

**BARBARA BROYLES ALZHEIMER AND DEMENTIA TRAINING PROGRAM FOR
NURSING ASSISTANTS**

Do not ask me to remember.
Don't try to make me understand.
Let me rest and know you're with me.
Kiss my cheek and hold my hand.

I'm confused beyond your concept.
I am sad and sick and lost.
All I know is that I need you.
To be with me at all cost.

Do not lose your patience with me.
Do not scold or curse or cry.
I can't help the way I'm acting.
Can't be different though I try.

Just remember that I need you.
That the best of me is gone.
Please don't fail to stand beside me.
Love me 'til my life is done.

Author unknown

The Office of Long Term Care wishes to extend sincere appreciation to University of Arkansas Athletic Director Frank Broyles, Representative Sandra Prater, Senator Mary Ann Salmon, Representative Shirley Borhauer, Dr. Cornelia Beck, and Gwynn Davis.

Representative Prater with assistance and encouragement from Representative Borhauer spent numerous hours creating and sponsoring the legislation that made possible the training provided by way of this curriculum, including the requisite funding. Without her initial impetus and unwavering efforts, Arkansas would still lack this necessary element of CNA training. Senator Salmon, recognizing the value of this necessary training, co-sponsored the legislation and helped shepherd it through the Arkansas Senate.

During the legislative session, Coach Broyles provided dramatic and very personal testimony of the struggles that he and his family faced while his wife, Barbara, battled with this terrible disease. In doing so, Coach Broyles gave a face and feelings to what can oft times be a purely theoretical discussion. His unselfish act of revealing these personal and intimate moments were instrumental in the swift and virtually unanimous approval of the law.

Dr. Cornelia Beck and Gwynn Davis, both of UAMS, proved to be invaluable in the actual content and creation of the curriculum. Without their expertise and efforts, not only would this manual have been significantly delayed, the quality would have suffered greatly.

This Alzheimer's/Dementia curriculum was developed to encompass provisions set forth in Act 1184 of 2005 and will be incorporated into the Arkansas' Office of Long Term Care regulations for Nursing Assistant Training Curriculum. The committee developing the Barbara Broyles Alzheimer's and Dementia Curriculum included the following persons:

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Barbara Broyles Alzheimer's and Dementia Training Program

Objective: The Trainee shall understand: Alzheimer's disease and dementia terminology, signs of disease progression, care at specific stages; demonstrate communication skills; discuss principles of nutrition and hydration as related to Alzheimer's disease; discuss common behaviors and interventions associated with Alzheimer's and dementia; and discuss burnout and burnout prevention.

Required Videos: Bathing Without a Battle; Look at Me

Required: Documentation of completion of Bathing Without a Battle

1.0 Introduction to Dementia and Alzheimer's disease

Key Terms

Cognition:	The ability to think quickly and logically
Confusion:	The inability to think clearly, causing disorientation and trouble focusing
Delirium:	A state of severe confusion that is reversible and occurs suddenly
Dementia:	A usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and inability to plan and initiate complex behavior
Irreversible:	A disease or condition that cannot be cured
Onset:	The time when signs and symptoms of a disease begins
Progressive:	The way a disease advances

- 1.1 Alzheimer's disease (AD) is a progressive disease that is characterized by a gradual decline in memory, thinking and physical ability. The decline occurs over several years.
- 1.2 Average life span following the diagnosis of Alzheimer's disease is eight (8) years, but survival may be anywhere from three (3) to twenty (20) years.
- 1.3 Because Alzheimer's disease is progressive, it is broken down into three stages: Early (Mild), Middle (Moderate) and Late (Severe).
 - a. Symptoms of the early stage include the following:
 1. Memory loss begins to affect everyday activities

2. Difficulty remembering names of people, places or objects
 3. Difficulty following directions
 4. Disoriented to time and place
 5. Increased moodiness, agitation or personality changes due to forgetfulness or embarrassment
 6. Has poor judgment and makes bad decisions
 7. Develops difficulty maintaining living spaces, paying bills and managing money
- b. Symptoms of the middle stage, which is the longest of the three stages, include the following:
1. Increased restlessness during the evening hours (sundowning)
 2. Increased level of memory loss; starts losing the ability to recognize family members
 3. Requires assistance with activities of daily living
 4. Increased problems with communication, ambulation and impulse control
 5. Increased behavioral issues; may become violent at times
 6. Urinary and fecal incontinence
 7. May experience auditory or visual hallucinations and become suspicious of caregivers
 8. Finally requires full-time supervision
- c. The late stage is considered the terminal stage. Symptoms include:
1. Loses ability to verbalize needs; may groan, grunt or scream
 2. Does not recognize self or family members
 3. Becomes bed-bound
 4. Total dependence for activities of daily living
 5. Body function gradually declines
 6. Death

1.4 Delirium and Dementia are often confused. Delirium is usually triggered by a rapid onset (acute) of illness or change in physical condition that is life threatening if not recognized and treated. Dementia is usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and inability to plan and initiate complex behavior

1.5 Signs and symptoms of acute delirium are:

- a. Rapid decline in cognitive function
- b. Disorientation to place and time
- c. Decreased attention span
- d. Poor short-term memory and immediate recall

- e. Poor judgment
- f. Restlessness
- g. Altered level of consciousness
- h. Suspiciousness
- i. Hallucinations and delusions

Notify the Charge Nurse immediately of any resident that begins to exhibit the above symptoms or behaviors and stay with the resident. Delirium is a medical emergency.

2.0 Maintenance of Respect, Dignity and Quality of Life

Key Terms

Dignity:	Respect and honor
Independence:	Ability to make decisions that are consistent, reasonable and organized; having the ability to perform activities of daily living without assistance
Quality of life:	Overall enjoyment of life
Respect:	Treated with honor, show of appreciation and consideration

- 2.1 Every human being is unique and valuable. Therefore, each person deserves understanding and respect. Dementia does not eliminate this basic human need. Person-centered care maintains and supports the person regardless of his/her level of dementia.
- 2.2 Residents' abilities, interests, and preferences should be considered when planning activities and care. As the disease progresses, adjustments will be required in order to maintain dignity.
- 2.3 It is important for staff to know who the resident was before the dementia started. An individual's personality is created by their background, including:
 - a. Ethnic group membership
 - 1. Race
 - 2. Nationality
 - 3. Religion
 - b. Cultural or social practices
 - c. Environmental influences such as where and how they were raised as children
 - d. Career choices
 - e. Family life
 - f. Hobbies

- 2.4 Encourage residents to participate in activities and daily care, but avoid situations where the resident is bound to fail. Humiliation is disrespectful, degrading, and can increase the likelihood of disruptive behaviors.
- 2.5 To promote independence do things *with* the resident rather than *for* them.
- 2.6 Allow time for the residents to express feelings, and take time to understand what they are feeling. Provide emotional support.
- 2.7 Long term care facilities must provide care for residents in a manner and an environment that promotes the maintenance or enhancement of each resident's dignity, respect, and quality of life.
- 2.8 Dignity means that during interactions with residents, Nursing Assistants and other staff assist the resident to maintain and enhance self-esteem and self-worth. By:
 - a. Respecting the resident's social status, speaking respectfully, listening carefully, treating residents with respect (e.g., addressing the resident with a name of the resident's choice, not excluding residents from conversations or discussing residents in a community setting);
 - b. Focusing on residents as individuals when staff converse with them and addressing residents as individuals when providing care and services.
 - c. Grooming residents based on their wishes (e.g., hair combed and styled, beards shaved or trimmed, nails clean and clipped);
 - d. Assisting residents to dress in their own clothes appropriate to the time of day and individual preference;
 - e. Assisting residents to attend activities of their own choosing;
 - f. Promoting resident independence and dignity in dining (such as avoidance of day-to-day use of plastic cutlery and paper/plastic dishware; use of napkins instead of bibs; dining room conducive to pleasant dining); and
 - g. Respecting the resident's private space and property (e.g., not changing radio or television station without the resident's permission, knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting the resident's personal possessions without permission)

3.0 Communication

Communication: Giving or exchanging information with words, body language or writing

- 3.1 Residents that are victims of Alzheimer's disease often experience problems in making their wishes known and in understanding spoken words. Communication becomes harder as time goes by.
- 3.2 Changes that are commonly seen in the Alzheimer's resident include:
 - a. Inability to recognize a word, phrase
 - b. Inability to name objects
 - c. Using a general term instead of specific word
 - d. Getting stuck on ideas or words and repeating them over and over
 - e. Easily losing a train of thought
 - f. Using inappropriate, silly, rude, insulting or disrespectful language during conversation
 - g. Increasingly poor written word comprehension
 - h. Gradual loss of writing ability
 - i. Combining languages or return to native language
 - j. Decreasing level of speech and use of select words, which may also cause the use of nonsense syllables
 - k. Reliance on gestures rather than speech
- 3.3 There are several components when assisting the resident with communication. These components are:
 - a. Patience with the resident.
 - b. Show your interest in the subject.
 - c. Offer comfort and reassurance.
 - d. Listen for a response.
 - e. Avoid criticizing or correcting.
 - f. Avoid arguments with the resident.
 - g. Offer a guess as to what the resident wants.
 - h. Focus on the feelings, not on the truth.
 - i. Limit distractions.
 - j. Encourage non-verbal communication.
- 3.4 The Nursing Assistant's method of communicating with the Alzheimer's resident is as critical as the actual communication. Utilizing the following techniques will decrease frustration for both the resident and the Nursing Assistant.
 - a. Obtain the resident's attention before speaking and maintain his or her attention while speaking.

- b. Address the resident by name, approach slowly from the front or side and get on the same level or height as the resident.
- c. Set a good tone. Use a calm, gentle, low-pitched tone of voice.
- d. If the conversation is interrupted or the Nursing Assistant or resident leaves the room, start over from the beginning.
- e. Slow down, do not act rushed or impatient. If the information needs to be repeated, do so using the same words and phrases as before.
- f. Speak clearly and distinctly using short, familiar words and short sentences, and avoiding long explanations.
- g. Emphasize key words, break tasks and instructions into clear and simple steps, offer one step at a time; and provide the resident time and encouragement to process and respond to requests.
- h. Use nonverbal cues, such as touching, pointing or starting the task for the resident. If the resident's speech is not understandable, encourage him/her to point out what is wanted or needed.

3.5 Communication strategies to use when communicating with residents that have dementia include:

- a. Listen carefully and encourage them; do not talk down to them, nor talk to others about them as if they were not present.
- b. Minimize distractions and noise.
- c. Allow enough time for the resident to process and respond; if they have difficulty explaining something, ask them to explain in a different way.
- d. Monitor your body language to ensure a non-threatening posture and maintain eye contact. Nonverbal communication is very important to dementia residents.
- e. Choose simple words and short sentences, and use a calm tone of voice. Call the person by name, and make sure you have their attention before speaking.
- f. Keep choices to a minimum in order to reduce the resident's frustration and confusion.
- g. Include residents in conversations with others.
- h. Do not make flat contradictions to statements that are not true.
- i. Change the way responses are made to avoid confusion, frustration, embarrassment, and behavioral outbursts.
- j. Use of communication devices (such as a picture board, books, or pictures) encourages the resident's independence and decreases frustration.

3.6 Communication tips to use when caring for the resident with Alzheimer's disease:

- a. Be calm and supportive.
- b. Focus on feelings, not facts.

- c. Pay attention to tone of voice.
- d. Identify yourself and address the resident by name.
- e. Speak slowly and clearly.
- f. Use short, simple and familiar words, and short sentences.
- g. Ask one question at a time.
- h. Allow enough time for a response.
- i. Avoid the use of pronouns (e.g., he, she, they), negative statements and quizzing.
- j. Use nonverbal communication such as pointing and touching.
- k. Offer assistance as needed.
- l. Have patience, flexibility, and understanding.

4.0 Behavior Issues

Key Terms

Behavior:	How a person acts
Catastrophic reaction:	An extreme response
Delusion:	A false belief
Depression:	A loss of interest in usual activities
Paranoia:	An extreme or unusual fear
Sundowning:	Increased agitation, confusion and hyperactivity that begins in the late afternoon and builds throughout the evening
Trigger:	An event that causes other events
Wandering:	Moving about the facility with no purpose and is usually unaware of safety

4.1 Alzheimer's disease progresses in stages, and likewise, so does the behavior. Behavioral responses that may be associated with each stage include, but are not limited to:

- a. Early stage
 1. Depression
 2. Anxiety
 3. Irritability
- b. Middle stage
 1. Wandering
 2. Agitation
 3. Sleep disturbances

4. Restlessness
5. Delusions
6. Hallucinations
7. General emotional distress

c. Late stage

1. Verbal or physical aggression
2. Agitation
3. Gradual behavioral decline as the disease progresses to death

4.2 Behavior is an observable, recordable, and measurable physical activity. People with normal brain function have the ability to control their responses. People with Alzheimer's disease and dementia have lost much of this ability.

4.3 Behavior is a response to a need. The resident is frequently unable to express his or her needs because of the cognitive losses. Nursing Assistants must be attentive to gestures and clues demonstrated by the resident.

4.4 Every behavior is a response to a need or situation. Gestures, sounds, and conversation may reveal the trigger to the behavior. As verbal skills diminish, behavior becomes the communication method.

4.5 Before choosing a specific behavioral intervention, the trigger of the behavior must be identified. Triggers may be environmental, physical, or emotional.

a. Environmental triggers may include:

1. Rearrangement of furniture
2. Increased number of people in the facility
3. Change in the daily schedule

b. Physical triggers may include:

1. New medications
2. Infections
3. Pain

c. Emotional triggers may include:

1. Reactions to loss
2. Depression
3. Frustration
4. Self-perception

- 5. Past life events
- 6. Personality

4.6 Effective behavior management includes the following:

- a. Identifying of the trigger
- b. Understanding the trigger
- c. Adapting the environment to resolve the behavior

Changing the environment (such as reducing excessive noise and activity) or providing comfort measures (such as rest or pain medication) may reduce the behavior. The intervention must meet the needs of the resident while maintaining respect, dignity and independence.

4.7 Successful behavioral interventions preserve the resident's dignity and helps staff gain confidence, improve morale, and increase job satisfaction. Behavior control also assists in reducing the use of restraints, decreases abuse and neglect, and increases family satisfaction.

4.8 Common behaviors:

- a. Wandering
- b. Sundowning
- c. Depression
- d. Disorientation to person, place, and/or time
- e. Inappropriate sexual behavior
- f. Emotional outbursts
- g. Combativeness (hostility or tendency to fight)
- h. Inappropriate toileting (use of inappropriate areas for toileting, such as a plant)
- i. Easy frustration
- j. Repetitive speech or actions
- k. Swearing, insulting, or tactless speech
- l. Shadowing (following others)
- m. Withdrawal
- n. Hoarding (hiding objects or food)
- o. Sleep disturbances
- p. Paranoia and suspiciousness
- q. Delusions and/or hallucinations
- r. Decreased awareness of personal safety
- s. Catastrophic reactions (extreme emotional responses such as yelling, crying, or striking out that seem out of proportion to the actual event)

4.9 Wandering is a known and persistent problem behavior that has a high risk factor for resident safety. Safety risk factors may include:

- a. Falls

- b. Elopement
- c. Risk of physical attack by other residents who may feel threatened or irritated by the activity

4.10 Residents wander for several reasons and may include:

- a. Trying to fulfill a past duty, such as going to work
- b. Feeling restless
- c. Experiencing difficulty locating their room, bathroom or dining room
- d. Reacting to a new or changed environment

4.11 Preservation of resident safety is the main objective when caring for the wandering resident. Interventions:

- a. Establish a regular route.
- b. Provide rest areas.
- c. Accompany the resident.
- d. Provide food and fluid.
- e. Redirect attention to other activities or objects.
- f. Determine if behavior is due to environmental stress.

4.12 Sundowning is a behavioral symptom of dementia that refers to increased agitation, confusion, and hyperactivity that begins in the late afternoon and builds throughout the evening. Interventions:

- a. Encourage rest times.
- b. Plan the bulk of activities for the morning hours.
- c. Perform quieter, less energetic activities during the afternoon.

4.13 Inappropriate sexual activity is another behavior issue. Offensive or inappropriate language, public exposure, offensive and/or misunderstood gestures are the characteristics of this behavior. Interventions:

- a. Treat the resident with dignity and respect.
- b. Remove the resident from the public situation.
- c. Redirect attention to an appropriate activity.
- d. Assist the resident to the bathroom.

4.14 Agitation occurs for a variety of reasons. Nursing Assistants must ensure the safety and dignity of the agitated resident while protecting the safety and dignity of the other residents. Interventions:

- a. Do not crowd the resident; allow them room to move around while still providing for safety.
- b. Ask permission to approach or touch them.
- c. Maintain a normal, calm voice.

- d. Slow down, do not rush the resident.
- e. Limit stimulation in the resident's area.
- f. Avoid confrontations and force.
- g. Avoid sudden movements outside of the resident's field of vision.

4.15 Disruptive verbal outbursts are one of the most persistent behaviors in a long-term care facility. These outbursts may include:

- a. Screaming
- b. Swearing
- c. Crying
- d. Shouting
- e. Loud requests for attention
- f. Negative remarks to other residents or staff (including racial slurs)
- g. Talking to self

4.16 Anger and aggression are often the visible symptoms of anxiety and fear. Interventions:

- a. Reassure the resident that they are safe
- b. Redirect their attention to an activity
- c. Assist the resident with toileting, feeding or fluids
- d. Move the resident to a quiet area

Notify the Charge Nurse immediately of aggressive behaviors that may threaten other residents and/or staff and stay with the resident.

4.17 Emotional, environmental, or physical triggers may result in a catastrophic reaction. Warning signs of a possible reaction may include:

- a. Sudden mood changes
- b. Sudden, uncontrolled crying
- c. Increased agitation
- d. Increased restlessness
- e. Outburst of anger (physical or verbal)

4.18 Catastrophic reactions are out-of-proportion responses to activities or situations. Interventions:

- a. Speak softly and gently in a calm voice
- b. Protect the resident, yourself, and others as necessary
- c. Remove the person from a stressful situation
- d. Avoid arguing with the resident
- e. Avoid the use of restraints
- f. Redirect the resident's attention
- g. Change activities if the activity is causing the reaction

- 4.19 Interventions that should not be used include the following:
- a. Arguing with the resident or other staff members
 - b. Speaking loudly to the resident or other staff members
 - c. Treating the resident like a child
 - d. Asking complicated questions
 - e. Using force or commanding the resident to do something
- 4.20 The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms (CMS F221; F222).
- 4.21 Restraints are protective measures to prevent injury, not to limit a resident's mobility for staff convenience. Examples of restraints include:
- a. Physical: any item, object, device, garment, or material that limits or restricts a person's freedom of movement or access to their body.
 1. Leg restraints;
 2. Arm restraints;
 3. Hand mitts;
 4. Soft ties or vests;
 5. Lap cushions;
 6. Lap trays the resident cannot remove easily;
 7. Side rails that keep a resident from getting out of bed on their own;
 8. Tucking in or using Velcro® to hold a sheet, fabric or clothing tightly so that a resident's movement is restricted;
 9. Using trays, tables, bars or belts with a chair that the resident cannot easily remove or prevents the resident from rising; or
 10. Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or getting out of the bed on their own.
 - b. Chemical: any drug that is used for discipline or convenience and not required to treat medical symptoms.
- 4.22 Nursing Assistants DO NOT make the decision of whether or not a restraint is used and are only used as a last resort option.
- 4.23 Restraints require a physician's order and frequent monitoring. Restraints must be checked every 30 minutes and released according to the care plan, but not to go beyond every 2 hours, for exercise, toileting, positioning, and hydration.
- 4.24 Caregiver behaviors that should be encouraged and used to decrease or prevent the use of restraints may include:

1. Maintaining a calm and non-controlling attitude.
2. Speaking softly and calmly.
3. Asking one question at a time and waiting patiently on the answer.
4. Using simple, one step commands, and positive phrases.
5. Avoiding crowding the resident with more people than needed for the task.
6. Providing a distraction such as an activity or music.

5.0 Activities

- 5.1 The goal in the care of residents with Alzheimer's disease is to give the support needed so that they can participate in the world around them to the best of their ability.
- 5.2 The Nursing Assistant must focus on the fact that the resident is involved and satisfied, not on the task or activity.
- 5.3 Activities fall into two categories--"doing" activities and "meaningful" activities. Doing activities keep the person busy and meaningful activities have value to the resident with dementia.
- 5.4 Activity-based care is care that is focused on assisting the resident to find meaning in their days rather than doing activities just to keep the person busy.
- 5.5 Principles of activity-based care are:
 - a. Focuses on giving caregivers the tools to create chances for residents with dementia to be successful in activities and their relations with other people.
 - b. Uses any daily activity that can be broken down into individual, sequential steps.
 - c. Works within the remaining abilities or strengths of the resident with Alzheimer's disease, helping to shift emphasis away from the resident's disabilities and impairments.
 - d. Adjusts an activity based on the resident's ability level.
 - e. Depends on the caregiver's interest and desire to create opportunities for successful interactions that are planned and guided to encourage the resident's full involvement.
 - f. Rewards the resident's attempts at participating in activities and provides them with a sense of being capable and alive.
- 5.6 Timing of activities is important and individualized. Attention/focus activities, physical activities and sensory activities that are provided

during each resident's prime time and on a set, routine basis may increase participation and satisfaction with that activity.

- 5.7 Cultural environment refers to the values and beliefs of the people in an area. Staff, residents, families, visitors and volunteers determine the culture of the facility. Promotion of a positive environment begins with inclusion of the residents and making them feel important to the relationships and activities going on.

6.0 Nutrition

- 6.1 Residents with Alzheimer's disease may have specialized nutritional needs based on their cognitive and physical status.
- 6.2 Dementia may lead to decreases in food and fluid intake because:
- a. Does not realize hunger or thirst
 - b. Reduced sense of smell and taste
 - c. Difficulty swallowing
 - d. Does not recognize eating utensils
 - e. Cannot feed self
 - f. Loses coordination
 - g. Depression
 - h. Restless and unable to remain seated during meals
- 6.3 Water is not the only fluid available to residents. Some residents may not like water and should be offered alternative fluids. Alternative fluids include, but are not limited to:
- a. Milk
 - b. Juices
 - c. Decaffeinated drinks (tea, coffee, soft drinks)
 - d. Popsicles
 - e. Ice cream
 - f. Gelatins
 - g. Fruit
 - h. Soups
 - i. Broths
- 6.4 Mealtime is just not a time to eat, but is also a social activity. Providing meals in an environment that encourages and enhances the eating process is beneficial to all residents. Residents that are easily distracted during meals should not be isolated from the rest of the residents; however, they may eat better in a quieter part of the dining room.

6.5 Observe residents for the following warning signs to minimize mealtime difficulties:

- a. Change or difficulty in swallowing or chewing
- b. Poor utensil use
- c. Refuses food and drinks

The Nursing Assistant must report the change and the circumstances surrounding the change to the Charge Nurse immediately.

6.6 Types of assistance may include:

- a. Setting up the meal tray
- b. Opening containers
- c. Verbal cuing or prompting to encourage self-feeding
- d. Physical cuing involving hand-on-hand assistance
- e. Total feeding

6.7 The resident with Alzheimer's sometimes has little awareness of food in their mouth. To remind the resident to chew, the Nursing Assistant may gently move the resident's chin or touch the tongue with a fork or spoon. To stimulate swallowing, gently stroke the resident's throat.

6.8 Nursing Assistants who are assisting the resident with eating should sit at the resident's level, make eye contact, and talk with the resident during the meal.

6.9 Consistency in meal times, seating arrangements and times will assist in promotion of the resident's independence and may decrease behavioral issues during meal service.

7.0 Staff Stress and Burnout

7.1 Providing care on a daily basis for the resident with Alzheimer's or dementia is extremely stressful. This population may be more prone than others in a facility to becoming victims of abuse or neglect. Because of this, staff that deals with Alzheimer's or dementia residents must take additional precautions to ensure that they do not over-react or react negatively to resident behaviors.

7.2 Regardless of the cause, staff must take the necessary steps to ensure that they do not react inappropriately to resident behaviors. Frustration can lead to:

- a. Negative, harsh or mean-spirited statements made to staff or residents

- b. Physical abuse of residents
- c. Emotional abuse of residents
- d. Verbal abuse of residents
- e. Neglect of residents

7.3 Staff must always remember that the statements and behaviors of residents suffering from Alzheimer's or dementia are beyond the control of the resident and not personally directed toward staff.

7.4 The usual profile of the employee who is subject to burnout is:

- b. Takes work personally and seriously
- c. Works over at the end of a shift
- d. Works extra shifts
- e. Takes on extra projects
- f. Very high or unrealistic expectations
- g. Perfectionist attitude

7.5 Signs of staff burnout include, but are not limited to, the following:

- a. No longer enjoying the work
- b. Irritability with residents and co-workers
- c. Fear of failure, inadequacy, job loss and obligation to supervisor, co-workers, family, et cetera
- d. Feelings of being overwhelmed
- e. Viewing work as a chore
- f. Frequent complaints of illness

7.6 Strategies to use to assist in preventing burnout include:

- a. Maintain good physical and mental health.
- b. Get adequate amounts of sleep on off days and before each shift.
- c. Remain active within your family and community.
- d. Maintain a separation between work and personal relationships.
- e. Maintain a sense of humor.

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