amartin@proactivemedicalreview.com

PRACTICAL SOLUTIONS TO REHAB DEMENTIA CARE PART 3 & 4

PROMOTING EACH PERSON'S BEST ABILITY TO FUNCTION

Treatment Approaches and Interventions

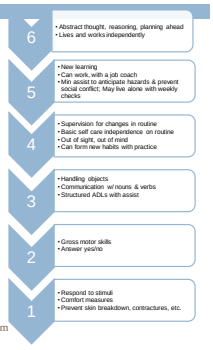
How do we start?

- Recognize cognitive impairment—even at early stages when verbal skills are strong
- Define cognitive ability using an evidence based measure (stage the dementia)
- Establish reasonable treatment plans within the capabilities of the resident
- Train everyone, so that we are all "speaking the same language" regarding cognitive ability.
- Work together to build an environment that provides comfort, just right stimulation, and safety for differing levels of cognitive ability

amartin@proactivemedicalreview.com

What do the ACL scores mean?

- 6 levels arranged in "a continuum of clinically observable, qualitative differences in ability to perform functional activities"
- There are 26 modes of performance within the 6 categories that allow for more sensitive measurement of function
- Lower score=lower functional expectation



Resource: Brief History of the Allen Battery by Cathy Earhart March 2005
www.allen-cognitive-network.org

amartin@proactivemedicalreview.com

Abilities are analyzed based on:

- What they will pay attention to
- Motor control expectations
- Communication ability

When is "learning" expected?

Benefit from instructions

- **Level 6**

Can learn through the use of language & written materials . Can plan ahead.

- **Level 5**

New models for new motor skills are formed

Benefit from demonstration

- **Level 4**

Out of the ordinary is recognized with striking sensory cues (usually visual). New models of performing tasks are imitated for situation specific tasks.

Lower level dementia training

- **Level 3**

Drilling practice under constant supervision to develop new habits using standardized, routine steps

- **Level 1 and 2**

Learning is not a treatment objective. Teach caregivers. Set up environment & daily activity structure .

As I grow older, I pay less attention to what men say. I just watch what they do." --Andrew Carnegie

OT Treatment Goals for the Physically and Cognitively Disabled, Allen et al; AOTA 1992

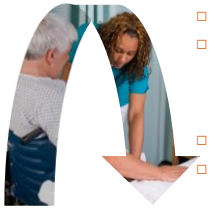
Falls Prevention

Treatment approaches and intervention planning based on ACLS findings

you can not do all the good the world needs, but the world needs all the good you can do."
--anonymous

amartin@proactivemedicalreview.com

Most Common Causes of NH Falls



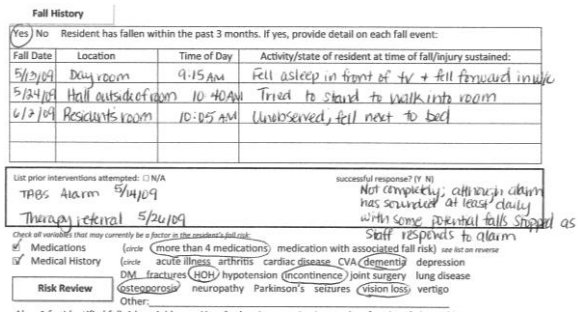
- 24% weakness & mobility issues
- 16-27% Environmental hazards
  - wet floors, poor lighting, incorrect bed height, improper wheelchair fit or maintenance
- Medications
- Other: transfer difficulty, poor foot care, poorly fitting shoes, improper use of walking aids

Resource: CDC

Dementia as a Fall Risk Factor

Dementia Risk	Contributing Factors
Residents w/ dementia fall nearly twice as often Van Doorn et. al	▫ Impaired judgment ▫ Gait deficits ▫ Visual spatial perception ▫ Decreased ability to recognize and avoid hazards

Documentation: Fall History Analysis



Fall History

(Yes) No Resident has fallen within the past 3 months. If yes, provide detail on each fall event:

Fall Date	Location	Time of Day	Activity/state of resident at time of fall/injury sustained:
5/13/09	Day room	9:15 AM	Fell asleep in front of tv + fell forward in wc
5/24/09	Hall outside of room	10:40AM	Tried to stand to walk into room
6/2/09	Resident's room	10:05 AM	Unobserved, fell next to bed

List prior interventions attempted: ☐ N/A — successful response? (Y N)

TABS Alarm 5/14/09 — Not completely; still wears alarm has sounded at least daily with some potential falls stopped as staff responds to alarm

Therapy referral 5/20/09

Check all variables that may currently be a factor in the resident's fall risk:

☑ Medications (circle) more than 4 medications — medication with associated fall risk) see list on reverse

☑ Medical History (circle) acute illness arthritis cardiac disease CVA dementia depression DM fractures HOH hypotension incontinence joint surgery lung disease osteoporosis neuropathy Parkinson's seizures vision loss vertigo

Risk Review — Other:

Using test scores

Cog Level	Pays Attention to:	Recalls	Fall management planning
4.0	Objects in **plain site** within arms reach –3 feet away	Info about 1 or 2 activities that are **high priorities** for them	Recognizes physical disability & asks for help if they need it. Provide visual cues (colored brake handles) & repetitive training of situation specific activities in routine environment(i.e. toilet transfers)

Using Test Scores

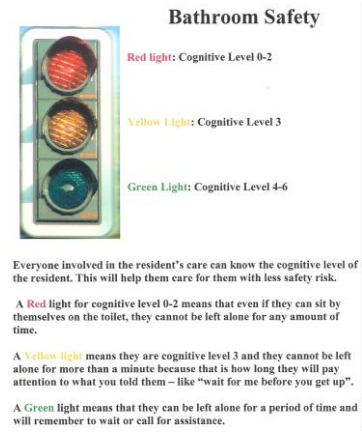
Cog Level	Pays Attention to:	Recalls	Fall management planning
3.0	Objects at eye level or on a table 6" away; **familiar objects** in immediate environment	Verbal directions for **about 2 minutes** and "wait a minute."	Reduce distractions, remove hazards. Cue to uneven surfaces, use grab bars, perform exercises. Provide consistent drilling of activity. Imitates ROM exercises.

Interventions are not one size fits all…

- 3.6 recalls information for how long?

Is the intervention "reminded to use call bell" appropriate?

1-2 minutes



Level 3 fall prevention interventions

- Supervised toileting plan
- Transfer training (esp. from bed) w/ demo of technique and repetitive drilling of motor actions. (learns to imitate effects w/ repetitive drilling)
- Cues to change position slowly. Will not recall safety precautions.
- W/C positioning for comfort, ease of mobility, maximal safety

Mary has fallen 2x in 2 weeks trying to get into bed. PT evaluated and found:

Assessment results	Action plan
Cognitive Level 3.2	Incorporate motor drilling of safe technique for bed transfers
BERG Balance test: reach forward while standing scored 2"	Incorporate dynamic reaching tasks at bedside
75 on the ABC (activities specific balance scale)	Incorporate secure, graded mobility & balance challenges. Try Wii games.
Bed mobility/transfers min A	Train staff re: optimal bed height to leave bed and afternoon rest schedule
Quadriceps strength 3+/5	Targeted strengthening to facilitate sit to stand

Using Test Scores

Cog Level	Pays Attention to:	Recalls	Fall management planning
2.0	Trunk stability and movement of their limbs. Large external objects	May respond to short **1 step** commands ("open mouth" for oral care etc.)	Answers yes/no to questions of comfort. Follows count of 3 to initiate movement. CGA EOB-trunk balance help. Goal of safe seating (2.4 may pace excessively) Fear of falling w/resistance to activities perceived as dangerous.

Level 2 fall prevention interventions

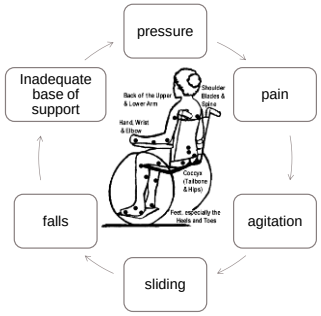
- Wander guard
- Facilitate proximity and clear pathway to bathroom
- Replacement repetitive motor activity if wandering unsafe
- Restorative program for mobility and strength/ROM maintenance

amartin@proactivemedicalreview.com

Wheelchair Seating

- Both feet on floor (or footrests) with knees flexed at 90 degrees.
- Kick space below the seat to allow one foot to slide underneath (consider the biomechanics of rising.)
- Avoid too soft cushions that hinder rising and make weight shifting difficult . Best type of cushion is relatively flat and firm with some resilience.
- Watch for slinging upholstery

Wheelchair Positioning



Looking for Home

"I know what I need, I need what I need"

Restless behaviors

- Wandering
- Rummaging
- Repetitive activities (picking)

- Some research suggests symptoms worsen as ability to interact with others and engage in former stimulation activities declines. The sense of loss (of home, of self, of belonging) increases.

Wandering behavior

- Some research suggests symptoms worsen as ability to interact with others and engage in former stimulation activities declines.

"Home is the place where I can remember"

--a man with early Alzheimer's

Wandering Behavior: ACL 2.4

- Environmental modification removing barriers below the knee, lighting
- 1:1 activities planning & diversions
- Rocking & rhythmic movement
- Pain management
- Rest plan
- Frequent snacks/supplements
- Avoid side-rails (tend to climb over)
- Wander guard

Amie Martin OTR/L
amartin@proactivemedicalreview.com

Wandering Behavior: Interventions

- Speech referral with FMP for 1:1 socialization opportunities and staff ed. on basic communication strategies
- Rocking chair and warm comfort item
- Remove trash cans, shoes from floor, etc.
- Keep purses, coats, umbrellas out of sight and change of shift conversation in check
- Disguise off limit areas
- Use stated address on room door

Wandering Intervention cont…

- Comfort and reassurance to increase feeling of safety
- Assess sleep health and promote night time rest (daytime sunlight, late morning exercise, limit caffeine, bedtime routine)
- If lost, search in the direction of dominant hand.

Clara has fallen 3x in 30 days usually when walking the halls at night:

Assessment results	Action plan
Cognitive Level 2.4	Tactile position sense cues to promote gravitational security
Wandering up to 4 hours per night	Replace ambulation with alternative rhythmic motor activity. Scheduled analgesic. Train staff re: optimal bed height to leave bed and afternoon rest schedule
Bed mobility/transfers MI but safety declines as she fatigues	
Footwear review	Alternate footwear. Regular skin checks
Review of sleep and bedtime patterns	Bedtime beats CD, warmed weighted blanket, lavender scented sheet spray

http://www.amazon.com/s/?ie=UTF8&keywords=bedtime+beats+cd&tag=mh0b-20&index=aps&hvadid=1471497703&ref=pd_sl_1nc7f6k9vs_e

Other Common Behaviors

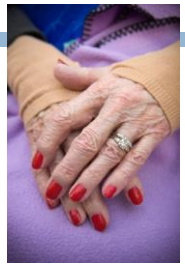
Actions and Reactions to the Environment

amartin@proactivemedicalreview.com

Rummaging

Safe Rummaging kits:
•Jewelry box
•Tackle Box
•Scarf box
•Sorting baby socks

Structured daytime routines
Buddy of 4.0 or higher



Resisting Care

Most likely to occur when:

- Approached by more than 2 people
- Caregiver is moving too fast
- Resident has no control in when and how care will take place

Tips for bath-time

- Use a primary caregiver
- Allow as much autonomy & power as possible
- Undress in bathroom; comfortable air and water temps; shampoo hair last.
- Use familiar toiletries
- Put something in their hands
- JUST RIGHT CHALLENGES based on ACL

Lack of purposeful activity

- What percentage of the day are residents engaged in meaningful pursuits?

Daily Activities

- Offer solutions for activities & just right challenge stimulation programs for all cognitive levels
- Remember to focus on skilled services. Diversion & entertainment is not skilled, individualized plans to reduce anxiety, provide appropriate stimulation and to temper wandering can be skilled if using an evidence based approach.
- Identify and implement individualized plans for comfort, structure, & management of escalating situations
- Foster a home like setting.

Montessori Principles

- Combats invasive memory loss by **focusing on spared capacity** through ***procedural memory and environmental supports*** that build on existing abilities.
- Common objects are used with easily recognized tasks that have meaning to the individual and that do not require extensive verbal explanation.
- Activities are matched with interests, needs and abilities.

Montessori continued

- Work in a clear, uncluttered space to prevent distraction
- Materials are free of unimportant letters, numbers, words, markings to minimize confusion
- Provide manipulatives, (hands-on moveable objects, as part of the activity)
- Activities should be an error-free source of success for the participant
- Activities are performed in a defined space (on a single tray, in a single container, on a single mat) to minimize distraction &/or confusion

http://www.healthpropress.com/store/camp267X/excerpt.htm

Amie Martin OTR/L
amartin@proactivemedicalreview.com

Communication

Actions and Reactions to the Environment

amartin@proactivemedicalreview.com

Communication Milestones

- 1.6 grunts, grimaces, smiles

Treatment Suggestion:

- Sensory stimulation program (pleasant, Smells, wind chimes, stuffed animals, snow globe, lotion on hands, warm lemon scented washcloth, icecream)

Communicating with 2.0

- Answers yes/no to questions of comfort, food preferences, go to bed. Responds to body language. Echoes counting to 3 to initiate movement. Expresses heightened pleasure to loved ones, favorite foods, clothes

Treatment ideas: life story book with family training on making visits more pleasurable.

Communicating with 2.6

- Incorporate singing into treatment and daily routines to help sequence steps

Communication tips 3.0

- 3.0-3.2 Staff training on:
  - Expressive: giving opportunities to name objects and use noun/verb phrases; states own name when asked
  - Receptive: simple, short phrases and how much processing time needed for following directions
- 3.4 incorporate strategy of talking self through tasks
- 4.0 work on using call bell/calling for help. May enjoy working in groups.
- 4.2 orientation strategies for day/date
- 4.8 Reads a schedule or simple directions

Communication 4.0

- 4.0 reading is not functional to follow directions
- 4.2 write name/short sentences
- 4.4 Gets new information via visual demonstration not reading directions, but will use simple memory book with practice
- 4.8 notices facial expressions of annoyance or verification; inflexible in routines

amartin@proactivemedicalreview.com

Feeding/Dining Issues

amartin@proactivemedicalreview.com

Consider test score

- 2.4 Eats and drinks with set up and mod assist to initiate / sustain actions. Restorative dining programming often needed.

Goal suggestions:

1. Initiate self feeding with (tactile/gesture/verbal) cue.
2. Sustain self feeding action to complete meal within 45 minutes with supervision on RNP

amartin@proactivemedicalreview.com

General Tips for Success

- Sensory cues to task
- Pleasant, quiet environment
- Reduce table clutter and distractions
- Be consistent from meal to meal
- Be prepared with special equipment, etc.
- Encourage as much independence as possible
- Encourage good positioning (90,90,90)
- Use info related to the patient's cognitive level to predict the appropriate challenge for the resident

Plays with or doesn't recognize food

- Offer environmental cues that remind that it is meal time such as a table with a tablecloth, napkins, placemats, bread basket, and cooking smells
- Increase finger food offerings such as sandwiches, carrot sticks, cereal bars, apple slices, ice cream cones
- Encourage utensil use if this is a reasonable goal. Limit the number of utensils available to reduce confusion

Limited Attention Span

- Use simple words and directions
- Touch and redirect to the task of eating
- May need 5-6 small meals vs. 3
- The meal may be a combination of sitting and walking w/finger foods
- Make sandwiches from the food on the plate
- Waist pouches on bibs may give a pacer a place to hold snacks

Unsure of expectations

- Establish the same routine at each meal.
- Use simple, 1-step directions using visual and gestural cues.
- Place the fork/spoon in the preferred hand
- Hand over hand help may trigger the eating process
- Meal tickets

Sleeping Through Meals

- Increase daytime activities, especially physical exercise, but avoid over exhaustion
- Avoid sugar, caffeine, and junk foods. Plan smaller meals throughout the day, such as half a sandwich before bed.
- Provide quiet, calm, structured activities in the evening hours (i.e. soothing music.)
- Provide opportunities for plenty of daylight with curtains open during the day, etc. to help reduce confusion of night/day
- Rest/wake schedule

Spills and Messy Eating

- Soups in mugs
- Finger foods
- Easy grip utensils and cups
- May need to give liquids separately instead of with food (i.e. pours over food)
- Limit items on tray/plate, precut food
- Use crumb catcher clothing covers/bibs

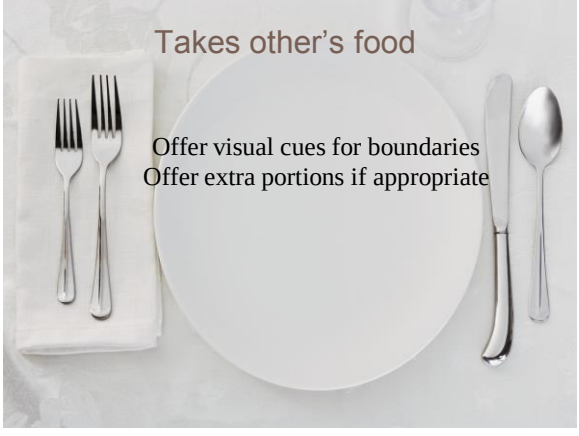
- Eating independently should take precedence over eating neatly or with proper table manners

Poor Appetite

- 5-6 smaller meals vs. 3 large ones
- Offer a big breakfast
- Routine structure and timing for meal
- Offer high protein, high calorie foods
- Offer snacks and fluids frequently
- Sweet foods are often preferred as sweet taste receptors are intact the longest

Unable to make choices

- Serve one course at a time so that there are fewer distractions.
- If they complain that there is too much food on the plate, use 2 plates serving half of the meal at a time
- Limit to two choices at a time when completing a menu



Visual Perceptual Problems

- Be sure there is color contrast between food and plate, plate and place mat, etc.
- Support visual discrimination between objects to reduce stress & spills
- Glare from lights can cause agitation
- Encourage natural sunlight
- Be aware of vision deficits and lighting needs of individual residents
- Low vision residents may need consistent tray set up & furniture placement in dining room

Amie Martin OTR/L
amartin@proactivemedicalreview.com

Pays attention to….

ACL	
3.2	Large, familiar objects at eye level 6"away
3.4	Will find bed or bathroom on own and learns new location in 2-3 weeks
4.2	Notices objects in plain site within arms reach (24")
4.4	3-4 feet in front and on either side
4.6	Looks at surroundings in plain site: counter top, cupboard at eye level; will scan for needed items and avoid obvious hazards
4.8	Scans environment and aware of people in the vicinity; notices expressions of verification or annoyance of others

amartin@proactivemedicalreview.com

Safe Transition Planning

amartin@proactivemedicalreview.com

Reasonable expectations

3.6--- 24 hour care and SBA

- Complete self care routine with set up/SBA in a linear sequence
- Exercise RNP with reciprocal pulleys & counting aloud
- Propels w/c with assist to turn corners

4.0—24 hour care to correct potential hazards-Distant Sup.

- Complete familiar self care routine with set up and increased time (2-3x)
- Asks for assistance as needed (goal to use call bell)
- Oriented x3 & follows schedule for preferred activities; reminders to keep non-routine appointments
- Keep medications out of sight

amartin@proactivemedicalreview.com

Reasonable expectations

4.4—home alone some

- Lives with someone but may be alone some with practiced procedure for calling for help
- Self care on routine
- Light home management with cues

4.6-live alone with daily checks

- Assist with bills
- Reminders to do household chores
- Learns best by demo
- Discusses internal state and external world

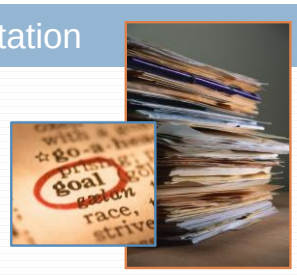
amartin@proactivemedicalreview.com

Driving

5.6

amartin@proactivemedicalreview.com

Documentation



amartin@proactivemedicalreview.com

Tips

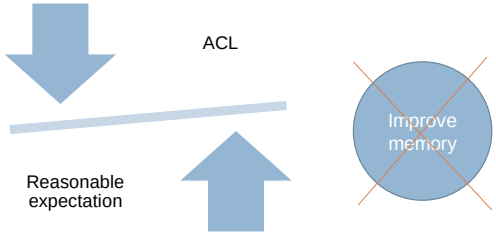
Assessment	Progress Reporting
▫ Goal to complete cognitive assessment at eval to guide treatment & DC plan ▫ Provide interpretation of ACL score ▪ note how you will adapt approach and set reasonable goals	▫ Document skilled interventions ▪ 4-striking visual cues/demonstration ▪ 3-motor drilling for new techniques ▪ 2-gross motor environmental mod staff training

Wording the goal for testing

Patient will participate in formal cognitive assessment to guide…

- ☐ *LTG adaptations for reasonable expectations of highest practicable function*
- ☐ *implementation of individualized treatment approaches*
- ☐ *therapeutic learning strategies for optimal efficiency and outcomes during rehab course*
- ☐ *safe d/c transition planning*

Goal setting



Finding the individual's "Just Right Challenge"

- Therapy referral from nursing based on a change in condition or identified deficit
- Therapy evaluation, objective cognitive assessment, and treatment plan based on findings
- Individualized FMP or restorative program development with staff training on recommendations and cognitive level findings
- Nursing/restorative follows through with FMP or restorative program and consults with therapy if changes in the program are needed prior to the quarterly screening

Cognitive Testing Links and resources

- **ACL caregiver guides**: http://www.ot-innovations.com/content/view/21/46/
- **ACL testing supplies** (L-ACLS –large screen)
  - S&S $89 http://www.ssww.com/item/large-allen-cognitive-level-screen-lacls-CU625/cmc=SRCH/v=YWNscw%2C%2C/p=1/
  - Therapro $72 www.theraproducts.com
  - Understanding Cognitive Performance Modes book $50 @ S&S or Amazon.

    http://www.amazon.com/Understanding-Cognitive-Performance-Modes-Book/dp/B002NMAS7S/ref=sr_1_1?ie=UTF8&qid=1384005197&sr=8-1&keywords=understanding+cognitive+performance+modes
- **Routine Task Inventory-free download**

  www.allen-cognitive-network.org/**pdf**_files/RTIManual2006.**pdf**

Thank you!

Please return all sign in sheets and lab worksheets to HTS so that certificates may be generated.

Amie Martin OTR/L
amartin@proactivemedicalreview.com