

DEMENTIA MADE SIMPLE

CONFIDENCE IN DEMENTIA CARE



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SKILLS2CARE CERTIFIED

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MODULE 1: INTRODUCTION

NEED TO KNOW:

PARTS OF A FLIGHT

PRE-BOARDING

TAKEOFF

FLIGHT

LANDING

PARTS OF A PLANE

BODY OF THE PLANE KEEPS IT TOGETHER

COCKPIT

CABIN

CARGO

WHAT MOVES THE PLANE FORWARD

LEFT ENGINE

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PUTTING IT ALL TOGETHER

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MODULE 2: THE COMMAND AND CONTROL CENTER

NEED TO KNOW:

COCKPIT

PILOT

CO-PILOT

INSTRUMENTATION

DEMENTIA MADE SIMPLE FORMULA FOR SUCCESS:

$$\underline{\mathbf{A. I. M^2 + P. E. A. C. E = E}}$$

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NEED TO KNOW:

THE CABIN

MULTIDISCIPLINARY TEAM

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	PHYSICAL THERAPIST		
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NATURAL SUPPORTS

CHURCH FAMILY			
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MEDICARE			

NICE TO KNOW:

THE CABIN

MULTIDISCIPLINARY TEAM

NATURAL SUPPORTS

FINANCIAL SUPPORTS

WHERE TO GO:

THE CABIN

MULTIDISCIPLINARY TEAM

Occupational Therapy www.aota.org

Physical Therapy www.apta.org

Speech Language Pathology www.asha.org

Dietitians www.eatrightpro.org

Bredesen Protocol <https://www.apollohealthco.com>

NATURAL SUPPORTS

Alzheimer's Association <https://www.alz.org/sc> 1-800.272.3900

Local Church Organizations

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MODULE 4: THE BURDEN BEING CARRIED

NEED TO KNOW:

CARGO

STAGES OF DEMENTIA AND DIFFERENT STAGING TOOLS

- Functional Assessment Staging Tool (Reisberg, Barry)
- Global Deterioration Scale (Reisberg, Barry)
- Allen Cognitive Disabilities Model
- Modified FAST
- The Brief Cognitive Assessment Test
- Montreal Cognitive Assessment (MoCA)

1. Functional Assessment Staging Tool (FAST Scale)

- a. The Functional Assessment Staging Tool © was developed by Dr. Barry Reisberg in 1984. It is a model of retrogenesis, meaning back to the beginning.
- b. It is divided into 7 stages with 16 sub-stages noted.
- c. The Functional Assessment Staging Scale (FAST) is a screening test to quantitatively assess the degree of disability and to document changes that occur over time.
- d. It is not intended to serve as the sole criterion for diagnosing dementia or to differentiate between various forms of dementia.

FUNCTIONAL ASSESSMENT STAGING TOOL:

1. No difficulty either subjectively or objectively.
2. Complaints of forgetting location of objects. Subjective work difficulties.
3. Decreased job functioning evident to co-workers. Difficulty in traveling to new locations.
Decreased organizational capacity. *
4. Decreased ability to perform complex tasks, e.g., planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc.
5. Requires assistance in choosing proper clothing to wear for the day, season, or occasion, e.g., patient may wear the same clothing repeatedly, unless supervised. *
6. A. Improperly putting on clothes without assistance or prompting (e.g., may put street clothes on over night clothes, or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks. *
6. B. Unable to bathe properly (e.g., difficulty adjusting bathwater temp.) occasionally or more frequently over the past weeks. *
6. C. Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*
6. D. Urinary incontinence occasionally or more frequently over the past weeks. *
6. E. Fecal incontinence occasionally or more frequently over the past weeks. *

7. A. Ability to speak limited to approximately a half-dozen intelligible different words or fewer in the course of an average day or in the course of an intensive interview.

7.B. Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview (the person may repeat the word over and over).

7. C. Ambulatory ability is lost (cannot walk without personal assistance).

7.D. Cannot sit up without assistance.

7. E. Loss of ability to smile.

7. F. Loss of ability to hold head up independently.

* Scored primarily on the basis of information obtained from knowledgeable informants. Adapted from: Reisberg B, Ferris SH, Franssen E. An ordinal functional assessment tool for Alzheimer's-type dementia. *Hosp Community Psychiatry*. 1985 Jun;36(6):593-5. doi: 10.1176/ps.36.6.593. PMID: 4007814.

Functional Assessment Staging (FAST)		
FAST Stage and Characteristics	Clinical Diagnosis	Duration of stage*
1. No functional decrement	Normal Adult	50 years
2. Subjective word difficulties	Normal Aged Adult	15 years
3. Decreased function in demanding employment settings	Compatible with possible incipient Alzheimer's disease in minority of cases	7 years
4. Decreased ability to handle complex tasks such as finances or planning dinner for guests	Mild Alzheimer's disease	2 years
5. Requires assistance in choosing proper clothing	Moderate Alzheimer's disease	18 months
6. a) difficulty dressing properly	Moderately severe Alzheimer's disease	5 months
b) requires assistance bathing		5 months
c) inability to handle mechanics of toileting		5 months
d) urinary incontinence		4 months
e) fecal incontinence		10 months
7. a) ability to speak limited to about six words	Severe Alzheimer's disease	12 months
b) intelligible vocabulary limited to single word		18 months
c) ambulatory ability lost		12 months
d) ability to sit up lost		12 months
e) ability to smile lost		18 months
f) ability to hold head up lost		Not applicable

**duration of stage in those entering the stage who progress into the next stage; not all patients progress.*

2. Global Deterioration Scale

- a. The Global Deterioration Scale (GDS), developed by Dr. Barry Reisberg provides caregivers an overview of the stages of cognitive function for those suffering from a primary degenerative dementia such as Alzheimer's disease.
- b. It is broken into 7 different stages.
- c. Stages 1-3 are the pre-dementia stages.
- d. Stages 4-7 are the dementia stages.
- e. Beginning in stage 5, an individual can no longer live without assistance.

- f. Within the GDS, each stage is numbered (1-7), given a short title (i.e., Forgetfulness, Early Confusional, etc. followed by a brief listing of the characteristics for that stage.
- g. Caregivers can get a rough idea of where an individual is during the disease process by observing that individual's behavioral characteristics and comparing them to the GDS.

GLOBAL DETERIORATION SCALE (GDS)

Stage	Deficits in cognition and function	Usual care setting
1	Subjectively and objectively normal	Independent
2	Subjective complaints of mild memory loss. Objectively normal on testing. No functional deficit	Independent
3	Mild Cognitive Impairment (MCI) Earliest clear-cut deficits. Functionally normal but co-workers may be aware of declining work performance. Objective deficits on testing. Denial may appear.	Independent
4	Early dementia Clear-cut deficits on careful clinical interview. Difficulty performing complex tasks, e.g. handling finances, travelling. Denial is common. Withdrawal from challenging situations.	Might live independently – perhaps with assistance from family or caregivers.
5	Moderate dementia Can no longer survive without some assistance. Unable to recall major relevant aspects of their current lives, e.g. an address or telephone number of many years, names of grandchildren, etc. Some disorientation to date, day of week, season, or to place. They require no assistance with toileting, eating, or dressing but may need help choosing appropriate clothing.	At home with live-in family member. In seniors' residence with home support. Possibly in facility care, especially if behavioural problems or comorbid physical disabilities.
6	Moderately severe dementia May occasionally forget name of spouse. Largely unaware of recent experiences and events in their lives. Will require assistance with basic ADLs. May be incontinent of urine. Behavioural and psychological symptoms of dementia (BPSD) are common, e.g. delusions, repetitive behaviours, agitation.	Most often in Complex Care facility.
7	Severe dementia Verbal abilities will be lost over the course of this stage. Incontinent. Needs assistance with feeding. Lose ability to walk.	Complex Care

Adapted by Dr. Doug Drummond from Reisberg B, Ferris SH, Leon MJ, et al. The global deterioration scale for assessment of primary degenerative dementia. American Journal of Psychiatry 1982;139:1136-1139.

3. Allen Cognitive Disabilities Model

- a. The cognitive disabilities model had its beginnings at the Eastern Pennsylvania Psychiatric Institute in the late 1960's when Claudia K. Allen, MA, OTR, FAOTA and her colleagues first observed patterns of performance difficulties in adult patients with mental disorders.
- b. The construct of "functional cognition" has since become a useful term for describing the focus of concern of the cognitive disabilities model.
- c. Functional cognition encompasses the complex and dynamic interactions between an individual's cognitive abilities and the activity context that produces observable performance.
- d. The modes of performance, a 26 point expansion of the original 6 cognitive levels, were published in *Occupational Therapy Treatment Goals for the Physically and Cognitively Disabled* in 1992 (Allen, Earhart, & Blue, 1992).
- e. In this text, Allen also articulated the framework for a clinical practice theory.
- f. Assessment tools described included
 - i. the ACLS-90;
 - ii. the Routine Task Inventory-2, an analysis of fourteen activities of daily living by cognitive level; and
 - iii. the Cognitive Performance Test, six standardized tasks of daily living analyzed by cognitive level.
- g. The *Routine Task Inventory-Expanded (RTI-E)* has since been developed by Katz (2006) and the CPT has been used to assess function in persons with dementia (Burns, 1994).

4. Modified FAST

- a. The adapted FAST has eight stages versus Reisberg's seven.
- b. The descriptions were changed to add Allen terminology.

5. The BCAT Test System

- a. The BCAT® Test System consists of six unique assessment instruments.
- b. The primary and foundational test is the **Brief Cognitive Assessment Tool (BCAT®)**. It can be administered in 10-15 minutes and is sensitive to the full spectrum of cognitive functioning (normal, MCI, dementia) It is able to predict basic and instrumental activities of daily living (ADL, IADL).

- c. The **BCAT®-SF** is designed as a shorter version of the full BCAT®. The Short Form can be administered in three minutes or less. It is a dependable cognitive screening tool. The Short Form can differentiate between persons with and without dementia.
- d. The **Brief Anxiety and Depression Scale (BADs®)** is a brief screening tool for mood impairment developed for older adults.
- e. The **Kitchen Picture Test of Judgment (KPT®)** was designed as a visually presented test of practical judgment. It is intended to help identify those who require supervision for IADLs.
- f. The **Verbal Test of Practice Judgment (VPJ®)** tests judgment. It helps identify judgment skills level and also identifies specific IADL dependencies associated with levels of impaired judgment.
- g. The **Brief Cognitive Impairment Scale (BCIS®)** was designed to assess the cognitive functioning of patients with *severe* dementia. The BCIS® is an 11-item, 14-point scale. It is most effective in confirming severe impairment and tracking cognitive changes over time in advanced dementia.

6. Montreal Cognitive Assessment

- a. The Montreal Cognitive Assessment (MoCA) is a brief, 30-question test that helps healthcare professionals detect cognitive impairments very early on, allowing for faster diagnosis and patient care.
- b. MoCA is one of the most sensitive tests available for detecting Alzheimer’s disease, measuring executive functions and multiple cognitive domains which are important components not measured by the MMSE.

NICE TO KNOW:

CARGO

TYPES OF DEMENTIA

CAUSES OF DEMENTIA

What Is Dementia

According to the World Health Organization, an estimated 47.5 million people live with dementia and this number is projected to increase to 75.6 million by the year 2030. Furthermore, diagnosed cases of dementia are estimated to more than triple by the year 2050.

Dementia is a chronic syndrome, and not a specific disease, but an umbrella term used to describe a group of symptoms caused by brain disorders that affect thinking, behavior, memory, and one's ability to function and perform in everyday life.

People who live with dementia may not be able to perform normal activities like eating and getting dressed due to their symptoms. They may also become agitated quickly and their personalities may change.

A common symptom of dementia is memory loss. However, although many think that memory loss by itself means you have dementia, this simply isn't true.

Even though dementia is common in elderly people, it is not considered to be part of normal aging.

In fact, despite people thinking it's normal and never really pay too much attention to it, dementia actually requires professional treatment. People living with it have problems with more than one brain function, typically in the executive functioning domain.

There are many diseases that are associated with dementia, such as Alzheimer's, Parkinson's, and Huntington's.

Types Of Dementia

There are several ways to classify dementia. It is classified based on the part of the brain that it affects, by whether it's progressive, or not, or by whether it is a result of another disease.

Cortical Dementia

This type of dementia is a result of problems in the outer layer of the brain, known as the cerebral cortex. People living with cortical dementia typically have a problem with memory loss and understanding language.

- Alzheimer's and Creutzfeldt-Jakob disease are two of the most common cortical dementia disorders.

Subcortical Dementia

As you might've guessed it, subcortical dementia attacks the area of the brain found beneath the cortex. Living with it won't usually leave you with language problems and memory loss, but it will affect your speed of thought and ability to begin performing certain activities.

- Huntington's and Parkinson's disease are known to cause subcortical dementia.

Primary Dementia

People who live with primary dementia don't have the symptoms as the result of another disease.

- The best example of primary dementia is Alzheimer's disease.

Secondary Dementia

When a patient is living with secondary dementia, it means that they got it from either an injury or a disease.

- Some of the most common causes of secondary dementia include progressive supra-nuclear palsy, brain infections, and multiple sclerosis.

Although there are certain causes of secondary dementia that can be reversed or stopped, most are degenerative, meaning that there is no way to reverse the damage.

Some of the reversible causes of secondary dementia include chronic alcohol abuse, the use of certain medications, brain tumors, low vitamin B-12 levels, and changes in sodium or calcium levels.

Progressive Dementia

Progressive dementia means that the condition of the patient living with it will only get worse over time. At first, it may not have a big negative effect on the lives of those living with it, but it will cause them to lose more of their abilities as time passes.

- Alzheimer's disease is a good example of progressive dementia.

Most Common Dementia Disorders

Alzheimer's Disease

- According to the Alzheimer's Association, 60% to 80% of all dementia cases are from Alzheimer's disease
- In 2017, there are more than 5 million Americans who live with Alzheimer's disease. 5.3 million of these cases are seen in people ages 65 and older, but about 200,000 individuals are younger than 65 years old living with early (young) onset of Alzheimer's
- 1 in 10 people age 65 and older or 10% live with Alzheimer's dementia
- Almost 2/3 of Americans who live with Alzheimer's are women

On a microscopic level, this disease will affect your brain by creating two abnormalities – neurofibrillary tangles and amyloid plaques.

- Neurofibrillary tangles are basically damaged tau proteins that come together and form tangles, which make it hard for nerve cells to function properly.
- Amyloid plaques are clumps of protein that are positioned between nerve cells, thus impairing communication between them.

It is still not known whether these abnormalities are the result of Alzheimer's disease or if they cause it, although newer research indicates it may be our brain's protective mechanism gone haywire.

The most common early symptoms of Alzheimer's disease include:

- Having difficulty remembering recent events
- Names or recent conversations
- Experiencing depression
- Apathy or lack of initiation
- As the development of the disease progresses, there will be disorientation, confusion, poor judgment, difficulty speaking and walking, impaired communication, and behavior changes.

Vascular Dementia

Vascular dementia is considered to be the second most common cause of dementia. However, it can also occur at the same time as Alzheimer's disease, which can then cause you to live with something even more dangerous – a group of symptoms known as mixed dementia.

Vascular dementia negatively affects the brain by not supplying it with enough blood carrying important nutrients and oxygen. This type of dementia is usually caused by damage from amyloidosis, atherosclerosis, strokes, and endocarditis.

The symptoms associated with vascular dementia either are caused by blood clots or blocked arteries.

The main difference between Alzheimer's disease and vascular dementia is that people living with the latter tend to maintain their personality.

Some of the most common symptoms of vascular dementia include:

- Difficulty concentrating
- Getting lost and wandering
- Inability to follow instructions
- Difficulty managing money
- Depression
- Crying or laughing at inappropriate times
- Nighttime wandering
- Short-term memory loss
- Hallucinations

Causes

Vascular dementia usually never develops in people who don't live with high blood pressure.

Other causes of this type of dementia include strokes, heart disease, diabetes, high cholesterol, and smoking.

Parkinson's Disease

People living with advanced Parkinson's disease usually begin living with dementia as well. The way Parkinson's disease affects your brain is by creating alpha-synuclein clumps in an area of the brain known as substantia nigra. This part of the brain has a big role when it comes to movement and reward. The clumps that form in the substantia nigra cause degeneration of nerve cells known for producing the famous feel-good brain chemical called dopamine.

Symptoms

- The lack of dopamine is exactly why people who live with Parkinson's disease may become irritable, depressed, or paranoid as the development of the disease progresses.
- Other symptoms associated with this disease include difficulty understanding visual information and performing simple daily tasks.
- Certain patients may also experience confusion, hallucination, and difficulty speaking or understanding what someone else is saying.

Lewy Body Dementia

Lewy body dementia represents the third most common type of dementia.

The Lewy body refers to an abnormal protein found in the brain of those living with this kind of dementia. Lewy bodies are made up of proteins known as alphasynucleins. When these alphasynucleins form, they prevent the brain from making enough dopamine and acetylcholine. Dopamine is a chemical that has a huge impact on your mood, sleep, and movement, while acetylcholine has an effect on both your learning and memory.

The most common symptoms of Lewy body dementia are pretty similar to those of Alzheimer's disease:

- These symptoms include confusion, poor judgment, and impaired memory.
- Lewy body dementia can also cause delusions, depression, anxiety, problems with your sleeping pattern, lack of interest, and hallucinations.
- It also causes Parkinsonism symptoms, such as shaking and inability to stand straight.

Multi-Infarct Dementia

Multi-infarct dementia (MID) is actually a type of vascular dementia. It is caused by a number of small strokes in different parts of the brain. These strokes can occur when the smaller blood vessels in your brain are blocked. They can happen anywhere, including both the areas of the brain that won't cause you to display any signs of disability when damaged and very important regions of the brain.

Symptoms

- The most common symptoms associated with MID include short-term memory loss, hallucinations, loss of bowel or bladder control, difficulty focusing, and wandering.

This type of dementia usually occurs in people aged between 55 and 75. It is much more common in men than in women.

The chances of living with Multi-infarct dementia can be increased due to previous strokes, diabetes, high blood pressure, cognitive decline, heart failure, atherosclerosis, excess alcohol consumption, poor diet, little or no physical activity, and smoking.

Huntington's Disease

This is a progressive brain disorder that can be caused by just a single defective gene. Huntington's disease is passed from parent to child through this defective gene. The gene then causes degeneration of nerve cells in a few parts of the brain. However, it almost always targets cells within the basal ganglia, which is a group of structures linked to the thalamus in the very base of the brain.

Symptoms

- Some of the most notable symptoms of this brain disorder include inability to move properly
- Irritability
- Anxiety
- Depression
- Decline in cognitive skills
- Some patients even show signs of psychotic behavior

Considering that this is a progressive brain disorder, Huntington's disease symptoms will only get worse over time.

Creutzfeldt-Jakob Disease (CJD)

CJD can attack both animals and humans and it is in the same family of diseases as bovine spongiform encephalopathy, better known as the mad cow disease. The main way this disease can harm you is by causing the prion proteins throughout your brain to fold into abnormal shapes. The shapes of these proteins will cause your brain cells to die.

The three main types of Creutzfeldt-Jakob disease are sporadic, infectious, and familial.

- Sporadic CJD is the most common type, but health experts are yet to find out what causes it.
- Familial CJD cases are a lot less frequent, and can only be genetically transmitted from parent to child.
- Finally, infectious CJD is the least frequent, and people can get it only from exposure to an external source of mis-folded prion protein.

The most common symptoms of Creutzfeldt-Jakob disease include:

- Muscle stiffness
- Depression
- Difficulty walking
- Mood swings
- Agitation
- Disorientation
- Memory loss
- Confusion
- Apathy

Corticobasal Degeneration

Corticobasal degeneration (CBD) is characterized by the loss of nerve cells in the basal ganglia and the cerebral cortex of your brain. Health experts believe that there are numerous factors that can contribute to CBD, such as environmental factors, genetic mutations, and different factors related to aging.

When it comes to symptoms, CBD shares some with Parkinson's and some with Alzheimer's disease:

- Poor coordination
- Memory loss
- Shaking
- Difficulty swallowing
- Difficulty speaking

People living with CBD often can't take care of themselves, and usually die from secondary medical issues like sepsis.

Frontotemporal Dementia

Previously known as Pick's disease, and now often referred to as frontal lobe dementia, this is a group of unusual disorders that affects the temporal and frontal lobes of your brain.

These brain regions are responsible for controlling your emotions, behavior, speech, judgment, and movement. Degeneration of the nerve cells found in the frontal and temporal regions of your brain is what causes frontotemporal dementia.

Symptoms

Symptoms of this type of dementia usually occur in patients who are in their 50s and 60. However, know that it can even affect people as young as 45 years old.

- Changes in behavior
- Lack of judgment
- Loss of empathy

- Apathy
- Lack of awareness
- Changes in eating habits
- Decline in personal hygiene
- Display of inappropriate actions

Dementia Pugilistica

Commonly referred to as boxer's syndrome, this type of dementia is the result of chronic brain injury, and is often the type of dementia many professional athletes (especially boxers) live with.

The most common symptoms of dementia pugilistica include:

- Physical tremors
- Memory loss
- Poor coordination
- Difficulty walking
- Slurred speech

Mixed Dementia

This is the last (and most serious) form of dementia. It refers to a condition where the person suffers from two or more types of dementia.

As previously mentioned, the most common combination that results in mixed dementia is Alzheimer's disease and vascular dementia.

The Jersey Alzheimer's Association notes that up to 45% of patients who live with dementia actually have mixed dementia, but simply aren't aware of it.

Depending on the combination of the disorders that result in mixed dementia, the symptoms can vary greatly.

The Causes Of Dementia

Researchers have yet to find answers to the many questions often asked about dementia. The thing we do know is that all forms of dementia are the result of either your brain cells dying and decaying, or due to certain abnormalities that may be created between brain cells.

In some types of dementia, certain abnormal proteins can form between your neurons, and cause you to experience the horrifying symptoms of dementia.

However, it is still unknown if these proteins can cause dementia, or if they're caused by it. Some types of dementia are hereditary, while others are caused by a combination of environment, lifestyle, and for some people, genetics. Just because there is a genetic component, DOES NOT MEAN THAT YOU WILL GET IT, especially if you are proactive.

The reason why you experience the symptoms of dementia is that the damage that your brain cells suffer interferes with their ability to communicate with each other. Your feelings, thinking, and behavior all get affected if your brain cells don't communicate well.

Some of the known causes of dementia include:

- Any type of poisoning (lead, alcohol, recreation drugs, or any other kind of poisonous substance)
- Deficiencies in vitamins B1, B6, and/or B12
- Electrolyte abnormalities
- Severe dehydration
- Low oxygen levels in the blood
- Acute infections like encephalitis, Lyme disease, Urinary Tract infections and meningitis.
- Brain tumors
- Traumatic brain injuries
- Some types of hydrocephalus
- Depression
- Thyroid problems
- High blood sugar

- Inflammation
- Mold/toxicity
- Suboptimal nutrition

Treatment Options For Dementia

Newer research is promising to prevent dementia, especially when started earlier, and combining different types of treatment can help. Treatment options vary depending on the type of dementia you're living with.

Alzheimer's Disease

Mainstream medical practitioners say there is no known cure for this disease. The medications used to treat Alzheimer's disease are known as cholinesterase inhibitors. These medications work by temporarily improving or stabilizing your thinking skills and memory but, ironically, can make your memory worse!

However, it's worth noting that it may not have any impact on certain individuals.

- Doctors prescribe antidepressants, sedatives, and anticonvulsants in order to treat some of the problems associated with Alzheimer's disease, such as sleep disorders, anxiety, insomnia, and depression.

Vascular Dementia

No type of treatment will help repair the damage already caused by vascular dementia. ***However, like all cardiovascular diseases, a healthy lifestyle can help slow down the development of this type of dementia.***

It can be extremely helpful to remind the patient what day it is, keep them connected to their loved ones, and leave reminder notes near them. If vascular dementia goes untreated, it usually leads to death from heart disease, stroke, or infection. It is interesting to note that health insurances are slowly starting to pay for health coaches to decrease risk of cardiovascular disease.

Parkinson's Disease

Unfortunately, there is no cure for Parkinson's disease, but newer research is also indicating that it can be mitigated through improved living and lifestyles. The current strategy that doctors use is prescribing medications to help you deal with some of the symptoms you may be experiencing.

- Some of the most common medications used to treat symptoms of Parkinson's disease include antipsychotics, cholinesterase inhibitors, clonazepam, and antidepressants.

Multi-Infarct Dementia

There is no known cure for multi-infarct dementia, although it is highly encouraged that patients use medication and do regular cognitive training to preserve their brain function. Lifestyle changes and improved blood sugar can help with multi-infarct dementia as well.

- Some of the most notable medications used to treat multi-infarct dementia include memantine, hydergine, nimodine, CDP-choline, and folic acid.
- Serotonin reuptake inhibitors and calcium channel blockers are also often used to treat MID.
- Additionally, rehabilitation, regular exercise, and cognitive training are all considered smart treatment options.

Huntington's Disease

There is no known way to stop or slow down the development of Huntington's disease.

- Doctors prescribe certain medications to help deal with movement and emotional problems associated with Huntington's

Life expectancy after diagnosis is between 10 and 15 years.

Creutzfeldt-Jakob Disease (CJD)

Although therapy and certain medications may help you cope with some symptoms, there is no treatment that will help you with stopping or slowing down the development of Creutzfeldt-Jakob disease.

Around 90% of people living with CJD die within a year of being diagnosed.

Lewy Body Dementia

There are no medications known for reversing or stopping Lewy body dementia. However, there are some medications and treatment options that may help relieve certain symptoms.

- Medications such as levodopa, donepezil, clonazepam, rivastigmine, and melatonin are often used to treat this type of dementia.
- Additionally, psychotherapy, counseling, and physical and occupational therapy are known for improving the condition of those living with Lewy body dementia.

Considering that LBD is a progressive disease, the lifespan of patients living with it is between 5 to 8 years after diagnosis.

Complications such as poor nutrition, pneumonia, immobility, and swallowing difficulties are what usually lead to death.

Corticobasal Degeneration

There isn't a treatment that could help stop or slow down the development of corticobasal degeneration.

- There are certain medications that may help treat symptoms of it. As time passes, your mental health will get much worse, since degeneration will start to occur in many different parts of the brain.

Frontotemporal Dementia

There is no way to slow down the progression or cure frontotemporal dementia.

- Antipsychotics and antidepressants usually are prescribed to patients in order to ease their symptoms.

The lifespan of people living with frontotemporal dementia is 6 to 8 years after diagnosis.

Dementia Pugilistica

There is no available treatment for stopping or slowing down the progression of dementia pugilistica.

- Patients living with this type of dementia often are prescribed some of the same medications as those living with Alzheimer's disease.

WHERE TO GO:

CARGO (THE BURDEN BEING CARRIED)

STAGES OF DEMENTIA

DEMENTIA STATISTICS

Alzheimer's Disease International

<https://www.alzint.org/>

Alzheimer's Association

<https://www.alz.org/>

Dementia Map

<https://www.dementiamap.com/>

TYPES OF DEMENTIA

2021 Update Dementia Overview

Jerry Beller Health Research

The End of Alzheimer's

Dr. Dale Bredezen

Preventing Alzheimer's

Dr. William Shankle and

Dr. Daniel Amen

CAUSES OF DEMENTIA

The End of Alzheimer's

Dr. Dale Bredezen

Grain Brain

Dr. David Perlmutter

PREVENTING DEMENTING

The End of Alzheimer's

Dr. Dale Bredeesen

Grain Brain

Dr. David Perlmutter

The Anti Alzheimer's Prescription

Dr. Vincent Fortanasce

MODULE 5: USING THE ENGINES TO MOVE FORWARD

RIGHT ENGINE

NORMAL PHYSICAL DEVELOPMENT

Infant -- birth to 1 year

- Able to drink from a cup
- Able to sit alone, without support
- Babbles
- Displays social smile
- Gets first tooth
- Plays peek-a-boo
- Pulls self to standing position
- Rolls over by self
- Says mama and dada, using terms appropriately
- Understands "NO" and will stop activity in response
- Walks while holding on to furniture or other support

Toddler -- 1 to 3 years

- Able to feed self neatly, with minimal spilling
- Able to draw a line (when shown one)
- Able to run, pivot, and walk backwards
- Able to say first and last name
- Able to walk up and down stairs
- Begins pedaling tricycle
- Can name pictures of common objects and point to body parts
- Dresses self with only a little bit of help
- Imitates speech of others, "echoes" word back
- Learns to share toys (without adult direction)
- Learns to take turns (if directed) while playing with other children
- Masters walking
- Recognizes and labels colors appropriately
- Recognizes differences between males and females
- Uses more words and understands simple commands
- Uses spoon to feed self

Preschooler -- 3 to 6 years

- Able to draw a circle and square
- Able to draw stick figures with two to three features for people
- Able to skip
- Balances better, may begin to ride a bicycle
- Begins to recognize written words, reading skills start
- Catches a bounced ball
- Enjoys doing most things independently, without help
- Enjoys rhymes and word play
- Hops on one foot
- Rides tricycle well
- Starts school
- Understands size concepts
- Understands time concepts

School-age child -- 6 to 12 years

- Begins gaining skills for team sports such as soccer, T-ball, or other team sports
- Begins to lose "baby" teeth and get permanent teeth
- Girls begin to show growth of armpit and pubic hair, breast development
- Menarche (first menstrual period) may occur in girls
- Peer recognition begins to become important
- Reading skills develop further
- Routines important for daytime activities
- Understands and is able to follow several directions in a row

LEFT ENGINE

NORMAL COGNITIVE DEVELOPMENT

There is general agreement that there are three core Executive Functions:

1. inhibition [inhibitory control, including self-control (behavioral inhibition) and interference control (selective attention and cognitive inhibition)],
2. working memory (WM), and
3. cognitive flexibility (also called set shifting, mental flexibility, or mental set shifting and closely linked to creativity).

From these, higher-order Executive Functions are built such as reasoning, problem solving, and planning . Executive Functions are skills essential for mental and physical health; success in school and in life; and cognitive, social, and psychological development.

INHIBITION AND INTERFERENCE CONTROL:

- a. Emotional regulation
- b. Forethought

- c. Attention/Concentration
- d. Self regulation (able to get back on task without external assistance)
- e. Behavioral inhibition (stop and think about what is happening and how to respond without becoming distracted by environment)

WORKING MEMORY:

[Business vector created by fullvector - www.freepik.com](https://www.freepik.com/vectors/business)



COGNITIVE FLEXIBILITY:

1. Ability to switch from one thought to another
2. Contemplate more than one thought at a time
3. Cognitive inflexibility results in:
 - a. Difficulty in learning new concepts
 - b. Difficulty when rules change
 - c. People with dementia really struggle with cognitive flexibility

	 A red triangular warning sign with a black exclamation mark in the center.
 A photograph showing a white alarm clock on a yellow background next to a clipboard with a pen. The clipboard has a piece of paper titled "Time Management" with a numbered list from 1 to 5.	
	 A photograph of several white eggs in a woven basket, each with a simple, hand-drawn face.



MODULE 6: AVOIDING TURBULENCE BY STABILIZING

THE STABILIZERS

- HORIZONTAL STABILIZERS CONTROL UP/DOWN OF NOSE
 - CHALLENGING BEHAVIORS
- VERTICAL STABILIZERS CONTROL SIDE TO SIDE SWINGING
 - MEANINGFUL ACTIVITIES

THE ELEVATORS

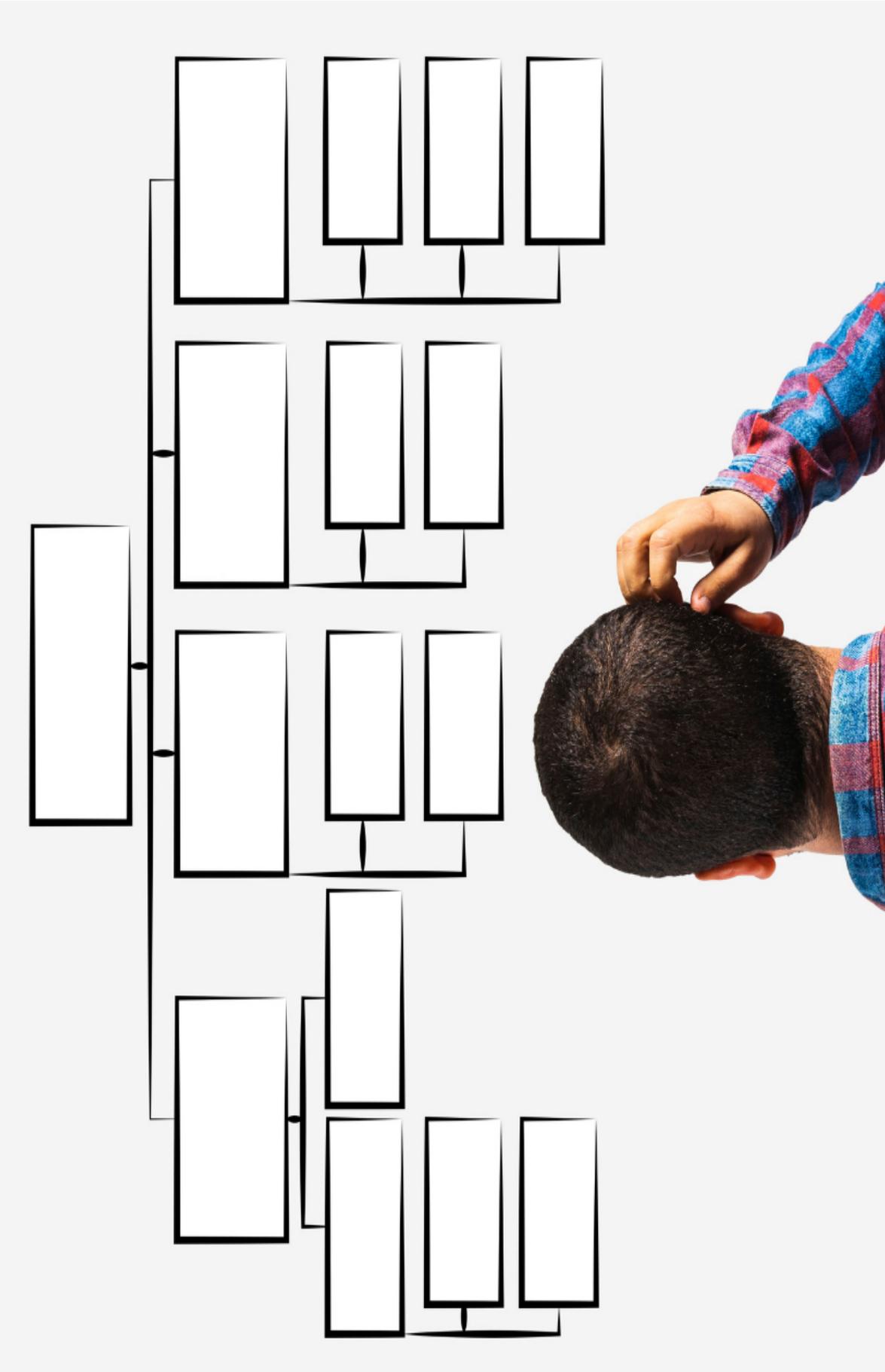
- CHANGE DIRECTION UP AND DOWN
 - COMMUNICATION STRATEGIES

THE SLATS

- INCREASE LIFT AND DRAG
 - CAREGIVER READINESS TO CHANGE

CHALLENGING BEHAVIORS:

What are “Challenging Behaviors” in dementia? How are we to look at them? Are they an attempt to communicate an unmet need? Or are they an attempt to communicate with us? Are they just what is left when we “draw back the cognitive curtain” and the rational thought processes go away and we are left with the emotional responses?



MEANINGFUL ACTIVITIES:

DEMENTIA MADE SIMPLE FORMULA FOR SUCCESS

A. I. M² + P. E. A. C. E = E

Caregiver Readiness to Change Transtheoretical Model

(Prochaska et al, 1992)

1. Pre contemplation:

- Pt/Caregiver demonstrates no understanding of problem, unable to attribute problem to level of independence, or seems confused or unclear about impact of problems on independence
- Pt/Caregiver will need basic education about the problem and simple strategies and activities that they can easily introduce are important to provide initially.

2. Contemplation:

- Pt/Caregiver recognizes something is wrong/has a problem but are not quite sure if change is necessary.
- Pt/Caregiver will need basic education about disease and validation that a change in their approach is necessary (adaptive devices, tools, environmental changes)

3. Preparation:

- Refers to a pt/caregiver who understands there is a problem, has thought about the ways they may need to change but are unclear what change entails and if they can manage it. Don't know what to do.
- Pt/Caregiver will need education and validation and specific instruction in strategies to implement activities/changes to the environment.
- This is where pt/caregiver teaching happens and is assimilated.

4. Action/Maintenance:

- The goal of the INTERVENTION is to move people to this stage.
- Some pt/caregivers may begin the INTERVENTION at this stage of readiness.
- Some pt/caregivers will never reach this during INTERVENTION

Hierarchy of Caregiving Needs:



Stress Reduction Techniques:

Self Care Strategies:

MODULE 7: KEEPING THE FLIGHT IN THE AIR

WINGS

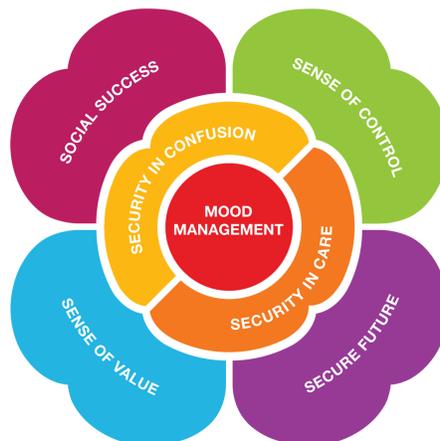
- ALLEN COGNITIVE DISABILITIES MODEL
- SKILLS2CARE
- POSITIVE APPROACH TO CARE
- DEMENTIA WITH DIGNITY

Allen Cognitive Disabilities Model:

Skills2Care:

Positive Approach To Care:

Dementia and Alzheimer's Wellbeing Network (DAWN):



MODULE 8: INFLIGHT SAFETY INSTRUCTIONS

CASE STUDIES

- CASE STUDY 1: MILD COGNITIVE IMPAIRMENT
- CASE STUDY 2: MILD DEMENTIA
- CASE STUDY 3: MODERATE DEMENTIA
- CASE STUDY 4: SEVERE DEMENTIA
- CASE STUDY 5: END OF LIFE

NICE TO KNOW SECTION:

- ADAPTIVE DEVICES
- BATHING
- DRESSING
- EATING
- EXERCISE AND ROM
- GROOMING
- LEISURE
- TOILETING
- TRANSFERS
- WALKING

 FAST/ACLS Approaches

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