



CareTalk

A Publication of Hope Hospice, Inc.

MEMORY CARE TIP

Behaviors as Communication

Aphasia, associated with Alzheimer's disease (AD), is a word for problems with language: it can affect speaking, understanding speech, reading, and writing. In the early stage, aphasia may present as difficulty in thinking of common words while speaking or writing. In time, the ability to understand what others are saying also declines.

As AD progresses, formal language usually disappears, and the patient may rely solely on non-verbal cues such as facial expressions and emotional commotions.

Most important, a patient who is not verbally communicative should be granted extra patience and compassion.

What may appear like an anger outburst—such as aggression, fighting hygiene care, or refusal to eat—is more likely the patient's attempt to communicate the only way she can.

In most cases, such undesired behaviors are the patient's way of communicating an unmet need. The caregiver should investigate common problems like a UTI and other pains. Most important, a patient who is not verbally communicative should be granted extra patience and compassion. ➔



Hallucinations and Paranoia in the Patient With Alzheimer's Disease

People with Alzheimer's disease (AD) may see, hear, smell, taste, or feel things that are not really there. The most common hallucinations are those that involve sight or hearing. Some people with AD develop strange ideas about what is actually happening and may come to believe that other people want to harm them. This kind of belief is called a delusion.

These symptoms are fairly common among people with AD, especially in the disease's middle stage, although they can present at any stage. The possible causes are many, mostly having to do with the parts of the brain affected by the disease. It is essential that you do not tell the person who is seeing or hearing things that you know what he sees is not real. To him, they *are* real, and your insistence to the contrary will cause further confusion and paranoia.

Reassure the person that you will keep him safe and try to understand the emotion behind the hallucination or delusion. This may be enough to enable the person to let go of these concerns, at least for the moment. If the hallucination is pleasant (e.g., a visit from an old friend who's not actually there), try to connect to him by joining in the fantasy ("That's wonderful, Jerry! I bet you enjoyed your visit."). You do not need to say that you see or hear the same things, but you can accept that he does.



(See "Hallucinations" on page 4)



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Increased Fall Risk With Alzheimer's Disease

A person with AD, even in the early stage, probably will have subtle changes in walking ability that will become more severe as time goes on. Commonly, patients living with AD and similar dementia-related diseases exhibit a shuffled gait. Causes are typically linked to sight deficits—trouble with depth perception is a big one—as well as declining muscular coordination related to brain deterioration.

This can create difficulty with balance. If the person has other illnesses, the problems may be more severe. It is natural that he will fear falling.

To help the person in your care feel more confident, adaptive devices such as walkers or canes can be useful, but you will have to remind him to use these devices. Bring the cane or walker to the person when he has forgotten it.

Exercises that you can do with the person in your care may improve his balance. Remember, before starting any type of exercise routine, get advice from the physician. Start slowly with only moderate effort. Give the care receiver time to build strength and stamina. ➔



The Role of the Brain's Amygdala Region

Dementia is a group of symptoms pointing to brain deterioration that interferes with the way the person processes her environment.

For example, the frontal lobe is the first part of the brain to begin to deteriorate as dementia diseases take hold, especially with AD. The frontal lobe is responsible for executive functions, including decision-making, evaluation, reasoning, judgment, and impulse control.

What's interesting is that the brain's amygdala region—the emotional center—is often intact to the end of life. The amygdala is involved with how a person

experiences feelings; some are positive (joy, love, humor), and others are negative (fear, agitation, loneliness).

Traditionally, the amygdala has been primarily associated with humans' fight-or-flight response. It is an automatic, ingrained survival response to particular stimuli, and it's something all humans experience. Under stress, we may become irritable or angry and take these feelings out on others. Or, reactions fall under the flight category, manifesting in such ways as depression, lethargy, and social retreat.

So what does this mean to caregivers? When the person with dementia experiences emotional negatives, she lacks help from the frontal lobe to properly process her

thoughts. So, the energy comes out in such behaviors as agitation, worsening confusion, repetitive speech, naughty speech, and possibly aggression. Caregivers may feel overwhelmed and exhausted when the patient exhibits such difficult behaviors.

It's important to understand that undesired behaviors are influenced by circumstances of day-to-day living. These behaviors can be avoided or reduced when the care provided addresses the person's preferences and wishes. At Hope, we call this *person-centered care*, and it simply means to consider the needs and unique desires of the patient first, over what is easier for the caregiver or facility.

At right are examples of ways to implement person-centered care.

PERSONAL CARE SUCH AS BATHING AND TOILETING. Conversations with family may provide insight into a patient's feelings of modesty. Some individuals, particularly within certain cultures, may feel embarrassed with a caregiver of an opposite gender providing personal care.

EXPLAINING FORTHCOMING CARE. While providing personal care and dressing assistance, explain with words and gestures what you're about to do before touching the patient. It can be jolting to the patient to just start undressing her.

LIKES AND DISLIKES. Perhaps a patient was never particularly fond of television entertainment and prefers reading classic literature. Having a care partner read aloud to the patient would be much more valued than joining movie night in her assisted living facility. ➔

QUICK QUIZ

Read the issue and answer True or False to the questions below.

1. *Aphasia* is a word for problems with language: it can affect speaking, understanding speech, reading, and writing.
True or False
2. Delusions and paranoia are common among people living with Alzheimer's disease.
True or False
3. The brain's frontal lobe is associated with the fight-or-flight response.
True or False
4. A shuffled gait is a common symptom associated with Alzheimer's.
True or False
5. Declining depth perception is one reason that people with dementia have a greater fall risk.
True or False
6. If a patient has reduced muscular coordination, you should immediately start a rigorous exercise schedule.
True or False
7. Person-centered care is about determining what is most convenient for the caregiver.
True or False
8. If a patient is seeing things that aren't really there, you should tell him that he is wrong.
True or False
9. If a patient's hallucination is positive, it's okay to play along.
True or False
10. If a patient experiences daily hallucinations or paranoia, it's time to start anti-psychotic medications.
True or False

Find the quiz answers at the bottom of page 4.

Hallucinations (continued from page 1)

People living with AD may also become suspicious and may accuse someone of stealing from them when they cannot find something. When he does not remember where he put an item, the idea that it has been taken by someone is, to him, a reasonable explanation for its being missing. Tell him you will help look for it, and don't mention that he is the one who misplaced it.

Paranoia in people with AD appears as unrealistic beliefs, usually of someone seeking to do them harm. They may hoard or hide things because they believe someone is trying to take their possessions. These symptoms can be very distressing both for patient and for the caregiver. Remember that what the person is experiencing is very real to him. It is best not to argue or disagree. In this

situation, it is best to offer to help the person to find the missing item. It will not be helpful to try to convince him that his explanation is wrong or based on his poor memory.

Do not tell the person who is seeing or hearing things that you know what he sees is not real. To him, they are real, and your insistence to the contrary will cause further confusion.

When these behaviors do not respond to supportive caregiving techniques, it may be necessary to consider medication, especially if the person is very upset or puts himself or others in danger because of his symptoms. These symptoms are sometimes caused by depression, which often accompanies AD.

Consult with the physician, who may recommend an antidepressant.

Other medications, called anti-psychotics, can be prescribed. However, it's important to note that this should be a last resort for two main reasons: First, these medications come with special warnings about medical side effects, primarily cardiac anomalies. Second, anti-psychotics have a sedative effect, and, in the case of patients with dementia, they are usually being prescribed to help calm a patient and make it easier for the care team to handle him. At Hope Hospice, the use of anti-psychotics would only be considered after all methods fail. Our practice is to first work with care partners (including our own clinicians and the patient's family care partners) to teach new tactics in dementia care that address the root causes of difficult behaviors. ➔



Available Topics

- Dementia care
- Pain in the elderly
- Skin care of the elderly
- Fall prevention
- Senior nutrition
- Medication administration
- Respiratory concerns
- MRSA/C-Diff
- Body mechanics
- Hospice education
- Agitation/terminal restlessness
- Advance healthcare directives

In-Service Training During COVID-19

As a safety measure during the ongoing pandemic, Hope Hospice has made our **in-service educational seminars available via Zoom teleconference**. We remain a resource to local hospitals, SNFs, board-and-care homes, and assisted living residences for complimentary education about senior-care topics. We want to help you maintain physical distancing at your facility and still offer valuable education to your staff and residents.

Please connect with us to discuss your needs and the logistics of offering these seminars remotely. ➔

For More Information

Please reach out to Hope Hospice Director of Outreach, Kari Rayford, LVN, at karir@hopehospice.com or (925) 829-8770 to discuss your team's needs.