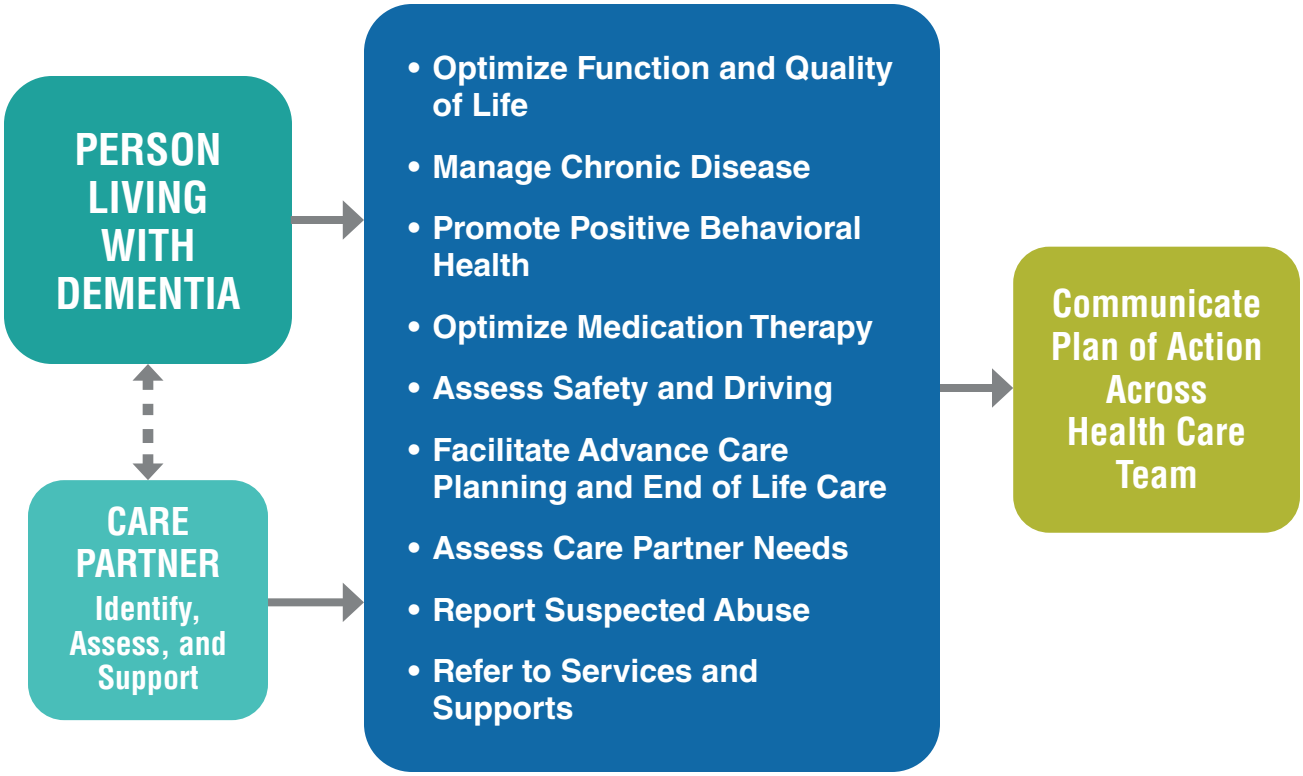
Dementia Action Collaborative Washington State

Dementia Care Plan and Clinical Tool Beyond Diagnosis

DEMENTIA THROUGH THE CONTINUUM



This document offers guidance for clinical care, primarily, after the diagnostic phase. For guidance on care during diagnosis and early stage needs, see the Clinical Provider Practice Tool.

How to use this tool:

Health Care Teams, find the topic of interest in the Table of Contents (page 2). Each area of interest includes professional resources, and resources to share with care partners and families.

Using Dementia as the Organizing Principle for Dementia Care and Comorbidities

TABLE OF CONTENTS

OPTIMIZE FUNCTION AND QUALITY OF LIFE

- Assess the cognitive and functional status.
- Identify preserved capacities/preferred activities; encourage socializing and participating in activities.
- Refer to an occupational therapist and/or physical therapist to maximize independence.
- Encourage lifestyle changes that may reduce disease symptoms or slow their progression (e.g., establish routines for a person with disease and care partner).
- Work with the health care team to appropriately treat conditions that can worsen symptoms or lead to poor outcomes, including depression, alcohol/substance use, hearing loss and existing medical issues.

Professional Resources

- Instrumental Activities of Daily Living (IADL): Try_This_General_Assessment_23.pdf (hign.org)
- Activities of Daily Living (ADL): Try_This_General_Assessment_2.pdf (hign.org)
- FAST Scale: hartfordhealthcare.org/file-library/education-and-research/continuing-medical-education/dementia---fast-scale.pdf
- Patient Health Questionnaire (PHQ-9) (ahrq.gov)
- Final Recommendation Statement: Cognitive Impairment in Older Adults: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
- Fundamentals of Person-Centered Care for Individuals With Dementia | The Gerontologist | Oxford Academic (oup.com)
- Person-Centered Assessment and Care Planning | The Gerontologist | Oxford Academic (oup.com)
- From Research to Application: Supportive and Therapeutic Environments for People Living With Dementia | The Gerontologist | Oxford Academic (oup.com)
- Hearing Loss and the Dementia Connection

Family Resources

- Alzheimer's Stages - Early, Middle, Late Dementia Symptoms | alz.org
- Free Best Friends™ resources - Best Friends Approach
- Support Groups | Alzheimer's Association
- iCare Home (icarefamily.com)
- Alzheimer's Help & Support | Alzheimer's Association
- Caregiving - Alzheimer's & Dementia | Alzheimer's Association
- Partnering with Your Healthcare Provider | Dementia & Palliative Education Network (uw.edu)
- Hearing Loss and Alzheimer's / Dementia – Links, Tips and Solutions

MANAGE CO-MORBID/CHRONIC CONDITIONS

- As dementia progresses, modify treatment goals and thresholds.
- Create a plan of care for chronic conditions (e.g., CHF, diabetes) to prevent potentially harmful hospitalization, minimize risks (e.g., infection, delirium).
- Schedule regular health care provider visits, encourage care partner presence and involvement.
- Ensure the person living with dementia and care partner have the knowledge and skills needed to carry out the care plan.

Professional Resources

- Guiding Principles for the Care of Older Adults with Multimorbidity: A Stepwise Approach for Clinicians (geriatricscareonline.org)
- Introducing GeriKit: A Geriatric Assessment Toolkit (aginghearts.org)
- Present Algorithms and Future Treatments for Alzheimer's Disease - IOS Press
- Comprehensive Geriatric Assessment (more) - CGA Toolkit Plus (cgakit.com)
- Evidence-Based Interventions for Transitions in Care for Individuals Living With Dementia | The Gerontologist | Oxford Academic (oup.com)
- Brief Cognitive Screening Tools for Primary Care Practice

Family Resources

- Tip Sheet: A Guide to Geriatric Syndromes: Common and Often Related Medical Conditions in Older Adults | HealthInAging.org
- Dementia Care Roadmap: A Guide for Family and Care Partners
- Dementia Road Map: A Guide for Family and Care Partners.pdf (Spanish version)

PROMOTE POSITIVE BEHAVIORAL HEALTH

- Key steps to promoting positive behavioral health include:
  - o If/when there are suden or acute changes in behavioral expressions and other symptoms, then consider other medical conditions including delirium.
  - o Define and categorize the target behavioral expression and other symptoms (Examples: hallucinations, delusions, physical aggression, spontaneous disinhibition, mood-related).
    - Identify and address the unmet need(s) (see Figure 1: Screening, Identifying, and Managing Behavioral Symptoms in Patients With Dementia on page 15).
    - Only treat conditions that are bothersome or negatively affect the quality of life of the person with the disease.
  - o Initiate non-pharmacologic therapies aimed at reducing the target symptom.
    - See Table 1: Potential Non-pharmacologic Strategies on page 16.
    - See Table 2: General Non-pharmacologic Strategies for Managing Behavioral Symptoms on page 18.
    - Teach or reinforce with families:
      - □ Routine is essential as is a stable environment.
      - □ Control the level of stimulation in the person's environment.
      - □ Give the patient "tasks" that match his/her level of competency.
      - □ Validate underlying feelings of behavior (e.g., sadness, frustration, fear); this means listening, comforting, redirecting, and/or reapproaching as needed.
    - Be proactive:
      - □ Write orders for non-pharmacologic interventions.
      - □ Teach families to think of behaviors as a form of communication or reflecting an unmet need.
      - □ Encourage families to learn about communication and behavior.
      - □ Provide resources and/or make referrals to connect families to the Alzheimer's Association and/or the Family Caregiver Support Program.
  - o Consider pharmacologic interventions only when non-pharmacologic interventions consistently fail and the person is in danger of harming self or others, or when intolerable psychiatric suffering is evident.
    - **Note: there is no FDA-approved medication for Behavioral and Psychological Symptoms of Dementia (BPSD); nor strong scientific evidence to support any particular class of medications.** Suppose these medications are used, for example in Palliative care. In that case, document in the medical record that the black box warning was discussed with

PROMOTE POSITIVE BEHAVIORAL HEALTH (continued)

family caregivers/ POA and counsel caregivers to monitor for degraded functional or cognitive status, sedation, falls, or delirium.

- Regularly attempt to wean or discontinue the anti-psychotic medication as soon as possible.
- Regularly monitor target behaviors to evaluate the efficacy of medication, if started.

Professional Resources

- Assessment and Management of Behavioral and Psychological Symptoms of Dementia/Using DICE Approach
- Management of Neuropsychiatric Symptoms of Dementia in Clinical Settings: Recommendations from a Multidisciplinary Expert Panel (diceapproach.com)
- Managing Behavioral Symptoms in Dementia: Podcast with Helen Kales (geripal.org)
- ABC of Behavior Management (dementiamanagementstrategy.com)
- Dementia Education | ACT on Alzheimer's
- Confusion Assessment Method.doc (mnhospitals.org)
- Pain Assessment Information | GeriatricPain.org - The University of Iowa
- Cohen-Mansfield Agitation Inventory (CMAI) (oregonbhi.org)
- Validation Therapy: Gladys Wilson and Naomi Feil - YouTube
- Clinical Practice Guidelines for Management of Delirium in Elderly (nih.gov)
- Non-pharmacological Management of Behavioral and Psychological Symptoms of Dementia: What Works, in What Circumstances, and Why? | Innovation in Aging | Oxford Academic (oup.com)
- Evidence-Based Non-pharmacological Practices to Address Behavioral and Psychological Symptoms of Dementia

Family Resources

- Alzheimer's Association - Challenging Behaviors
- Patient education: Delirium (Beyond the Basics) - UpToDate
- Delirium: A guide for families | University of Iowa Hospitals & Clinics (uihc.org)
- Caregiver Toolkit.pdf (geriatricpain.org)
- 20 Questions to Change the Direction of Dementia Anxiety and Aggression (myalzheimersstory.com)
- Caregiver Training Videos - UCLA Alzheimer's and Dementia Care Program (uclahealth.org)
- TheEldercareMethodInterdisciplinaryTeamModel.docx (nursinghometoolkit.com)
- Tip Sheets for Family and Care Partners | DSHS (wa.gov)

OPTIMIZE MEDICATION THERAPY

- Perform and document a medication reconciliation, including vitamins and herbal remedies. Pharmacists or technicians may help in identifying the most recently filled items.
- Employ a multimodal approach to pain, considering topical and non-opioid options first. Only use opioids for acute pain syndromes. Avoid the use of opioids for chronic noncancer pain. Taper opioids as able. For patients with mild to moderate dementia, consider non-pharmalogical / complementary therapies such as chicropractic, physical therapy, occupational therapy, acupuncture.
- Evaluate for polypharmacy or adverse drug reactions. Identify medication side effects and avoid prescribing new medications to address these.
- Periodically reassess the value of any medications, including those being used for cognitive symptoms; consider a slow taper if the continued benefit is unclear.
- Recommend a care partner or health care professional oversees/dispenses medications as needed; bubble packs may facilitate medication adherence.
- Avoid or minimize anticholinergics, benzodiazepines, z-drugs as well as antipsychotics. Ask about over-the-counter sleep aids and allergy treatments. Medications such as Tylenol PM or Benadryl or products that contain diphenhydramine are a significant cause of delirium in dementia. They can increase risk of dementia in the general population.
  - Consult updated Beers Criteria or the STOP/START or Deprescribing.org for guidance.
- Behavioral symptoms in patients with underlying dementia may often be addressed with non-pharmacological methods: special attention should be paid to pain and basic needs (urinary retention, constipation, etc.) that may be overlooked inadvertently. Addressing these can make pharmacologic treatment unnecessary. Generally, antipsychotics should not be used as the first choice to treat behavioral and psychological symptoms of dementia due to limited benefit and substantial risk including worsening cognition, increased likelihood of falls, strokes, and mortality more generally. choosingwisely.org.
- Benzodiazepines have limited benefit; unless at the end of life and in rare complex situations.
- In the acute management of agitation in patients with a history of dementia who have failed non-pharmacologic management and pose an imminent threat to themselves or others, second-generation antipsychotics including quetiapine should be considered above benzodiazepines and first-generation antipsychotics due to adverse drug reactions. Use the lowest dose for the shortest period of time.
- Special considerations should be given to giving atypical antipsychotics to those with underlying Parkinson's or Lewy Body Disease.

OPTIMIZE MEDICATION THERAPY (continued)

Professional Resources

- For Older People, Medications Are Common; Updated AGS Beers Criteria® Aims to Make Sure They're Appropriate, Too | American Geriatrics Society
- START (screening tool to alert doctors to the right treatment)—an evidence-based screening tool to detect prescribing omissions in elderly patients | Age and Ageing | Oxford Academic (oup.com)
- STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions): application to acutely ill elderly patients and comparison with Beers' criteria | Age and Ageing | Oxford Academic (oup.com)
- Basics-of-individualized-quality-care-factsheet-final.pdf (theconsumervoice.org)
- Psychopharmacologic Interdisciplinary Medication Review (mpqhf.org)
- IA-ADAPT | Iowa Geriatric Education Center - The University of Iowa (uiowa.edu)
- Cumulative use of strong anticholinergics and incident dementia: a prospective cohort study - PubMed (nih.gov)

Family Resources

- Improve Dementia Care by Reducing Unnecessary Antipsychotic Drugs
- Antipsychotic Medicines for People with Dementia (mpqhf.org)
- AntipsychotFactsheet.pdf (oregon.gov)

ASSESS SAFETY AND DRIVING

- Continue to discuss safe driving.
  - o Refer to driving rehabilitation specialist for clinical and/or in-vehicle evaluation.
  - o Report an at-risk driver.
- Continue to discuss home safety and fall risk.
  - o Refer to an occupational therapist and/or physical therapist, if indicated, to address fall risk, sensory/mobility aids, and home modifications.

Professional Resources

- WA State Licensing (DOL) Official Site: Report unsafe drivers
- Physician's Guide to Assessing and Counseling Older Drivers-Table of Contents (nhtsa.gov)
- Summaries of the Updated American Geriatrics Society/British Geriatrics Society / Clinical Practice Guideline for Prevention of Falls in Older Persons and the 2010 AGS/BGS (geriatricscareonline.org)
- AOTA - Find A Driving Specialist
- Update: Evaluation and Management of Driving Risk in Dementia (aan.com)
- Practice Parameter Update - Evaluation and Management of Driving Risk in Dementia

Family Resources

- At the Crossroads: Family Conversations about Alzheimer's Disease, Dementia, and Driving
- Dementia & Driving | Alzheimer's Association
- 24/7 Wandering Support for a Safe Return | alz.org
- Dementia Safety Info Kit | Dementia Action Collaborative

FACILITATE ADVANCE CARE PLANNING AND END OF LIFE CARE

- **Recommend the patient completes their healthcare advance directives, DPOA for healthcare, and DPOA for finances.**
  - o This becomes even more important to complete in persons with a new diagnosis of dementia or MCI. The ability to imagine future outcomes and name preferences for care, especially in writing, is lost early.
  - o A dementia directive is a specific document that may be used as a supplement or addendum to a standard advance directive, which may not adequately cover dementia.
  - o Offer or review the Dementia Legal Planning Toolkit link or hardcopy.
- **Continue to discuss care goals, values, and preferences with a person with the disease and family.**
  - o Begin discussion early in the disease and continue throughout the course of the illness.
  - o Include information about the disease process and end of life, to help manage expectations and set appropriate goals of care.
  - o Prior to the advanced stages of dementia, a person may still maintain the ability to say what is important to them in verbal interactions, especially with those they trust.
- **Complete POLST form early in the disease and routinely re-evaluate / modify the plan of care as appropriate.**
  - o As dementia progresses, medical interventions and medications that were once beneficial may have deleterious effects in persons with advanced dementia, particularly for those approaching end of life.
  - o POLST forms should be updated to reflect evolving goals of care.
  - o Continued communication between caregivers, family members, and providers is essential to ensuring that these goals of care are upheld.
- **Discuss the role of palliative care in providing anticipatory guidance and symptom management.**
  - o Palliative care is a consulting medical specialty for people with serious, life-limiting illnesses whose primary goal is symptom management including pain and other forms of suffering.
  - o Palliative care also frequently assists families with making difficult and complex medical decisions including advance care planning. They can provide the person with dementia and their family anticipatory guidance as the illness progresses and assist in implementing a plan that fits their goals of care. Topics and symptoms to discuss often include feeding difficulties/ appetite changes, mood and sleep disturbances, infections, polypharmacy, and skin break-down related to limited mobility.
  - o Patients followed by a palliative care team may continue to receive full treatment for their diseases. Palliative care can be found in both inpatient and outpatient settings, depending on local resources.

FACILITATE ADVANCE CARE PLANNING & END OF LIFE CARE (continued)

- **Encourage timely and appropriate referrals to hospice.**
  - o Hospice provides comfort-focused medical care and support services for patients who have a terminal diagnosis with a prognosis of 6 months or less as determined by a healthcare professional.
  - o The hospice team includes a nurse, social worker, spiritual support, the oversight of a hospice physician, and multiple other components including medical equipment and bereavement support.
  - o When considering referral to hospice it is helpful to ask the question, "Would you be surprised if this person died in the next 6 months?"
  - o Although most hospice care is delivered at home, it is available in many other settings including nursing facilities.

Professional Resources

- Prognostication in Dementia - Palliative Care Network of Wisconsin (mypcnow.org)
- Medicare hospice benefit guidelines for dementia prognosis - UpToDate
- Local Coverage Determination for Hospice - Determining Terminal Status (L33393) (cms.gov)
- Myths About Advance Directives - Palliative Care Network of Wisconsin (mypcnow.org)
- Washington State Medical Association POLST (Portable Orders for Life-Sustaining Treatment)
- Palliative Care for People with Dementia: Why Comfort Matters in Long-Term Care (capc.org)
- Patient Priorities Care

Family Resources

- Washington State Medical Association POLST (Portable Orders for Life-Sustaining Treatment)
- Legal Planning | DSHS (wa.gov)
- Dementia Legal Planning Toolkit | WashingtonLawHelp.org | Helpful info about the law in Washington
- CaringInfo: Resources for serious illness and end-of-life care decision-making and caregiving
- Palliative Care Road Map: A Guide for patients and those who care for them (wa.gov)
- Home - Washington State Hospice & Palliative Care Organization (wshpco.org)
- The Conversation Project - Have You Had The Conversation?
- Advance Directive for Dementia (dementia-directive.org)
- Home - Honoring Choices PNW
- Patient Priorities Care - Implementation Toolkit - Patient-facing Materials

ASSESS CARE PARTNER / FAMILY CAREGIVER NEEDS

- Identify care partners and assess their health and emotional well-being.
- Identify care partners in their own medical record (if accessible).
- Encourage care partners to review Partnering with Your Healthcare Provider toolkit and to utilize the suggested care management tools.
- Encourage selfcare of care partner.
  - o Offer suggestions to the care partner for maintaining their own health and well-being.
  - o Include care partner support services (e.g., counseling, support groups, respite) in the care plan for the person with dementia.
- Consider reserving a portion of the visit to speak with the older adult patient alone to allow time for open communication. Example questions to ask: "Is anyone hurting you?" "Is anyone taking your money without your permission?" "Are you afraid of anyone?"

Professional Resources

- Caregiver-Self-Assessment-Questionnaire.pdf (healthinaging.org)
- Zarit Burden Interview (apa.org)
- Using a HIPAA-compliant form, you can refer a family caregiver to the Family Caregiver Support Program (FCSP) https://washingtoncommunitylivingconnections.org/consite/connect/refer_a_patient.php
- Geriatric-Injury Documentation Tool (Geri-IDT) | USC Center for Elder Justice

Family Resources

- Alzheimer's Association 24/7 Helpline: 1-800-272-3900 (accommodates more than 200 languages) or www.alz.org
- Dementia Road Map: A Guide for Family and Care Partners | Dementia Action Collaborative
- Dementia Road Map: A Guide for Family and Care Partners.pdf (Spanish version)
- Washington State's Family Caregiver Support Program (FCSP) uses an evidence-based assessment tool to identify specific stressors for each family caregiver and develops a plan of helpful resources and services. The FCSP offers various of support services to help the person with dementia and/or the family caregiver that are free or low cost.

HELP PROTECT VULNERABLE ADULTS AND REPORT SUSPECTED ABUSE

- Adult Protective Services (APS) is dedicated to serving vulnerable adults. APS investigates reports regarding the suspected abuse and maltreatment of vulnerable adults in Washington State. APS collaborates with other agencies to offer protective services as needed. The goal is to promote lives free of harm while respecting individual choices.
  - Learn more about APS services: Adult Protective Services (APS) | DSHS (wa.gov)
  - Learn about the types of abuse: Vulnerable Adult Mistreatments | DSHS (wa.gov)
- Report suspected abuse, neglect (including self-neglect), or financial exploitation.
  - Under Washington statutes, licensed health care professionals and professionals engaged in the care of a vulnerable adult are mandated to report suspected maltreatment of a vulnerable adult. Anyone can report suspected abuse, abandonment, neglect, self-neglect, or financial exploitation to Adult Protective Services (APS) Central Intake.
  - Online Incident Report (wa.gov) The benefits of online reporting include a confirmation number and 24-hour availability to reporters, seven days a week.
  - By phone: 1-877-734-6277
  - By Email: apscentralintake@dshs.wa.gov

Professional Resources

- Recommendation: Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
- Report Concerns Involving Vulnerable Adults | DSHS (wa.gov)
- NCEA BRIEF: APS wouldn't take my report. Why? (acl.gov)
- The Abuse Intervention Model: A Pragmatic Approach to Intervention for Elder Mistreatment (nih.gov)

Family Resources

- S.A.F.E. (Stop Abuse & Financial Exploitation) Elders Initiative
- Adult Protective Services - Help Protect Vulnerable Adults
- Community Connections - Vulnerable Adult Abuse Prevention

REFER TO SERVICES AND SUPPORTS

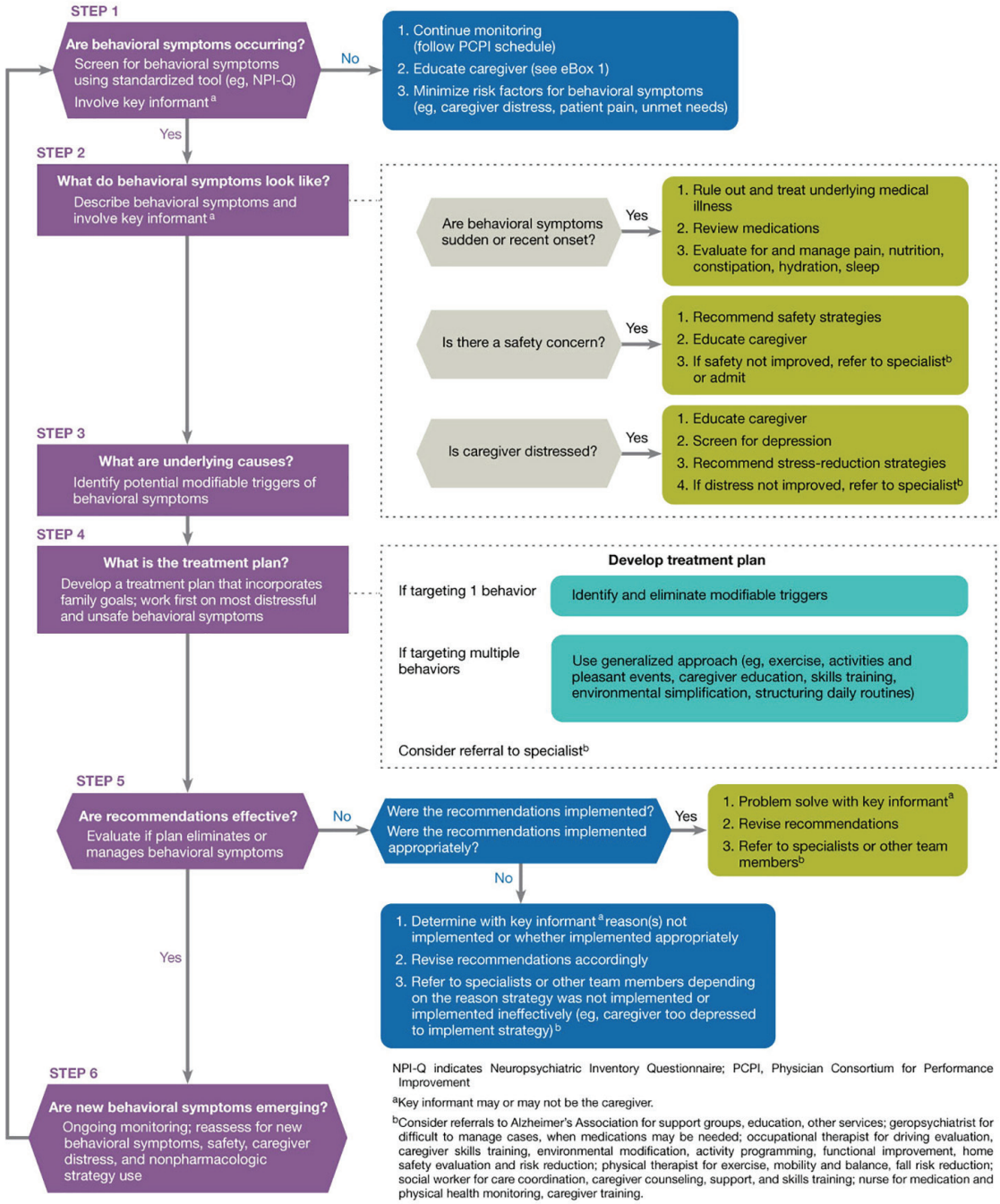
- Alzheimer's Association 24/7 Helpline at 1-800-272-3900 or visit them online at www.alz.org
- Community Living Connections: Links to personalized care and support options. 1-855-567-0252 or memorylossinfowa.org
- Hearing Loss Association of America - Washington State

RESOURCES

- Alzheimer's Disease and Other Dementias | Bree Collaborative (qualityhealth.org)
- Dementia Legal Planning Toolkit | WashingtonLawHelp.org | Helpful information about the law in Washington
- Dementia Road Map: A Guide for Family and Care Partners.pdf (wa.gov)
- Dementia Road Map: A Guide for Family and Care Partners.pdf (Spanish version)

FIGURES AND TABLES

FIGURE 1: Screening, Identifying, and Managing Behavioral Symptoms in Patients with Dementia



NPI-Q indicates Neuropsychiatric Inventory Questionnaire; PCPI, Physician Consortium for Performance Improvement

[a]Key informant may or may not be the caregiver.

[b]Consider referrals to Alzheimer's Association for support groups, education, other services; geropsychiatrist for difficult to manage cases, when medications may be needed; occupational therapist for driving evaluation, caregiver skills training, environmental modification, activity programming, functional improvement, home safety evaluation and risk reduction; physical therapist for exercise, mobility and balance, fall risk reduction; social worker for care coordination, caregiver counseling, support, and skills training; nurse for medication and physical health monitoring, caregiver training.

*Figure from Gitlin LN, Kales, HC, Lyketsos CG. Nonpharmacologic management of behavioral symptoms in dementia. *JAMA*. 2012; 308(19):2020-2029. Used by permission. © 2012 American Medical Association. All rights reserved.

FIGURES AND TABLES (continued)

TABLE 1: Potential Non-pharmacologic Strategies

Targeted Behavior by Presenting Dementia Stage	Select Non-pharmacologic Strategies
MILD COGNITIVE IMPAIRMENT	
Forgetfulness about taking medication	• Evaluate capacity for taking medications independently • Use assistive aids (calendar to remind of time for medication, checklists, pill dispenser • Supervise medication taking and secure medications
General forgetfulness; disorientation to time	• Use memory aids (calendar or white board showing current date) • Simplify daily routines
MODERATE DEMENTIA	
Falling and poor balance	• Use a fall alert system if patient can remember to activate • Consider referral to occupational therapy for home safety evaluation and removal of tripping hazards • Minimize alcohol intake • Consider referral to physical therapy for simple balance exercise
Hearing voices or noises (especially at night)	• Evaluate hearing and adjust amplification of hearing aids • Evaluate quality and severity of auditory disturbances • If hallucinations are judged to be present, evaluate whether they present an actual threat to safety or function in deciding whether or not to use antipsychotic treatment
Inability to respond to emergency (difficulty calling for help)	• Educate caregiver about need to supervise patient • Inform neighbors, fire department, and police of situation Develop emergency plan involving others if possible
Leaving the home; wandering outdoors	• Outfit with an ID bracelet (eg, Alzheimer Safe Return Program) or badge with patient's name and address • Notify police and neighbors of patient's condition • Identify potential triggers for elopement and modify them

FIGURES AND TABLES (continued)

TABLE 1: Potential Non-pharmacologic Strategies (continued)

Targeted Behavior by Presenting Dementia Stage	Select Non-pharmacologic Strategies
MODERATE DEMENTIA	
Memory-related behavior (e.g., disorientation or confusion with object recognition)	• Label needed objects • Remove unnecessary objects to reduce confusion with tasks Present a single object at a time as needed • Keep all objects for a task in a labeled container (eg, grooming)
Nighttime wakefulness, turning on lights, awaking caregiver, feeling insecure at night	• Evaluate sleep routine • Evaluate environment for temperature, noise, light, shadows, level of comfort, or other possible disturbances • Eliminate caffeinated beverages (starting during the afternoon) • Create a structured schedule that includes exercise and activity engagement throughout the day • Limit daytime napping • Address daytime loneliness and boredom that may contribute to nighttime insecurities • Implement good sleep hygiene • Use nightlight • Hire nighttime assistance to enable caregiver to sleep • Create a quiet routine for bedtime that includes calming activity, calming music
Repetitive questioning	• Respond using a calm, reassuring voice • Use calm touch for reassurance • Inform patient of events as they occur (vs indicating what will happen in near or far future) Structure daily routines • Provide meaningful activities during the day to engage patient Use distraction

FIGURES AND TABLES (continued)

TABLE 2: General Non-pharmacologic Strategies for Managing Behavioral Symptoms

DOMAIN	KEY STRATEGIES
Activities	• Introduce activities that tap into preserved capabilities and previous interests • Introduce activities involving repetitive motion (washing windows, folding towels, putting coins in container) • Set up the activity and help patient initiate participation if necessary
Caregiver education and support	• Understand that behaviors are not intentional • Relax the rules (eg, no right or wrong in performing activities/tasks as long as patient and caregiver are safe) • Consider that with disease progression, patient may have difficulty initiating, sequencing, organizing, and completing tasks without guidance and cueing • Concur with patient's view of what is true and avoid arguing or trying to reason or convince • Take care of self; find opportunities for respite; practice healthy behaviors and attend preventive physician visits • Identify and draw upon a support network
Communication	• Allow patient sufficient time to respond to a question • Provide 1- to 2-step simple verbal commands • Use a calm, reassuring tone • Offer simple choices (no more than 2 at a time) • Avoid negative words and tone • Lightly touch to reassure, calm, or redirect • Identify self and others if patient does not remember names • Help patient find words for self-expression
Simplify environment	• Remove clutter or unnecessary objects • Use labeling or other visual cues • Eliminate noise and distractions when communicating or when patient is engaging in an activity • Use simple visual reminders (arrows pointing to bathroom)
Simplify tasks	• Break each task into very simple steps • Use verbal or tactile prompt for each step • Provide structured daily routines that are predictable