Understanding the Early Stage of Dementia for an Interprofessional Team

MODULE 5

LAKE ERIE INTEGRATED GERIATRIC HEALTH TEAM

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Outline

- Introduction
- Manifestations of early-stage dementia:
  - Overview
  - Alzheimer's disease (AD)
  - Vascular dementia (VaD) (and vascular cognitive impairment [VCI])
  - Lewy body dementia (LBD)
  - Frontotemporal degeneration (FTD)
- General strategies to address manifestations of dementia
- Identifying transitions to middle-stage dementia
- Addressing common manifestations and care partner issues of early-stage dementia

Learning Objectives

After completing this module, participants will be able to:

- Describe hallmark signs of early-stage dementia.
- List changes in cognitive status that are typical of early-stage dementia.
- Identify common manifestations and issues that arise during early-stage dementia.
- Describe general strategies for managing symptoms of dementia.

Key Take-Home Messages

- Not all types of dementia manifest with the same symptoms during early-stage dementia. Most are characterized by memory impairment that becomes noticeable to others.
- There are no clear delineations of the stages of dementia and staging can provide information and framework for medical and psychosocial care needs.
  - Persons with early-stage dementia remain independent and retain much of their cognitive functioning but can have impairments that interfere with their daily activities.
  - Persons with early-stage dementia have difficulties with instrumental activities of daily living (IADL) and as the dementia progresses will eventually lose the ability to perform basic activities of daily living (ADL).

Key Take-Home Messages (continued)

- Specific dementias —including Alzheimer's disease, Lewy body dementias, and vascular dementia —have underlying damage in specific and different areas of the brain.
- The behavioral and psychological symptoms of dementia—mood symptoms, sleep disorders, psychosis, and agitation—may first manifest during early-stage dementia and worsen during subsequent stages. These are the most disruptive symptoms for the patient and the care partner.
- Physical activity (PA) may improve cognitive thinking, physical fitness, and mood, but is not curative for dementia and probably does not slow its progression.
- The benefits of symptomatic treatments are modest at best.
- Care partner roles depend on stage and type of dementia and the residence (home or institutional setting). In the earlier stages, assistance is provided with transportation and housekeeping; in the later stages, personal care and decision-making are provided.

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Introduction

- Dementia involves progressive deterioration of cognitive and functional abilities.
- Staging of dementia can provide information and the framework for medical and psychosocial care needs.
- People with early-stage dementia remain independent and generally retain much of their cognitive functioning but can have impairments in cognitive and executive functioning that interfere with their daily activities.
- Behavioral and psychological symptoms of dementia (BPSD) are important components of dementia with substantial consequences to the older adult and care partner (Kales et al, 2014).

Dementia as the Organizing Principle of Care

- Dementia affects every aspect of a person's life (Lazaroff et al., 2013)
- Most persons living with dementia (PLwD) are managed in primary care practices (Hogan et al., 2008).
  - Many PLwD live at home as long as possible.
- There is no cure for dementia; progressive mental and cognitive decline is inevitable (Apesoa-Varano et al., 2011).
- Historical biomedical emphasis on "cure" is not appropriate for dementia—it has been replaced with focus on "caring" by interprofessional team (Apesoa-Varano et al., 2011; Hogan et al., 2008) and on maximizing or sustaining function and quality of life.

Treatment Goals

- Treatment goals (Lazaroff et al., 2013):
  - Provide symptom relief.
  - Minimize negative effects of dementia on persons living with dementia and care partners.
  - Maximize functional independence of the persons living with dementia.
  - Manage behavioral, psychosocial, and safety issues that may arise.
  - Optimize management of comorbid conditions.
  - Provide guidance and support for care partners.
- When possible, integrate the subjective experiences of the PLwD into the treatment plans (Zwijsen et al., 2016).

Organizing Care by Dementia Type and Stage

- PLwD have specific needs and concerns based on the type of dementia and the severity (or stage) of impairments.
- The progressive nature of dementia requires continuous adjustments in treatment approaches and goals (Lazaroff et al., 2013).
- As dementia progresses, the ability of PLwD to participate in their own health care decisions deteriorates.
- It is important for the interprofessional team to understand global abilities and impairments associated with each type of dementia during the early, middle, and late stages (Apesoa-Varano et al., 2011).

Frailty

- Common geriatrics syndrome (Chen et al., 2014; Ni Mhaolain et al., 2012)
- Age-associated decline in physiologic reserve and function
- Specific clinical criteria include
  - Weakness, measured in part by grip strength
  - Slowness, measured in part by walking speed
  - Unintentional weight loss
  - Low level of physical activity
  - Self-reported exhaustion
- Possible additional consequences to PLwD at any stage

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Manifestations of Early-Stage Dementia: Overview

- Dementia is characterized by cognitive and executive function impairments that eventually lead to loss of ability to perform ADL (Verlinden et al., 2016).
- Initially, PLwD generally retain a fair degree of cognition, capabilities, and personality (Stewart, 2012).
- Memory impairment is influenced by type of dementia (Schubert et al., 2016) and location of brain cell damage (Kuceyeski et al., 2011).
  - Initial memory impairment occurs in short-term/working memory and semantic memory (Wilson et al., 2011).

Manifestations of Early-Stage Dementia: Overview (continued)

- Other impairments may result from normal aging, progressive damage to the brain (Roberts et al., 2016) and type of dementia (Auning et al., 2011; Possin, 2010; Roberts et al., 2016).
- PLwD have difficulties first with IADL before losing ability to perform basic ADL (Verlinden et al., 2016).
- Persons with early-stage dementia may also manifest Behavioral and psychological symptoms of dementia (BPSD) (Aarsland et al., 2014; Desai et al., 2012; Kales et al., 2015).
  - Care partners do not usually notice or report substantial changes in the personality of PLwD (Stewart, 2012).

Cognitive and Executive Functioning Impairments

Beginning in early-stage and throughout the course of dementia, there is continued and progressive decline in:

- Memory and executive functioning (Galvin, 2012; Giebel et al., 2015)
- Functional impairments
- Impairments in language skills, visual perception, ability to focus and pay attention
- Ability to perform IADL

Visuoperceptual Difficulties

- Causes of visuoperceptual difficulties such as problems with depth perception, sharpness, and loss of peripheral vision, problems adapting to changes in light levels, and impairments in audio-visual speech capabilities:
  - Normal aging is associated with structural and functional changes in vision, hearing, and perceptual acuity (Alm et al., 2013; Chang et al., 2015; Eichenbaum, 2012; Huyse et al., 2014; NEI, 2011).
  - Dementia adds progressive damage to the brain.
- Each type of dementia can affect visuoperceptual abilities differently (Caputi, et al., 2015; Diaz-Santos et al., 2015; Paxton et al., 2007; Wood et al., 2013).

Behavioral and Psychological Symptoms of Dementia

- Behavioral and psychological symptoms of dementia (BPSD) occur across all stages of dementia; type and prominence depend on the stage and individual considerations of the PLwD (Aarsland et al., 2014; Desai et al., 2012; Kales et al., 2015).
- BPSD are among the most complex symptoms to manage, particularly during the later stages of dementia (Kales et al., 2014; Lyketsos et al., 2011).
- BPSD cause significant suffering to PLwD and their care partners. They are a predominant (if not primary) cause of (premature) institutionalization (Kales et al., 2014).

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Early-Stage Alzheimer's Disease: Clinical Manifestations

- Early-stage Alzheimer's disease is characterized by mild to moderate decline in memory (Galvin, 2012; Giebel et al., 2015; Godefroy et al., 2016), executive functioning, visual-spatial issues, and the emergence of BPSD (Galvin, 2012; Godefroy et al, 2016; NIA, 2017e).
- Executive dysfunction is common in early stages of Alzheimer's disease (Godefroy et al., 2016).
  - Decreased ability to plan and organize (Giebel et al., 2015; Godefroy et al., 2016)
  - Difficulties completing tasks and with IADL (Liu-Seifert et al., 2015; NIA, 2017e)
  - Problems finding words in speaking or writing (NIA, 2017e)
  - Becoming lost or disoriented in familiar places
  - Impairments in judgment and reasoning (NIA, 2017e)
  - Withdrawal from work or social activities (Galvin, 2012)
  - Changes in mood or personality (depression, apathy) (Galvin, 2012; Godefroy et al., 2016; NIA, 2017e)

Factors Influencing Rate of Progression in Alzheimer's Disease

- AD course is progressive, but rate varies widely among individuals.
- There are 2 common approaches to define "rapid cognitive decline" (Arevalo-Rodriguez et al., 2015; Aubert et al., 2015).
- Factors associated with slower rate of decline (Aubert et al., 2015; Galvin, 2012; Williams et al., 2010):
  - Diet, cognitive abilities/reserve, physical activity, social/leisure activities
- Factors associated with more rapid decline (Aubert et al., 2015; Galvin, 2012; Williams et al., 2010):
  - Older age, comorbidities
  - Initiating anticholinergic medications (Carriere et al., 2009; Shah et al., 2013)
- Vascular factors (e.g., hypertension, hypercholesterolemia) are not significantly associated with AD progression (Galvin, 2012; Williams et al., 2010).

Early-Stage Vascular Dementia

- VaD encompasses numerous etiologies that can manifest with different clinical features (Karantzoulis et al., 2011; Roh et al, 2014).
- Signs and symptoms depend on:
  - Area(s) of brain affected (Gorelick & Nyenhuis, 2013; Sahathevan et al., 2012)
  - Presence or absence of underlying conditions
  - Volume/location of underlying pathology (Gorelick & Nyenhuis, 2013)
- VaD can have both focal neurocognitive deficits based on location of stroke lesions or a more diffuse (global) pattern (Karantzoulis et al., 2011).
- Post-stroke vascular dementia can also manifest with physical impairments.

Clinical Manifestations of Early-Stage VaD

- Executive dysfunction: A “hallmark” of vascular cognitive impairment (VCI) but is not specific to cerebrovascular disease
- Similarities and differences between vascular dementia (VaD) and AD:
  - Memory deficits less overt than in AD (Gorelick & Nyenhius, 2013; Gorelick et al., 2011; Karantzoulis et al., 2011)
  - Personality changes and loss of social skills
  - Possible mild visuospatial deficits with subcortical VaD as with AD (Karantzoulis & Gavin, 2011)
  - Affective disturbances common in VaD (Karantzoulis & Gavin, 2012; Mayo Clinic, 2018)

Clinical Manifestations of Early-Stage VaD (continued)

- Sensory impairments include slurred speech and language problems (Mayo Clinic, 2018).
- Hallucinations and delusions may be present (Mayo Clinic, 2018).
- However, there is no evidence that vascular risk factors have a causal effect on dementia in either Alzheimer's disease or VCI (Sahathevan et al., 2012).

Early-Stage Lewy Body Dementia (LBD): Overview

- LBD encompasses dementia with Lewy bodies (DLB) and Parkinson's Disease Dementia (PDD).
- Defining features of LBD include cognitive impairment, motor Parkinsonism, behavior and mood changes, plus alterations in sleep and autonomic function (Aarsland, 2016).

Early-Stage Lewy Body Dementia (LBD): Overview (continued)

- DLB and PDD share many clinical and pathological similarities and are sometimes considered as different points on a spectrum (Aarsland, 2016; Connolly & Fox, 2014).
  - PDD is characterized by a period of pure motor symptoms first; cognitive symptoms develop more than a year after onset of movement problems (Aarsland, 2016; Miller & Boeve, 2011).
  - DLB occurs in older adults, who develop before or around the same time as motor symptoms (Connolly & Fox, 2014) and is often associated with a more severe course than PDD (Aarsland, 2016).
- LBD rate of decline is much faster and its survival time is shorter compared with AD (Aarsland, 2016).
- Greater impairments are associated with DLB than with PDD (Jicha et al., 2010; Yoon, et al., 2014).

Early-Stage LBD: Clinical Manifestations

- Marked attentional and executive function disorders are present in LBD with significant cognitive fluctuations (Karantzoulis et al., 2011; Lee et al., 2012).
- Rapid eye movement (REM) behavioral disorder (RBD) is a sleep difficulty predominantly associated with LBD (Karantzoulis et al., 2013; Mayo Clinic, 2018).
- Mild cognitive impairment (MCI) is present at the time of PD diagnosis in about one-third of individuals and in approximately half of all older adults afflicted with nondemented Parkinson's disease after 5 years (Aarsland, 2016; Connolly et al., 2013).
- Hallucinations are among the most common core features of DLB prior to the initial evaluation, followed by Parkinsonism and cognitive fluctuations (Auning et al., 2011).

LBD Versus Alzheimer's Disease

LBD and Alzheimer's disease have some similarities and numerous differences (Auning et al., 2011; Karantzoulis et al., 2011). Compared with persons with Alzheimer's disease, persons with LBD are:

- More likely to have psychiatric symptoms and more functional impairments at time of diagnosis (Connolly et al., 2013; Grover et al., 2015; Karantzoulis & Galvin, 2011)
- More likely to have sleep disturbances, cognitive fluctuations, well-formed visual hallucinations, and muscle rigidity or Parkinsonian movement problems early in the disease (ACT on Alzheimer's, 2012; Auning et al., 2011)
- Likely to have pronounced visuospatial impairments in LBD that appear earlier in the disease course (Karantzoulis et al. 2012)
- Memory may be relatively intact in early LBD; in later stage disease, LBD is harder to differentiate from AD (Karantzoulis et al., 2011)
- More likely to have nonmotor behavioral symptoms (Aarsland, 2016; Grover et al., 2015; Wood et al., 2010)

Early-Stage Frontotemporal Degeneration (FTD): Overview

- FTD is a heterogeneous group of diseases with overlapping clinical symptoms but different causative genes and differing underlying pathologies (Lashley et al., 2015; Riedl et al., 2014).
- FTD is caused by damage to frontal and/or temporal lobes (Piguet et al., 2011). Impairments generally progress quickly but memory often remains intact.
- Distinctive clinical syndromes, with heterogeneous neuropathology (NIA, 2017b):
  - Progressive behavior/personality decline (Borroni et al., 2015; Mioshi et al., 2010)
  - Progressive language decline: Primary progressive aphasia (PPA) initially language related (Kremen et al., 2011; Mioshi et al., 2010; Piguet et al, 2011)
  - Progressive motor decline (less common) (NIA, 2017b)

Early-Stage Frontotemporal Degeneration (FTD): Overview (continued)

- Persons with FTD demonstrate changes in behavior and personality, language problems, and motor problems (Ferrari et al., 2011; NIA, 2017b; Piguet et al., 2011).
- Memory impairment is minimal in early stages (Arlt, 2013; Schubert et al., 2016).

Behavioral Variant Frontotemporal Degeneration (bvFTD): Clinical Manifestations

- FTD is a progressive disorder with no clear indications of transition points between stages (Borroni et al., 2015; Mioshi et al., 2010).
- Persons with early stage bvFTD have (Borroni et al., 2015; Mioshi et al., 2010, NIA, 2017b):
  - Substantially greater functional and behavioral changes compared with PPA (Mioshi et al., 2010).
  - Marked variability in initial symptomatic presentations (Karantzoulis et al., 2011).
  - Behavioral manifestations (NIA, 2017b).
- PPA is characterized by progressive language decline, including impaired ability to speak, understand, read, and write (NIA, 2017b) and impairments to knowledge regarding meaning of words and objects (Karantzoulis & Galvin, 2011).
- FTD is associated with progressive motor decline: movement problems/slowed movement, muscle rigidity (Parkinsonian symptoms), body stiffness, changes in behavior or language.
- Binge eating habits are possible (Ferrari et al., 2011; Piguet et al., 2011).

Early-Stage Behavioral Variant Frontotemporal Degeneration (bvFTD): Unique Concerns

- Disinhibition (Laforce, 2013)
- Sexuality concerns:
  - Hypersexual behavior may be early manifestation of bvFTD (Mendez & Shapira, 2013).
  - Sexuality concerns may affect up to 18% of older adults with bvFTD.
  - Studies suggest either hypersexuality or hyposexuality in early-stage bvFTD (Ahmed et al., 2015).
- Early driving concerns:
  - There are few studies on PLwD not associated with AD.
  - Older adults with FTD are more likely to show dangerous driving behaviors in early stage compared with older adults with AD (Fujito et al., 2016).

Early-Stage Behavioral Variant Frontotemporal Degeneration (bvFTD): Unique Concerns (Continued)

- Criminality:
  - New onset criminal behavior may be early manifestation of bvFTD or sFTD.
  - Theft, traffic violations, sexual advances, trespassing, and public urination may be evident (Liljegren et al., 2015).

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General Strategies

- There are many general strategies that a provider or care partner can use to help manage behavioral and psychological symptoms of dementia (BPSD) (Cohen-Mansfield et al., 2015; Kales et al., 2014, 2015; Nordgren et al., 2014).
  - Patient engagement
  - Physical activity
  - Communication
  - Sensory stimulation
  - Environmental changes
  - Task simplification
  - Guidance for care partner
- Nonpharmacologic versus pharmacologic interventions
  - Cognitive stimulation

Engaging Persons Living with Dementia

- Contributes to greater sense of well-being (Smit et al., 2016)
- Person-centered care approaches (Edvardsson et al., 2013; Keating et al., 2012; Ortigara et al., 2013; Trahan et al., 2014)
- Benefits of social support networks
- Focus on current, not prior, skills
- Recognize that environmental influences affect persons living with dementia

Activity/ Physical Activity

- Physical activity (PA) may improve cognitive thinking, physical fitness, and mood, but is not curative for dementia and does not slow its progression (Faulk et al., 2014; Kiepe et al., 2012; Kumar et al., 2014; Williams et al., 2010).
  - Not just ”exercise”—walking, dancing (Holmerova et al., 2010; Vankova et al., 2014), gardening
- Many studies suggest that PA positively affects cognitive function in AD (Phillips et al., 2015) and PD (Ahlskog, 2011).
- Prospective studies note benefits of midlife physical activity on minimizing risk of Parkinson’s disease (Ahlskog, 2014).
- A recent Cochrane Review (Forbes et al., 2015) shows:
  - Promising evidence that PA programs may improve ability to perform ADL
  - No clear evidence that PA benefits cognition, BPSD, or depression
- Activities can be simple, such as involving repetitive motions (like folding towels or putting coins in a holder) (Kales et al., 2014).
  - Care partner can help set up the activity.
  - Care partner can help an older adult participate.

Communication

- Allow PLwD sufficient time to respond to comment/question (Kales, et al., 2014).
- Use simple verbal commands, broken down into small steps.
- Use a calm, reassuring voice.
- Avoid harsh tones, negative words.
- Offer no more than 2 simple choices at a time.
- Identify self or others for person who is unable to remember names.
- Help person find appropriate words for self-expression.
- Lightly touch the person to provide reassurance, to calm, or to redirect if upset.

Cognitive Stimulation to Improve Cognitive Functioning

- In Cognitive Stimulation Therapy a range of activities aims to stimulate thinking, concentration, and memory in social settings (Spector et al., 2010; Woods et al., 2012)
  - Belief exists that lack of cognitive stimulation can lead to cognitive decline.
  - There is evidence of some benefit to persons with early- to middle-stage dementia.
  - Evidence suggests it is not beneficial or appropriate for persons with severe dementia.
- Reminiscence therapy (discussing past experiences) (Kales et al., 2015)

Sensory Stimulation

- Music therapy, white noise (with/without calming sounds) (Blackburn et al., 2014; Cohen-Mansfield et al., 2015; Li et al., 2015)
- Art/craft therapy (Pollanen et al., 2014; Safar, 2014)
- Bright light therapy (Figueiro et al., 2014; Forbes et al., 2014; Li et al., 2015; van Maanen et al., 2015)

Environmental Changes

- Environmental modifications (Trahan et al., 2014)
  - Remove clutter (Kales et al., 2014).
  - Use labels, visual cues (signs, arrows pointing to bathroom).
  - Change “objects and property” (Trahan et al., 2014).
  - Change “space demands.”
  - Change “social demands.”
  - Change “sequence and timing.”

Task Simplification

- Break tasks into simple steps (Kales et al., 2014).
- Use cues or prompts at each stage.
  - Verbal
  - Tactile
- Create structured daily routines.

Miscellaneous Nonpharmacologic Interventions

- Many other nonpharmacologic interventions that have been or are currently being investigated (Kales et al., 2014)
- Animal-assisted therapies (Cohen-Mansfield et al., 2015; Nordgren et al., 2014)
- Complementary and alternative therapies
  - Generally benign and of some limited benefit:
    - Massage, reflexology, chiropractic (Cohen-Mansfield et al., 2015)
  - Herbal supplements or dietary supplements: not always benign; be cautious.

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Care Partners Managing Memory Impairments and Executive Dysfunction

- Provide cues or prompts (Kales et al., 2014).
- Address repetitive questioning (Kales et al., 2014):
  - Respond with calm reassuring voice.
  - Use calming touch for reassurance.
  - Structure with daily routines.
  - Use distraction and meaningful activities.
  - Inform patient of events only as they occur.
- Address difficulties with IADL.

Mood Disturbances: Addressing Apathy

- Apathy is a common behavioral disturbance in all types of dementia, across all stages of dementia (Desai et al., 2012):
  - Apathy is commonly reported by family members and worsens over time (Kales et al., 2015).
  - Prevalence increases with increasing cognitive impairment.
  - Prevalence differs across different dementias (Brodaty et al., 2012; Desai et al., 2012; Kales et al., 2015).
  - It contributes to poor quality of life for PLwD and care partners.
- It is distinct from depression and does not necessarily coexist with other mood disturbances.

Mood Disturbances: Addressing Apathy (continued)

- Nonpharmacological management may reduce apathy (Brodaty et al., 2012; Kales et al., 2014).
  - Engaging the person living with dementia
  - Activity
  - Sensory stimulation
  - Environmental changes

Mood Disorders: Depression

- Depression is another common mood disorder in dementia (Desai et al.,2012; Kales et al., 2015; Kitching, 2015).
- Prevalence of clinically significant depression decreases with increasing cognitive impairment.
- Depression often coexists with anxiety symptoms (Desai et al., 2012).
- Relationship between depression and dementia is complex and not well understood (Bennett et al., 2014).
  - Evidence supports early life depression as risk factor for later life dementia (Bennett et al., 2014).
  - Later life depression is considered as a prodrome to dementia (Bennett et al., 2014).
  - Both show similar neurobiological changes (Kales et al., 2015).

Treating Depression in Dementia

- Depression has similar manifestations in persons with or without dementia (Kitching, 2015):
  - Low mood, irritability, anger; low energy, low appetite
  - Major depressive episodes more common in older persons with than without dementia
- It may be challenging to make differential diagnosis between depression and dementia because they can have some similar symptoms (Kitching, 2015).
- Management of depression in dementia can be similar to that of depression in the person without dementia (Kitching, 2015):
  - Nonpharmacologic strategies
  - Cognitive behavioral therapies (only in early-stage dementia)
  - Pharmacotherapy may be necessary (often with SSRIs)
  - Electroconvulsive therapy (ECT)

Medications for Cognitive Impairment in Early-stage Alzheimer's Disease

- Overall, benefits of symptomatic treatments are modest at best.
- Cholinesterase inhibitors are indicated for mild-to-moderate AD and may take up to 6 weeks before any apparent improvement (NIA, 2018b; Uriri-Glover et al., 2012).
  - Rivastigmine
  - Galantamine
  - Donepezil (may also be used for moderate-to-severe AD)
- Memantine: *N*-methyl-d-aspartate (NMDA) noncompetitive glutamate receptor antagonist is for moderate-to-severe AD (PubMed Health, n.d.).
- Combination of donepezil + memantine for persons with moderate-to-severe AD (Howard et al., 2012; Matsuzono et al., 2015).

Providing Support to the Care Partner

- Help the care partner recognize when the person living with dementia has an unmet need (NIA, 2017c).
  - What is the relationship of the PLwD to the care partner?
- Zero in on troubling behaviors of the PLwD.
  - What is the behavior that concerns the care partner and what is it related to?
  - Does the behavior need to change or can the care partner live with it?
  - If it needs to change, what can be done?
- Utilize care partner strengths to see how many potential solutions can be found.
- Help the care partner recognize the importance of self-care.

Providing Support to Care Partners of Adults with Intellectual Disability

- Many PLwD who have an intellectual disability continue to live with a family member or an unrelated care partner. With progression from early dementia this may pose new care challenges for the care partners (Heller et al., 2018)
- Behavior will deteriorate and language skills lost
- Person may remain ambulatory for a prolonged time, but eventually become non-ambulatory
- Physical needs will become more prominent
- Care at home in early stages can enable continuity due to familiar setting and people that are known. Family may need supports for continued home care (respite, home modifications, aides to help primary care partner, financial assistance).
- With progression to latter stages, help with planning for advanced dementia and end of life care, palliative care, and hospice.

Case Study

Joellen, once an excellent cook, is beginning to experience difficulty in the kitchen. Her husband and primary caregiver is taking over many of the duties in the kitchen. His main challenge is how to keep his wife safely engaged in a task she has previously enjoyed doing and in which she was once quite accomplished. The problem is that she is at risk of causing potentially dangerous situations, such as putting a metal bowl in the microwave or putting a dish towel on the burner, or leaving the stove on.

Her husband solved this problem by arranging for them to cook meals together with him providing more supervision, asking Joellen to contribute by taking specific steps such as washing fruit and vegetables or assembling a salad, or having her assist with mealtime tasks outside of the kitchen such as setting the table.

Addressing Care Partner Issues

- Care partner roles depend on stage and type of dementia and where the PLwD resides (home or institutional setting) (Huang et al., 2015).
  - Early-stage dementia: Care partners provide assistance with transportation and housekeeping (Huang et al., 2015).
  - Middle-stage dementia: Care partners continue to aid and assist with mobility, ADL, and protection/safety (Huang et al., 2015).
  - Late-stage dementia: Care partners provide personal care of the PLwD and decision-making (Huang et al., 2015).
- Caring for PLwD, though rewarding and gratifying, can be stressful and difficult; caregiving responsibilities are increasingly time-consuming (Lazaroff et al., 2013).
  - Care partner requires support, education, guidance in providing appropriate care for PLwD as well as self.
  - Interprofessional team can provide education, identify support services to ensure care partner's needs are recognized and addressed (Lazaroff et al., 2013).

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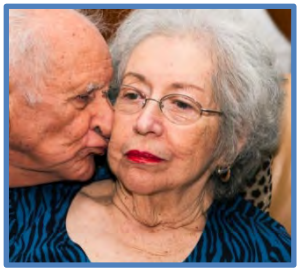

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Symptoms Suggestive of Middle-Stage Dementia

- There are no clear biomarkers identifying stages for any cause of dementia (Archer et al., 2011).
- Increasing neurologic damage interferes with the (Archer et al., 2011):
  - Ability to express thoughts.
  - Ability to perform routine tasks.
  - Ability to perform ADL.
- There are more obvious problems with memory, confusion, behavioral and psychological symptoms of dementia (BPSD), and ADL (Ortigara et al., 2013).

Summary and Conclusions

- The older adult with early-stage dementia demonstrates noticeable impairments in memory and cognition along with some functional deterioration.
  - Generally able to remain at home and independent, with some assistance
- Behavioral and psychological symptoms of dementia (BPSD)—particularly sleep disorders and mood changes, and less frequently psychotic symptoms and agitation—often have the greatest effect on the older adult and care partner.
- An interprofessional team approach provides education, care, and support to the older adult and the care partner.

Evaluation

1. **Which of the following is a hallmark sign of early-stage Alzheimer's disease?**
   a. Inability to live independently any longer
   b. Visual hallucinations
   c. Impairments in short-term memory
   d. Substantial personality changes

2. **Persons living with early-stage dementia are likely to have difficulties with:**
   a. Their ability to focus and pay attention
   b. Toileting
   c. Remembering the name of their spouse or children
   d. Their balance

Evaluation (continued)

3. **Behavioral and psychological symptoms of early-stage Alzheimer's disease include:**
   a. Auditory hallucinations
   b. Mood disorders
   c. Psychosis
   d. Delusions

4. **What are the recommended first-line strategies for managing behavioral and psychological symptoms of early-stage dementia?**
   a. Pharmacologic interventions
   b. Nonpharmacologic interventions
   c. Ignoring the symptoms
   d. Rationalizing with the person living with dementia

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