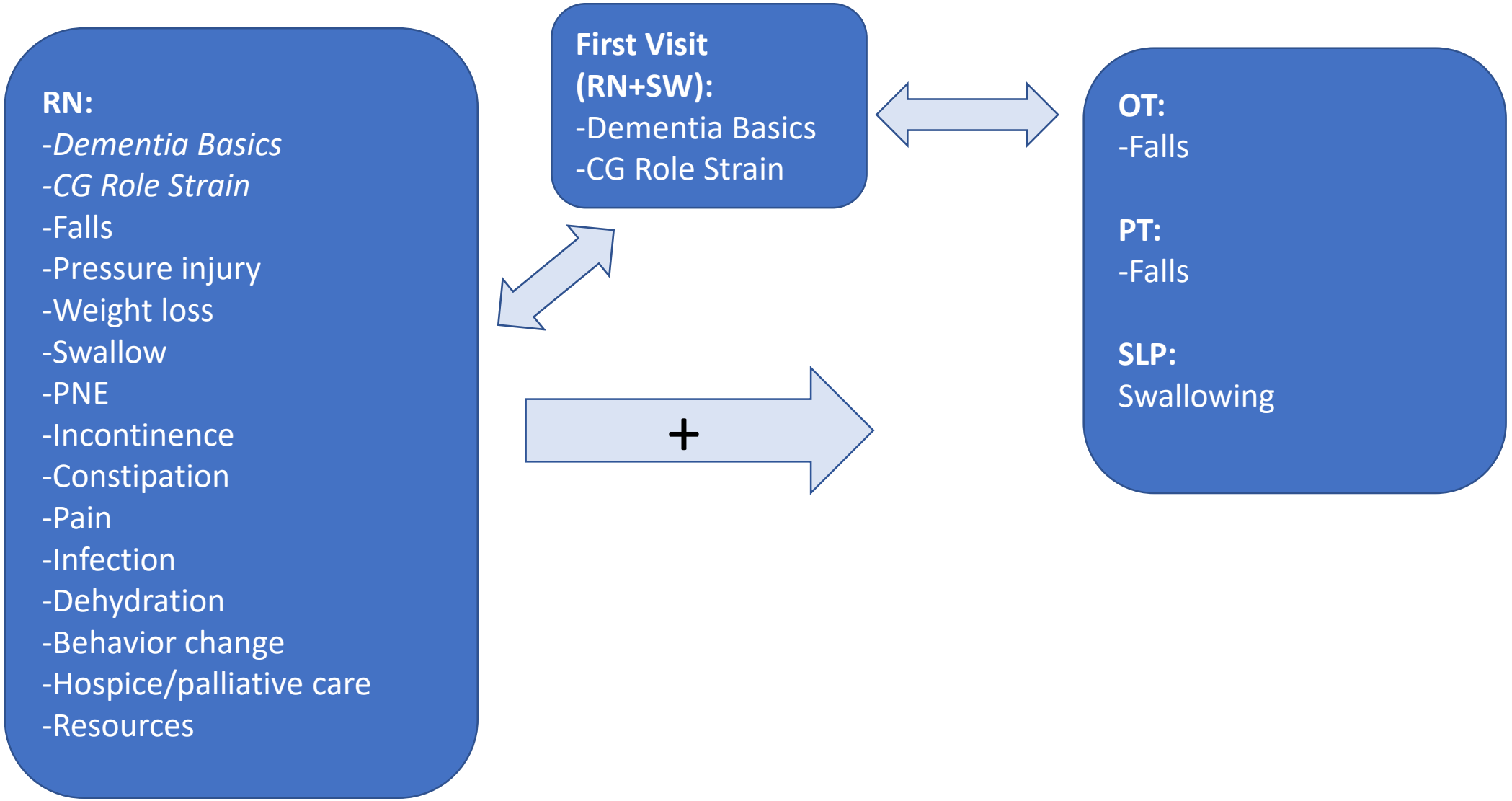
Clinical referral flows: PT+SLP+SW referrals



Clinical referral flows: PT+SW referrals



Clinical referral flows: Nursing-led+SW referrals



Dementia

DSM-5 Terminology: Major Neurocognitive Disorder

Dementia is a syndrome (cluster of symptoms)

- Deficits in 2 or more cognitive areas
- Significant decline from previous abilities
- Interferes with independence in everyday activities
  - Cooking, laundry, grocery shopping, finances, medications, driving
- Not better explained by another condition

(APA, 2013)

These criteria are required for a "suspected" diagnosis. Confirmed diagnosis requires assessment of the neuropathology described by Dr. Alzheimer.

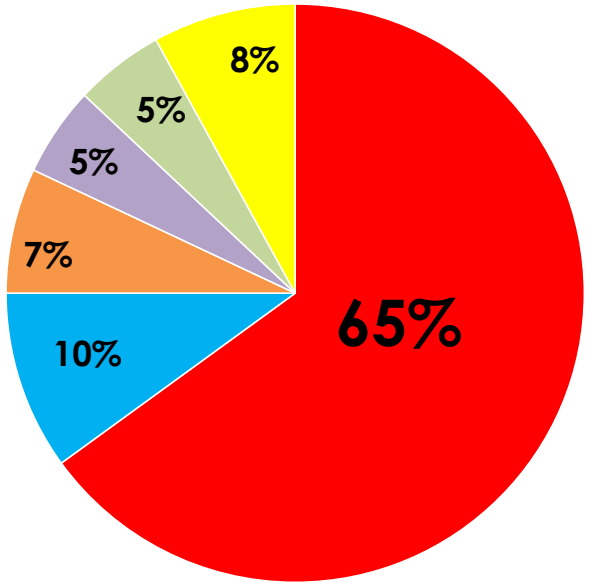
- Presence of amyloid Beta plaques in the interstitial space and Tau protein/ fibrillary tangles in the neuronal bodies and axons (autopsy)

Neurocognitive Domains

- **Complex attention**: sustained, divided, selective attention, processing speed
- **Executive function**: planning, decision making, working memory, responding to feedback/error correction, overriding habits/inhibition, mental flexibility
- **Learning and memory**: immediate memory, recent memory (including free recall, cued recall, and recognition memory), very long-term memory (semantic, autobiographical), implicit (procedural) memory
- **Language**: expressive (naming, word finding, fluency, grammar, syntax) and receptive
- **Perceptual-motor**: visual perception, visuoconstructional, perceptional-motor, praxis and gnosis
- **Social Cognition**: recognition of emotions, theory of mind (ability to consider another person's mental state)

American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (**DSM-5**). American Psychiatric Association, Arlington, VA 2013

Causes of Dementia



- Alzheimer's Disease (AD): 65%
- AD & Vascular: 10%
- Lewy body: 7%
- AD and Lewy body: 5%
- Vascular: 5%
- Other: 8%

- ✓ Mixed pathology cases are likely more common than this
- ✓ One study suggests 30% of brain bank dementia cases have pure Alzheimer's disease, and 58% are AD+ another pathology (Schneider et al., 2007)

Data from www.alz.org

Dementia Stages

Quick Dementia Rating Scale (QDRS)

- Mild (Early Stage) QDRS score 6-12
- Moderate (Middle Stage) QDRS score 13-20
- Severe (Late Stage) 20-30

Moderate Stage

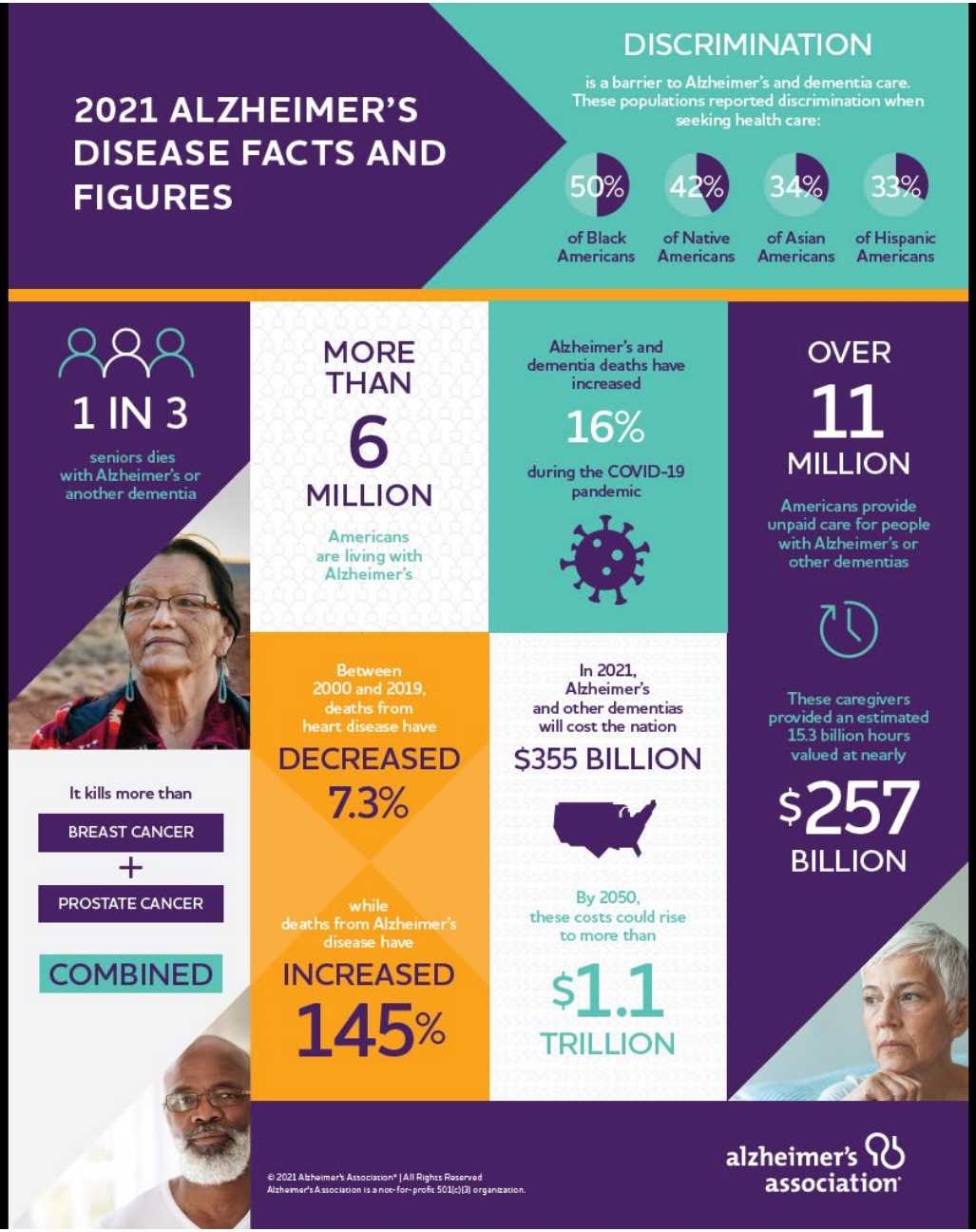
- No clear cut-off to indicate the transition to moderate stage
- Increasing problems with cognition, executive function, and functional ability
- BPSD are common – particularly mood disorders, sleep disorders, psychotic symptoms, and agitation
- Significant decline in memory
- Overt personality changes
- Increasing problems or total dependence in IADLs
- Begin to need assistance with ADLs

Severe Stage

- Inability to recognize family members
- Delusions, anxiety, agitation
- Remembering few if any details of childhood or early life
- Inability to walk
- Inability to speak
- Incontinence of bowel and bladder

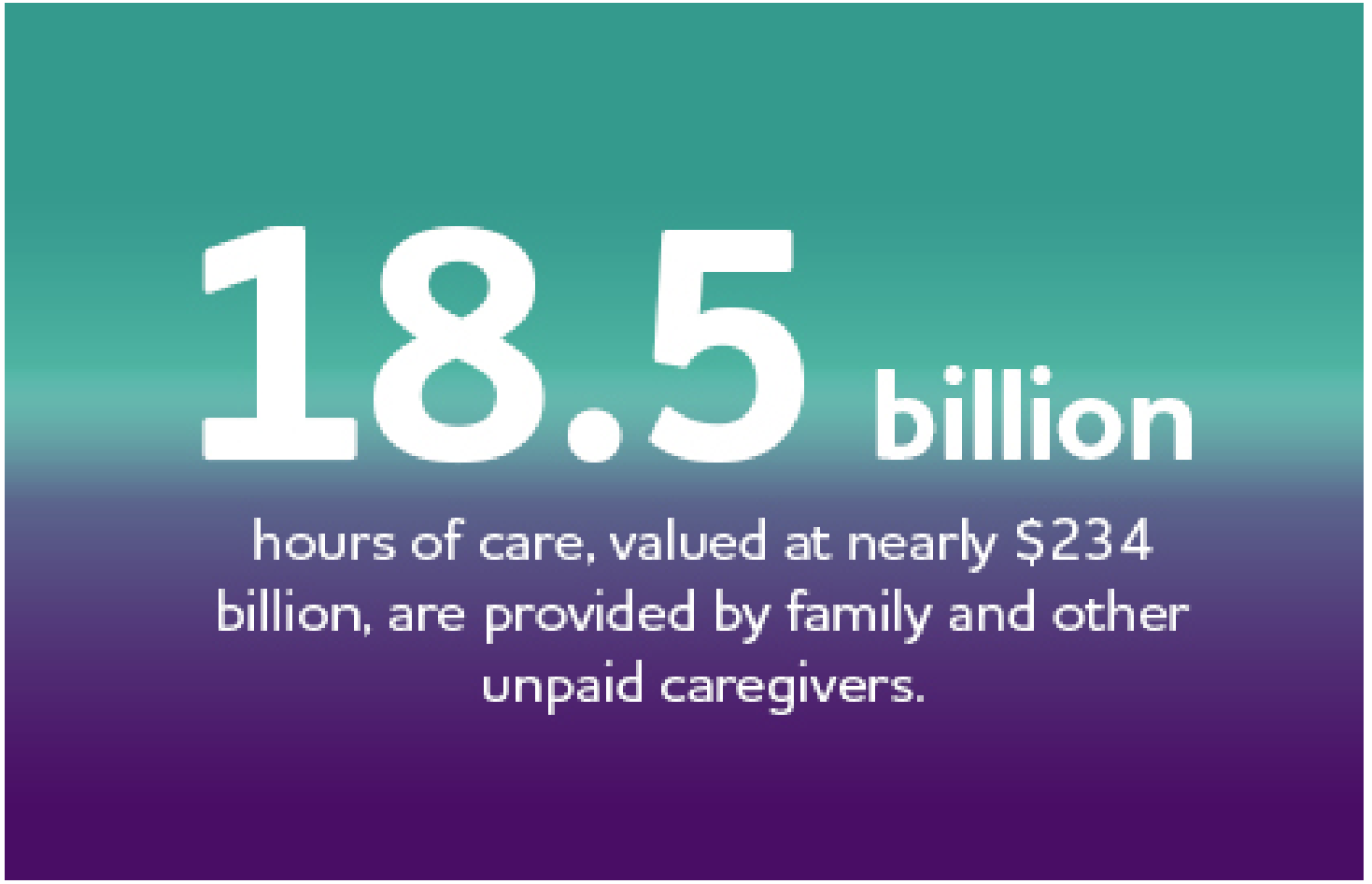
Complications of Dementia

- Behavioral and psychological symptoms (BPSD)
- Falls
- Pressure injury
- Weight loss
- Swallowing problems
- Communication deficits
- Pneumonia
- Incontinence
- Constipation
- Pain
- Infection
- Dehydration



https://alz.org/media/Documents/alzheimers-facts-and-figures-infographic-2019.pdf

Caregiving for someone with AD



Alzheimer's Association. Retrieved from https://alz.org/alzheimers-dementia/facts-figures

Caregiving for someone with AD

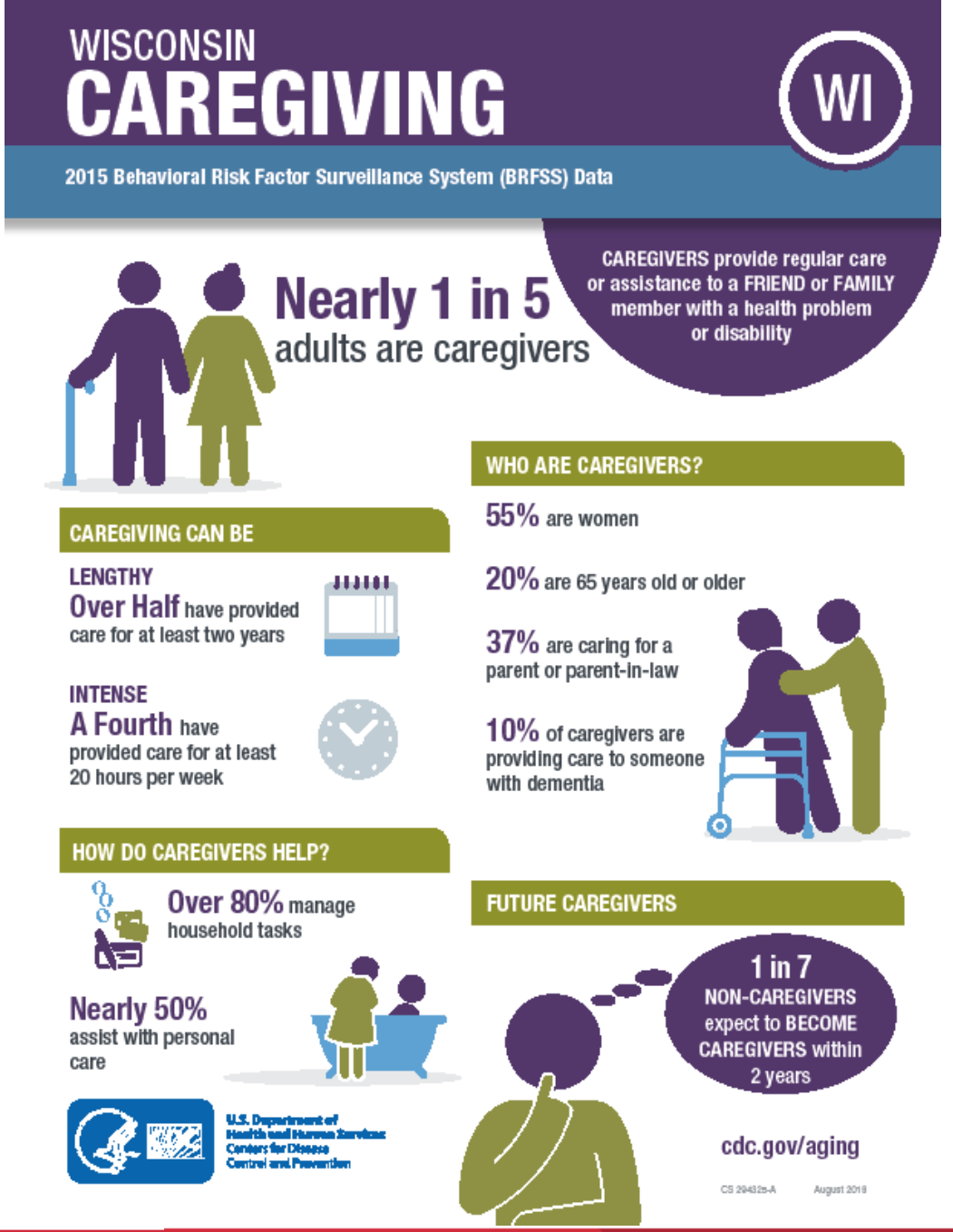
- **Eighty-three percent of the help provided to older adults in the United States comes from family members, friends or other unpaid caregivers. Nearly half of all caregivers who provide help to older adults do so for someone living with Alzheimer's or another dementia.**

Who are the caregivers?

- One third are age 65 or older.
- Two thirds are women, and over one-third are daughters.
- Two thirds live with the person with dementia in the community.
- One quarter are "sandwich generation" caregivers.
- Higher risk for emotional, financial and physical difficulties.

Alzheimer's Association. Retrieved from https://alz.org/alzheimers-dementia/facts-figures

Caregiving in Wisconsin



https://www.cdc.gov/aging/data/pdf/2015-brfss-wisconsin-caregiving-h.pdf

Caregiver Role Strain

Risks for Dementia Caregivers	
Physical	Lack of time to rest, exercise, recover from illness Less likely to engage in preventative health care More chronic illness Increased mortality
Social	Lack of time to socialize Higher rates of conflict with family members and spouses
Psychological	Higher risk for stress, anxiety, fatigue, depression, insomnia
Financial	Often work and have to adjust, cut back, retire early, or quit Increased costs due to their own poor health

Resources for Caregivers

- Teach this module first, involving the Social Worker
- Assess for home and community support
- Think through possible scenarios and help the caregiver to identify their resource network
- Introduce evidence-informed community programs

Behavioral and Psychological Symptoms of Dementia (BPSD)

Adverse impact on caregivers strongly linked to:

- Institutional placement
- Increased morbidity
- Increased mortality
- Hospital admission

(Kales et al, 2015; Karon et al, 2015)

BPSD – Contributing factors

- Comorbid medical conditions (constipation, dehydration, sleep disturbance)
- Medication side effects (benzodiazepines, opiates, anticholinergic medications)
- Infections (UTI, pneumonia)
- Pain
- Unmet needs (boredom, loneliness, inactivity)
- Environmental changes or transitions (noise, temperature)
- Routine changes
- Caregiver factors (stress, depression, communication techniques, cultural factors)
- Psychiatric conditions (major depression, anxiety, bipolar, schizophrenia)

(Kales et al, 2015, HRSA, 2017)

BPSD Assessment

- ABC method (Antecedent, Behavior, Consequence)
- Unmet needs method (Howell, 2013; Scho¨lzel-Dorenbos, Meeuwsen, & Olde Rikkert, 2010)
- Learning and behavior (Bourgeois & Hickey, 2009)
- Environmental vulnerability/reduced stress threshold (Cohen-Mansfield, 2001)

BPSD Management

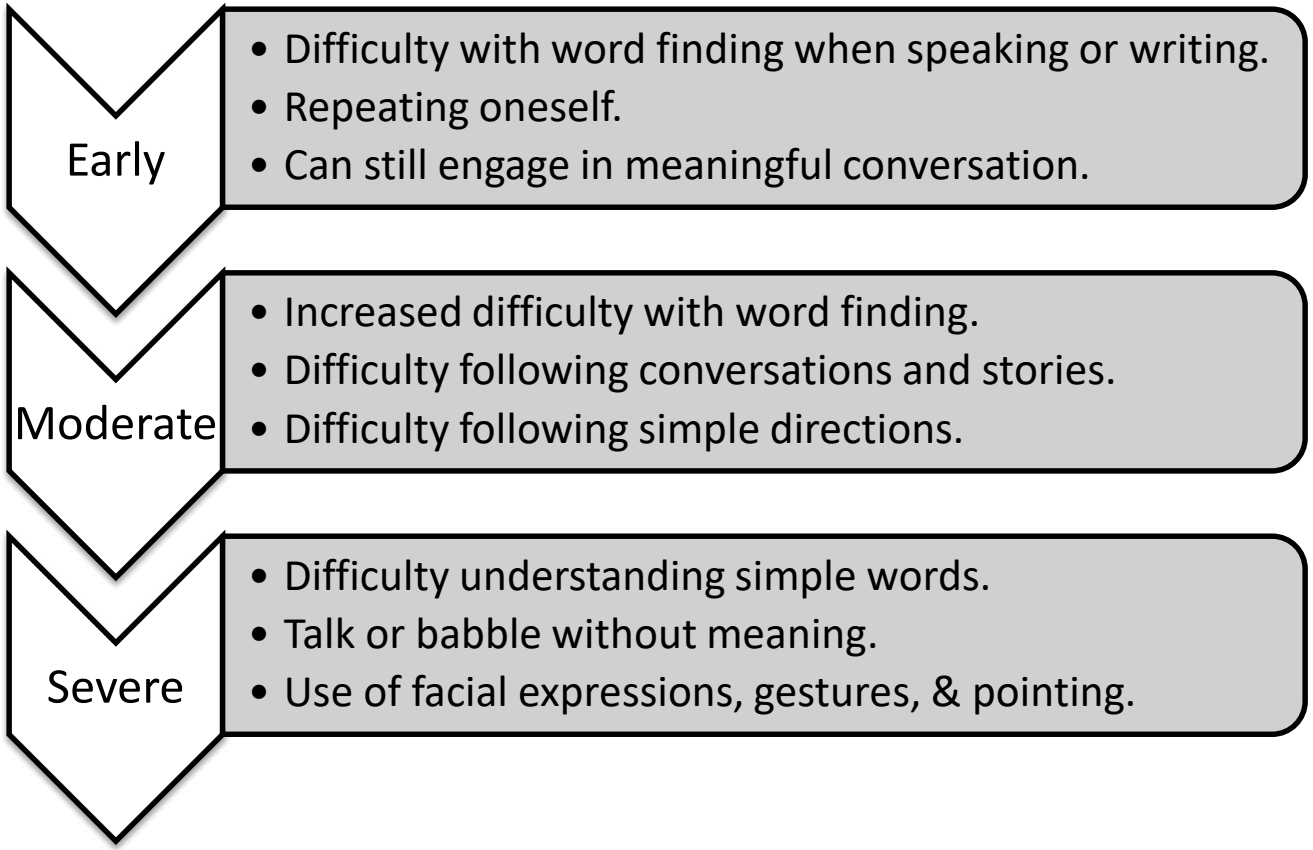
1st line – Non-pharmacological methods:

- DICE Method (Describe, Investigate, Create, Evaluate)(Kales et al, 2015)
- Communication adjustments
- Person-centered environment-based interventions (Jensen & Padilla, 2017)

Indications for pharmacologic management:

- If BPSD are significant enough to put the person with dementia or others at risk for harm.
- When BPSD are so significant that the person with dementia can't participate or benefit from non-pharmacologic interventions
- When BPSD fail to respond to non-pharmacologic interventions (Howell, 2013)

Communication Changes



Communication Strategies

- Environmental adjustments
- Effective listening
- Use simple language
- Simplify choices
- Provide step by step instructions
- Model tasks
- Consider reorientation, compassionate fibbing, and acknowledgement

Falls

- People living with dementia have twice the risk as other older adults
- Higher morbidity and mortality when they do fall
- More likely to be moved into a NH as a consequence (5X)
- Risk factors are disease-related or environmental
- Vary greatly depending on the individual and environment

Fall Prevention

Most fall prevention studies designed for older adults with normal cognition, but some interventions likely to help include:

- Home safety assessment and modifications (OT)
- Vitamin D supplement if deficient
- Pacemakers if needed
- Cataract surgery or discontinue bifocals if needed
- Progressive strength and balance training
- Medication management

High risk medications related to falls

- Benzodiazepines
- Tricyclic antidepressants
- Neuroleptics and antipsychotics
- Anticholinergic medications
- Taking 4 or more prescription medications

When there's a fall

Gather detailed history if possible

Assess:

- Orthostatic vitals
- Cardiovascular system
- Musculoskeletal system
- Neurological system
- Other systems as indicated

Infection

- Older adults have higher morbidity and mortality
- Atypical presentations lead to delay in treatment
- Dementia is an independent risk factor for the likelihood of atypical presentation (Limpawattana et al, 2015)

Infection

Ambulatory: respiratory infections, UTI, intra-abdominal infections (cholecystitis and diverticulitis)

LTC: pneumonia (aspiration), UTI, skin and soft-tissue infections, GI

Acute care: nosocomial infections, IV catheter-associated bacteremia and sepsis

(Norman, 2016)

Infection - Non-classical presentation

- Meningitis – lack of stiff neck or presence of severe cervical spine osteoarthritis
- Pneumonia without cough, dyspnea, or fever
- Intra-abdominal infection with a normal abdominal PE
- UTI of upper and lower tract with no symptoms
- Presentation of infection mismatch with severity of illness
- “The older the colder”

Infection - Fever

- A temperature > 2º F above baseline
- Oral temperature > 99º F or rectal temperature > 99.5º F on repeated measures
- Single oral temperature > 100ºF

(High et al, 2008)

Infection- Signs

Suspect infection for:

- acute change in mental status
- decline in function
- anorexia
- falls
- urinary or fecal incontinence
- tachypnea (Norman, 2016)

Infection - Management

- First consideration is wishes of the patient & family
- Evidence to suggest there's little benefit to antibiotics for UTI and pneumonia in people with severe dementia (Dufour et al, 2015; van der Steen et al, 2012)
- Higher risk for nosocomial infections, delirium among older adults with dementia in the hospital setting

Pneumonia

Risk factors for people living with dementia:

- Use of antipsychotics, benzodiazepines or anticholinergic medications – especially in the first 30 days of use (Taiplae, 2017; Lampela, 2017)
- Use of a Proton Pump Inhibitor (PPI)
- Smoking
- Male gender
- Cerebrovascular disease
- Chronic pulmonary disease
- Congestive heart failure (CHF).
- Diabetes (Ho, 2017).
- Sedentary

Pneumonia - Prevention

- Immunizations
- Upright positioning during mealtimes
- Improve, sustain mobility
- Smoking cessation
- Reduce exposure to second-hand smoke
- Avoid hospitalization

Pneumonia - Assessment

- Most commonly missed diagnosis
- In one study, only 31% of OAs presented with the classic symptoms of pneumonia - cough, dyspnea and fever
- Total WBC may be normal or marginally elevated despite a left shift
- Altered mental status, confusion, falls, sudden decline in functional status may be the only indications of pneumonia
- Tachypnea with or without SOB may be the most reliable sign of an acute respiratory condition in an older adult (Rehman & Qazi, 2013)

Pneumonia - Management

<u>Indications for hospital admission:</u>

- individuals with poor oral intake
- rapid functional decline
- respiratory rate > 30
- systolic blood pressure < 90 mm/Hg or diastolic BP < 60 mm/Hg decline in renal function
- hypothermia
- bilateral or multi-lobe infiltrates

Dysphagia

- Between 84 to 93% of people living with dementia experience dysphagia
- Nearly universal in moderate to severe dementia
- Consequences include social and functional decline, weight loss, malnutrition, aspiration pneumonia, and death (Jian et al, 2016)

Dysphagia

Moderate Stage – coughing with food/fluids, forgetting how to chew, difficulty attending to eating

Severe Stage – high risk for dehydration, malnutrition, aspiration resulting in pneumonia, inability to manage secretions

Dysphagia – signs and symptoms

- Inability to swallow
- Pain with swallowing
- Sensation of food getting stuck in the throat
- Coughing with liquids or solids
- Drooling
- Vomiting during meals
- Gagging
- Gurgling sounds after swallowing
- Complaining of heartburn
- Weight loss

Stage of Swallowing	Potential deficits in a person living with dementia
Pre-oral	• Forgetting when last ate • Difficulty recognizing food and utensils • Difficulty performing actions like lifting spoon to mouth • Socially inappropriate mealtime behavior such as eating too quickly or slowly • Poor posture or inability to sit due to physical impairment (Parker & Power, 2013)
Oral	• Inability to move food from the front of the mouth to the back • Forgetting how to chew • Spitting lumps of food out of the mouth • Unable to open the mouth or inconsistently opens the mouth (Parker & Power, 2013)
Pharyngeal	• Coughing • Choking • Absent swallow reflex • Aspiration
Esophageal	• Possibly impaired due to autonomic dysfunction (Affoo et al, 2013)

Dysphagia – Education for Caregivers

- Allow plenty of time for the meal
- Meals should happen in places with few distractions
- Make the environment pleasant
- Encourage the person to sit up in a chair with feet supported. If a person is drinking or swallowing in bed, or reclining at an angle, the neck is not tucked and this opens the airways increasing the risk of aspiration.
- Simple place settings and table ware. It may be appropriate to use a spoon and bowl alone
- Serve foods that are appealing to the person that are easy to chew and swallow
- If possible, allow the person to feed him or herself. It can be helpful to model the motion of bringing food to the mouth
- You may need to remind the person to chew and swallow
- Alternate solids with liquids
- Be alert to signs of choking (coughing with eating or drinking may be a sign) especially with liquids
- Soft or pureed foods may be easier to swallow for those who have problems chewing or forget to chew

Weight loss

- People living with dementia are at high risk for unintentional weight loss
- Risk of malnutrition among people living in the community is 15 – 42%
- Unintentional weight loss is correlated with increased caregiver burden

Weight Loss - Risk Factors

Medical	Social	Psychological
Poor appetite Dysphagia Poor dentition Loss of taste and smell Chronic dyspnea Gastrointestinal disorders such as malabsorption or reflux Endocrine disorders such as diabetes or thyroid problems Physical disability Drug side effects or interactions Dementia	Lack of knowledge about food, cooking Isolation/loneliness Poverty Inability to shop or prepare food	Confusion Depression Bereavement Anxiety or agitation

Weight Loss - Management Strategies

- Talk to family about missing dentures or dentures in need of repair
- Speech therapy for dysphagia
- Discuss nutrition supplements with provider
- Discuss laboratory testing with the provider, such as a CBC, Vitamin B12, folate levels
- OT for devices and strategies to help with self-feeding skills
- Consider medications

On PEG tubes

Percutaneous endoscopic gastrostomy (PEG) tubes:

- Weight loss is expected in advanced dementia
- American Geriatric Society (AGS) recommends against the use of PEG tubes in people living with advanced dementia (2014)
- Do not increase survival or quality of life
- Do not reduce incidence of aspiration pneumonia
- Associated with complications

Dehydration

- Cost of preventable hospitalizations for older adults with a primary diagnosis of dehydration in the US $1.1 to 1.4 Billion (Xiao, 2004)
- Mortality from dehydration in older adults may exceed 50% (Bourdel-Marchasson et al, 2004)

Dehydration – Contributing Factors

Older adults	Additional risk factors for people with dementia
• Impaired homeostatic mechanism (reduced sensation of thirst) • Fear of incontinence • Medications • Lack of air conditioning • Dysphagia • Change in sleep-wake cycle and daily routine • Frailty (Campbell, 2016)	• Mobility problems • Loss of executive function • Inability to communicate needs

Dehydration - Consequences

- Delirium
- Falls
- Thromboembolic complications
- Kidney stones
- Renal failure
- Pressure injuries
- Infection
- Drug toxicity
- Death

Dehydration

Isotonic dehydration: loss of sodium and water, common in GI illness

Hypertonic dehydration: water loss exceeds sodium loss – common in fever or limited fluid intake

Hypotonic dehydration: sodium loss is higher than water loss – diuretic use

Dehydration - Assessment

Unreliable signs and symptoms of dehydration in older adults:

- absent axillary moisture
- orthostasis
- hypotension
- low urine output
- reduced fluid intake
- urine color
- urine specific gravity
- heart rate
- dry mouth
- thirst (Shah et al, 2014)

Dehydration - Assessment

Baseline: Oral intake, mental status, mobility, function

A change in baseline, together with caregiver history and physical signs of dehydration are key to identifying those at risk or experiencing dehydration

Dehydration - Assessment

Consider medications:

- Diuretics
- Antidepressants
- Antipsychotics
- Anticonvulsants
- Anticholinergic medications
- ACEs and ARBs
- Benzodiazepines

Dehydration - Management

Routes:

- Oral
- Subcutaneous rehydration therapy
- Intravenous

Tips for oral rehydration:

- Serve beverages at appropriate temperature
- Offering flavored or favorite drinks
- Serve drinks in brightly colored containers that do not blend with the surrounding
- Any fluid is helpful, including broth
- Provide cues

Incontinence

Incontinence - "involuntary loss of urine which is objectively demonstrable and a social or hygienic problem" (Abrams et al, 1988)

- Not a disease in itself but a symptom
- Not a normal part of aging
- Often treatable, not just containable
- Prevalence among older adults ranges from 53 to 90% (Aminoff et al, 2008; Mui et al 2010)

Incontinence

Necessary for Continence:

- Functioning lower urinary tract
- Adequate cognition
- Physical mobility
- Motivation
- Supportive environment

Consequences of Incontinence

- LTC placement
- Depression
- Anxiety
- Falls
- Fractures
- Sleep disturbance
- Pressure Injury
- UTI (Alexander et al, 2015)

Incontinence - Types

Types of Incontinence	Features
Acute Incontinence	Sudden onset, associated with medical or surgical condition – suspect a medication or infection
Chronic incontinence	Continues or worsens over time. Major causes are stress, urge, overflow and functional incontinence
Stress incontinence	Loss of urine as the result of increased intraabdominal pressure, such as with coughing, laughing or sneezing
Overflow incontinence	When a chronically full bladder increased bladder pressure, overcoming urethral resistance
Functional incontinence	Loss of urine due to inability or unwillingness to toilet due to physical, mental, psychological or environmental factors
Mixed incontinence	Combination of two or more types of incontinence

Incontinence – Prevention

- Keep a clear path to the toilet
- Keep toilet or commode in line of sight
- Keep the bathroom door open
- Utilized raised toilets, grab bars, bedside commodes
- Prompted and scheduled toileting
- Remove planters, waste-paper baskets, buckets or anything else that might resemble a toilet in the immediate vicinity
- Prevent constipation
- Eliminate caffeinated beverages

Drugs associated with incontinence

- Alcohol
- Alpha adrenergic agonists (midodrine or pseudoephedrine)
- Alpha blockers (doxazosin or tamsulosin
- ACE inhibitors
- Caffeine
- Cholinesterase inhibitors (donepezil or rivastigmine)
- Diuretics
- Anticholinergic medications
- Opioids
- Sedatives or hypnotics (Alexander et al, 2015)

Incontinence - Management

- May require a multi-disciplinary approach
- Involve the caregiver
- PT & OT address functional components (mobility, caregiver's transferring skill and capacity, lower body hygiene and dressing, bathroom environment and access, cues and modifications to the routine)
- Medications to manage incontinence may be appropriate
- Benefits of any improvement in incontinence in someone living with dementia should not be underestimated

Constipation

Chronic constipation is defined by the Rome III criteria (Shih & Kwan, 2007):

Two or more of the following symptoms present for at least 12 weeks in the previous 6 months:

- Straining at defecation at least 25% of the time
- Emptying stools that are lump/hard at least 25% of the time
- Experiencing a sensation of incomplete evacuation at least 25% of the time
- Having three or fewer bowel movements a week

Constipation

- Affects 30% of adults over 65
- Affects 50% of adults over 65 in SNFs and hospitals (Soumekh et al 2016)
- Risk factors: underlying medical conditions, medication side effects, lack of appropriate toileting facilities or assistance with toileting, reduced mobility, inadequate oral intake of food and fluids

Constipation - Consequences

- Hemorrhoids
- Anal fissures
- Fecal impaction
- Rectal prolapse
- Bowel obstruction

- Pain, discomfort, distress that can lead to BPSD

Constipation - Assessment

- Baseline pattern of bowel movements
- Able to sit on a toilet with or without supports?
- Cognitive ability to find toilet
- Suitable environment?

Medical causes:

- Irritable bowel syndrome
- Cancer
- Diverticular disease
- Hypothyroidism
- Pelvic floor dyssynergia
- Structural lesions
- Lack of mobility
- Dehydration
- Stimulant/laxative abuse
- Bowel obstruction
- Hypercalcemia
- Physical immobility
- Lack of dietary fiber

Medications that contribute to constipation

- 5-HT3 antagonists (ondansetron)
- Calcium or aluminum-containing antacids
- Calcium channel blockers (amlodipine, verapamil)
- Drugs with anticholinergic effects (antidepressants, antipsychotics, antihistamines, antispasmodics)
- Ferrous sulfate
- Opioid analgesics
- Calcium supplements
- Phenothiazines

Constipation - Management

1. Identify and treat underlying cause
2. Increase fluid intake to 1500 mL/day and dietary fiber to 6-25g/day
3. Increase physical activity if possible
4. Consider medication after consulting with provider (bulking agent, osmotic agent, stimulant laxative, colonic secretagogue 2-3 times/week, Power Pudding)

Constipation – Medication Management

Medication Class	Onset of Action	Examples
Bulk laxatives	12 – 72 hours	Methylcellulose (Citrucel), Psyllium (Metamucil), Polycarbophil (Fibercon)
Osmotic laxatives	24-96 hours	Polyethelene glycol (Miralax), Lactulose, Sorbitol 70%
Stimulant laxatives	15 minutes to 10 hours	Bisacodyl tablet (Dulcolax), Senna (Senokot)
Colonic secretagogues	48-96 hours	Lubiprostone (Amitiza), Linaclotide (Linzess)

Pressure Injury

In Dementia – prevalence of 39 to 47% (Jual & Meiron, 2017)

- Motor neuron pathology which impairs mobility
- Sensory deficits
- Diminished pain response
- Blood pressure dysregulation causing hypotension and poor peripheral perfusion
- Higher risk of fecal and urinary continence

Prevention and Management for the Interdisciplinary team

- OT and PT for mobility, transfers, and hygiene self-care
- Dietary consults for malnutrition
- Speech therapy for dysphagia
- Incontinence management
- Specialty beds, seat cushions, or mattresses
- Pain management
- Wound care specialists
- Caregiver education

Pain

- Chronic pain experienced by 20 to 50% of adults > 65 years
- Estimated to be double that among people living with dementia
- Can be an underlying cause of BSPD
- Under-detected and under-treated in people living with dementia (Malara et al, 2016)

Pain - Consequences

- BPSD
- Depression
- Anxiety
- Increased hospitalizations
- Premature death
- Loss of functional ability
- Decreased socialization
- Impaired sleep (Jones & Mitchell, 2015)(Louis & Meiner, 2006)

Pain - Assessment

- Assessment of Pain in Advanced Dementia Scale (PAINAD)(Warden et al, 2003)
- Visual Analog Scale (VAS)
- Faces Pain Scale (FPS) (Corbett et al, 2012)

AGS Panel on Persistent Pain in Older Persons (2002)

Facial expressions	Slight frown; sad, frightened face; grimacing, wrinkled forehead; closed or tightened eyes; rapid blinking, any distorted expression
Verbalizations, vocalizations	Sighing moaning, groaning, grunting, chanting, calling out, noisy breathing, asking for help, verbally abusive
Body movements	Rigid, tense body posture, guarding, fidgeting, increased pacing, rocking, restricted movement, gait or mobility changes
Changes in activities or patterns	Refusing food, appetite change, increase in rest periods, sleep, sudden cessation of common routines, increased wandering
Mental status changes	Crying or tears; increased confusion; irritability or distress

Pain - Management

- People with dementia receive less pain medication than those without dementia
- When they receive opioids, dose is 30% of the dose prescribed to individuals without cognitive impairment
- Acetaminophen is an appropriate and safe first-line treatment (up to 3,000 mg in 24 hours)
- Pain management can reduce BPSD

(Achterberg et al, 2013; Reuben et al, 2013)

Palliative and Hospice Care

- Dementia is progressive and there is no cure
- Average life expectancy after diagnosis is 4.5 years (Xie, Rayne, & Matthews, 2008)
- Last year of life is characterized by the inability to walk, recognize family members, or perform activities of daily living in addition to urine and fecal incontinence and minimal speech
- High risk for pain, shortness of breath and medical complications
- We have only recently begun to see dementia as a terminal diagnosis
- 2015 – only 16.5% of people who died in hospice had a diagnosis of dementia

Teach-Back

- The teach-back method is a way of checking understanding by asking caregivers to state in their own words what they need to know or do to care for the person with dementia.
- There are a few teach-back prompts after each topic for the caregiver to answer to check their understanding of the material.
- If the caregiver is unable to or has difficulty responding to the prompt, clinicians can go back and provide additional teaching on that topic.

Resources:

- bhw.hrsa.gov/grants/geriatrics/alzheimers-curriculum
- www.alz.org/scwisc/
- www.alzwisc.org/, support@alzwisc.org
- www.wai.wisc.edu/
- www.dhs.wisconsin.gov/adrc/index.htm, OR www.daneadrc.org

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