PART Trainer Lesson Plan
Dementia Enhancement

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Teaching Timelines & Training Materials

Use this Dementia Enhancement in conjunction with the PART program materials. It may take just over an hour to teach this information, so you will need to make some adjustments for the classroom session, such as:

- not using an ice breaker
- completing written activities as a group rather than individually
- adjusting the time for stretch/lunch breaks
- managing your class size appropriately

Ensure you use your current PART Trainer Manual, and:

- teach all appropriate modules
- retain the role play activities
- appropriately demonstrate techniques (PART Intermediate)
- retain adequate time for everyone to practice
- allow for enough time for each participant to provide you with a return demonstration.

Familiarize yourself with the participant handout on dementia. There is space in the handout for participants to write; encourage participants to take notes as you work through the material.

If you need assistance with incorporating this enhancement into your sessions, please connect with SASWH.

Learning Outcomes

Learning outcomes with this enhancement are:

- understanding dementia - high level overview
- identification of potentially violent situations (understanding triggers)
- safe work practices to minimize or eliminate risk (approach, documentation/care plan, own self-control plan)
- appropriate response (de-escalation, person-centered care, validation, skills training)

Recommended Lesson Plan utilizing PART’s Dementia Enhancement in Conjunction with current PART training materials on Identification and Response.

Section 4: Identification

Utilize the current PART Models [legal, stress, etc.] topping up or placing emphasis on the following (depending upon the group).

Ask:
What is Dementia?[1]

Answer:
Dementia is an overall term for a set of symptoms that are caused by disorders affecting the brain. Symptoms may include memory loss and difficulties with thinking, problem-solving or language, severe enough to reduce a persons’ ability to perform everyday activities. A person with dementia may also experience changes in mood or behaviour.

Dementia is progressive, which means the symptoms will gradually get worse as more brain cells become damaged and eventually die.

Dementia is not a specific disease. Many diseases can cause dementia, including Alzheimer's disease, vascular dementia (due to strokes), Lewy Body disease, head trauma, fronto-temporal dementia, Creutzfeldt-Jakob disease, Parkinson's disease and Huntington's disease. These conditions can have similar and overlapping symptoms.

Reprinted from the Alzheimer Society of Canada "What is Dementia" available at:
www.alzheimer.ca/en/About-dementia/What-is-dementia

Delirium
Delirium is sometimes mistaken for dementia

Ask:
What is delirium?

Answer:
The Merriam-Webster dictionary (https://www.merriam-webster.com/dictionary/delirium - Aug/18) provides the following definition of delirium:

> an acute mental disturbance characterized by confused thinking and disrupted attention usually accompanied by disordered speech and hallucinations

Do: Go Through *The Best Friends ™ Dementia Bill of Rights* with the group.

Learning Activity:
1. have a discussion on how the points can be met, or
2. have participants write down ways they can meet these points then discuss.

Virginia Bell and David Troxel published The Dementia Bill of Rights

The Best Friends™ Dementia Bill of Rights

Every person diagnosed with Alzheimer's disease or other dementia deserves:

- To be informed of one's diagnosis.
- To have appropriate, ongoing medical care.
- To be treated as an adult, listened to, and afforded respect for one's feelings and point of view.
- To be with individuals who know one's life story, including cultural and spiritual traditions.
- To experience meaningful engagement throughout the day.
- To live in a safe and stimulating environment.
- To be outdoors on a regular basis.
- To be free from psychotropic medications whenever possible.
- To have welcomed physical contact, including hugging, caressing, and handholding.
- To be an advocate for oneself and others.
- To be part of a local, global, or online community.
- To have care partners well trained in dementia care.

Ask:
What do you think person-centred care means?

Do: read the following to the group; encourage some discussion

Person-centred care
Person-centred care is a philosophy that recognizes that individuals have unique values, personal history and personality and that each person has an equal right to dignity, respect, and to participate fully in their environment. The term "environment" refers to both the social and physical environment. This includes the importance of the assumptions made about people with dementia, attitudes of care providers, care models and care practices implemented, organisational and cultural factors as well as structural elements such as flooring and lighting.

It is a holistic philosophy across the continuum of services which takes into account the specific needs of each person. It is grounded in mutually beneficial partnerships established between people with dementia and their caregivers.

Person-centred care is founded on an interactive process, in which people with dementia are active participants in their own care throughout the various stages of the disease and family members play a vital role in ensuring the health and well-being of their relative.

The ultimate goal of person-centred care is to create partnerships among care home staff, people with dementia and their families that will lead to the best outcomes and enhance the quality of life and the quality of care of people with the disease. Services and supports are designed and delivered in a way that is integrated, collaborative, and mutually respectful of all persons involved, including the person with dementia, family members, caregivers and staff.

The person-centred philosophy focuses on the individual rather than on the condition, and on the person's strengths and abilities rather than losses.

Reprinted from the Alzheimer Society of Canada "Guidelines for Care: Person-centred care of people with dementia living in care homes" available at: http://alzheimer.ca/sites/default/files/files/national/culture-change/culture_change_framework_e.pdf

Ask:
Are you familiar with the purpose of a care plan?

Do: read the following to the group; encourage some discussion
The Care Plan
The care plan could be a means to capture information to support person-centred care. It should indicate the needs of the client - what are their likes, dislikes. Knowing this could prevent an incident; not knowing may cause an incident. If your client needs to hold something to keep their hands busy, a face cloth or rolled towel might work fine. The care plan may also indicate the appropriate and safe approach techniques (male or female worker; loud/soft voice, left/right side), triggers to avoid (words, areas/rooms), interventions that work with that client.

Ask and encourage some discussion:

- Is there a care plan in place for each client?
- What are some of the notes that would be/are in a care plan?
- Do you follow the care plan?
- Can/do you recommend changes to the care plan based on what you are learning when caring for a client?

As you teach PART's Stress Model (PART Trainer Manual pages 24-26)**, top up with the following:**

- Be aware of a client's trigger(s); a trigger can be seen, it can be a memory, delusion/hallucination. Triggers may be obtained from discussions with family or the client themselves, or from the client's chart.
- Eliminate or manage the triggers - can a change be made to avoid certain environments or situations?
- Understand that the client's trigger may be real or imagined/a memory per say. Their perception is very well their reality and they may not be able to change how they respond or react.
- When you are faced with a negative or challenging response from a client with dementia, it is YOU who will make a change - change your attitude, approach, body language/non-verbal communication.

As you teach PART's Communication Model (PART Trainer Manual pages 29 & 30)**, top up with the following:**

Use the STOP strategy:

- **S**low down: avoid rushing, communicate effectively, use your observation skills
- **T**hink about what is happening: what is the client doing, saying, perceiving? Do they see us as their mother, sister, a friend, a foe? Are they agitated, calm?
- **O**ptions: what can you change, do differently, say differently?
- **P**lan to have some time to yourself: do not take the situation personally

Section 5: Response

Utilize the current PART Models [legal, stress, etc.] topping up or placing emphasis on the *Common Knowledge Flowsheet for Dementia Clients* (depending upon the group) on the next page.

- A client with dementia may not demonstrate fear, frustration, manipulation or intimidation - it might just be the only way they are able to respond.
- Validate their feelings and emotions.
- Allow a person with dementia to believe what he or she wants.
- Redirect when necessary - change the conversation; include their need in the conversation.

The *Common Knowledge Flowsheet for Dementia Clients* chart may help with understanding signs of impending aggression along with possible approaches/techniques to aide in de-escalating the situation.

Common Knowledge Flowsheet for Dementia Clients

Possible motive	Possible Signs	Possible Approach/Technique
memory loss	▪ difficulties with thinking, problem-solving or language, severe enough to reduce a persons' ability to perform everyday activities ▪ changes in mood and/or personality ▪ being withdrawn	▪ give choices but limit options, such as "would you like the red or blue sweater" ▪ consider changing your attitude, approach, body language/non-verbal communication ▪ use the STOP strategy ▪ ask general questions, being too detailed may add more confusion and may cause frustration ▪ use visual cues, for example a sign to show where the bathroom is ▪ use personal belongings or visuals (pictures) to help trigger memory
hallucination, delusion, confusion	▪ they may understand that their minds are playing tricks on them or they may be completely absorbed in the experience and believe that it is really occurring ▪ decreased or poor judgement ▪ confused with time and/or place ▪ looking "lost" or confused	▪ understand that these experiences can be quite vivid and upsetting to the client ▪ consider changing your attitude, approach, body language/non-verbal communication ▪ use the STOP strategy ▪ validate their feelings and emotions/allow them to believe what he/she wants ▪ never argue with them ▪ relaxed and open hands in full view ▪ redirect when necessary (change the conversation or change the environment ▪ simple prompting to show them what you want them to do, such as putting the fork in their hand and motion them to eat, shows that you want them to start eating

worker training/ understanding	escalation of client and/or worker	▪ provide appropriate training to workers that is reviewed, practiced and supported
		▪ develop a care plan to support person-centred care, that includes, but not limited to:
		  ▪ the client's history/past (e.g., their job, culture, childhood – details that can help with appropriate response)
		  ▪ likes, dislikes
		  ▪ interventions, such as do they need something to hold to keep their hands "busy"
		  ▪ preferences such as male or female worker, using a loud/soft voice, approaching left/right side
		  ▪ triggers to avoid, such as certain words, areas/rooms
		  ▪ input from the client, family and care providers
		▪ understand that every day/moment can be different for the client, change your approach appropriately

Do: read the following to the group; encourage some discussion

Processing Information

All of us have experiences that affect our reaction to things around us. Our brain is a complex part of our body. It is continually processing information - whether consciously or unconsciously.

Our brain screens what our senses “find” - what we see, hear, smell, taste and feel. It processes if we’ve experienced it before, or if it is new. This could then bring an old memory to life, or create a new memory for us.

The frontal lobe of the brain reviews feelings and information - it uses judgement, reasoning and insight to determine our response. The frontal lobe also decides our impulse control - our instincts to react. So people with dementia may eventually lose their instinctive ability to react to the situation - their behaviour may then be seen by us as inappropriate; while to them it is appropriate because of the way their brain is processing information.

Learning Activity:

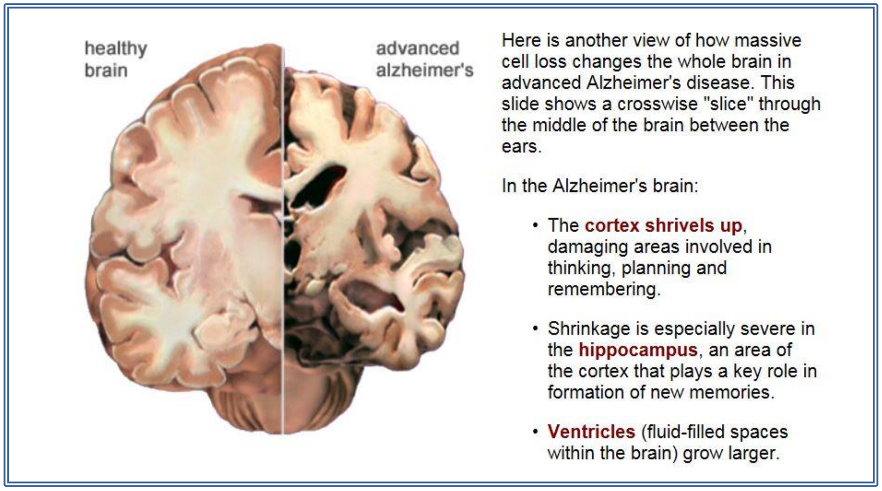
The learning activity should help with understanding how each person is different in processing information. You can choose your own activity or one of the following:

1. Ask participants to think about a song that might bring a memory to life - have a brief discussion…OR
2. Show an apple; ask participants to give one word to describe it. The descriptive words may be bright, shiny, juicy, tangy, red, round, etc. - summarize how this shows the different ways to process information.

Do: read the following to the group; encourage brief discussion

Brain Health

The graphic in your handout shows a healthy brain and one with severe Alzheimer’s disease - this will help you see how a brain may be damaged. It may be that information isn’t processed the same in a healthy brain as in a damaged brain.



Here is another view of how massive cell loss changes the whole brain in advanced Alzheimer's disease. This slide shows a crosswise "slice" through the middle of the brain between the ears.

In the Alzheimer's brain:

- The **cortex shrivels up**, damaging areas involved in thinking, planning and remembering.
- Shrinkage is especially severe in the **hippocampus**, an area of the cortex that plays a key role in formation of new memories.
- **Ventricles** (fluid-filled spaces within the brain) grow larger.

source: https://www.alz.org/braintour/neuron_forest.asp

We should not expect a person with dementia to be able to respond the same as a person with a healthy brain.

Ask:
Have you heard of the “Seven A’s of Dementia”?

Learning Activity:
The learning activity should help with understanding the “A”s. As you work through this information, you can choose your own activity or one of the following:
1. Ask participants to write down an example for each “A”; SASWH has included an example of each “A” for you to use or you can use your own examples…OR
2. Role-play each of the “A”s by dividing the group into 2 where one role-plays the client and the other role-plays the worker. You can also have each group keep their “A” a secret from the other groups - following role-play the groups then guess which A the role-play was about.

Seven A's of Dementia[2]
One way of understanding how dementia affects the brain is to look at the seven A's of dementia. Each A represents damage to a particular part of the brain. Please keep in mind that someone with dementia may not experience all of the A's.

Anosognosia means that you can no longer recognize that something has changed and that there is something wrong. You might not understand why you have cognitive problems or that you are experiencing any problems at all. Because the part of your brain that helps you reason is damaged, you do not see the changes in your abilities that others may see.

> SASWH’s example: a resident says “I don’t live here, I am just waiting for a ride”.

Agnosia means you can no longer recognize things through your senses: sight, sound, taste, touch, and smell. You might not be able to sort out what you see or hear. You might have trouble recognizing familiar people. Your safety may be at risk if this part of the brain is affected because you might confuse objects and what they are used for.

> SASWH’s example: not able to recognize people or objects; such as using a toothbrush to comb their hair.

Aphasia means you lose the ability to use language. This includes the ability to speak, understand, read and write. Although a person may retain the ability to speak for some time, the ability to understand what other people are saying may be affected early in the disease. If you cannot understand what is being said to you, this can lead to misunderstandings between you and those around you. You might find yourself withdrawing from social interactions because you are worried that you will not understand others or that they may not understand you.

> SASWH’s example: may not understand or may not be able to speak; words may come out muddled/jumbled (like a word salad - they can understand the words spoken but they don’t make sense in a sentence).

Apraxia means you have lost the ability to tell your body how to carry out purposeful movement. As well, if you have apraxia, you may also have trouble understanding terms such as back, front, up, down. When this happens, it becomes difficult to do things such as tying shoelaces, doing up buttons and zippers, and any activity involving co-ordination. The ability to move your body according to a certain pattern, such as coordinating hand and leg movement, also affects your ability to do specific activities such as driving.

> SASWH's example: fine motor skills affected such as unable to take a step back; unable to button/unbutton clothing.

Altered perception happens when you misinterpret the information your senses are giving you. For some people, this is a bigger problem in the late afternoon or early evening when light changes. Another important change is the loss of depth perception—the ability to see in three dimensions. It becomes harder to judge how high, deep, long, wide, near or far things are. For example, if the floor and furniture are the same colour, it may be difficult to judge when one is close enough to a chair to try to sit.

> SASWH's example: black flooring perceived as a hole so they won't step onto it; a television program could be perceived as real life. Sundowning - a progressive decline in functioning and behaviour that worsens throughout the day, with increased susceptibility to stimuli, aggression and restlessness.

Amnesia means loss of memory. This is an important loss because most things we do depend on our ability to remember. For example, a person with short-term memory problems loses the ability to remember what was just said. This explains why you might find yourself asking questions over and over again. Earlier in the disease a person's short-term memory will be affected. As the disease progresses, long-term memories will become harder to retrieve.

> SASWH's example: forget their family is coming for lunch; may remember having to do chores as a child but now can't remember to come to breakfast

Apathy is not being able to take initiative. The part of the brain that helps you start to do something, either to carry out an activity or to communicate, is damaged. You might find that you have difficulty beginning activities. You may need someone else to give you cues (hints) to keep you involved in a conversation or a task.

> SASWH's example: appear to be depressed but they aren't; need encouragement/an invitation; need to be involved

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Reprinted from the Alzheimer Society of Canada "What is Dementia" available at:
http://alzheimer.ca/en/york/About-dementia/What-is-dementia/Seven-A-s-of-dementia

Say:
I'm going to read you a story, and I'm going to read it slowly so that you've time to absorb what I will read. If you want, you can close your eyes and visualize what I will read.

Do: ensure you read this slowly, adding emphasis in some areas and softening tones in other areas (refrain from monotone).

The Train Journey[3]

BY Dawson, et al., 1993 xiv-xv

I am going on a long journey by train. As I begin, the city skyscrapers and county landscape look familiar. As I continue my journey, the view reminds me of times gone by and I feel relaxed and comfortable. The other passengers on the train appear to be feeling the same way and I engage in pleasant conversation with them.

As the journey progresses, things begin to look different. The buildings have odd shapes and the trees don't look quite the way I remember them. I know that they are buildings and trees, but something about them is not quite right. Maybe I'm in a different country with different architecture and plant life. It feels a bit strange, even unnerving.

I decide to ask the other passengers about the strangeness I feel, but I notice that they seem unperturbed. They are barely taking notice of the passing scenery. Maybe they have been here before. I ask some questions but nothing seems different to them. I wonder if my mind is playing tricks on me. I decide to act as if everything looks all right, but because it does not, I have to be on guard. This places some tension on me, but I believe I can tolerate it for the remainder of the trip. I do, however, find myself becoming so preoccupied with appearing all right that my attention is diverted from the passing scenery.

After some time I look out the window again, and this time I know that something is wrong. Everything looks strange and unfamiliar! There is no similarity to anything I can recall from the past. I must do something. I talk to the other passengers about the strangeness I feel. They look dumbfounded and when they answer, they talk in a new language. Why won't they talk in English I wonder? They look at me knowingly and with sympathy. I've got to get to the bottom of this, so I keep after them to tell me where the train is and where it is going. The only answers I get are in this strange language, and even when I talk, my words sound strange to me. Now I am truly frightened.

At this point I figure that I have to get off this train and find my way home. I had not bargained for this when I started. I get up to leave and bid a pleasant good-bye. I don't get very far, though, as the other passenger's stop me, and take me back to my seat. It seems they want me to stay on the train whether I want to or not. I try to explain, but they just talk in that strange language.

Outside the window the scenery is getting even more frightening. Strange, inhuman-looking beings peer into the window at me. I decide to make a run for it. The other passengers are not paying much attention to me, so I slip out of my seat and quietly walk toward the back of the car. There's a door! It is difficult to push, but I must. It begins to open and I push harder. Maybe now I will get away. Even though it looks pretty strange out there, I know I will never find my way home if I do not get off the train. I am just ready to jump when hands suddenly appear from nowhere and grab me from behind. I try to get away. I try to fight them off, but I can feel them pulling me back to my seat.

I realize now that I will never get off this train; I will never get home.

How sad I feel. I did not say good-bye to my friends or children. As far as I know they do not know where I am. The passengers look sympathetic, but they do not know how sad I feel. Maybe if they knew they would let me off the train. I stop smiling, stop eating, stop trying to talk and avoid looking out the window. The passengers look worried. They force me to eat. It is difficult because I am too sad to be hungry.

I have no choice now. I have to go along with the passengers because they seem to know where the journey will end. Maybe they will get me there safely. I fervently wish that I had never started out on this journey, but I know I cannot go back.

Reprinted from the Alzheimer Society of Canada "What is Dementia" available at:
http://www.alzheimer.ca/en/sagamiesaguenaylacstjean/Get-involved/Share-your-experience/Creative-Space/Writing-room/The-Train-Journey

Ask this question and encourage brief discussion:
How did this story help you understand how a client with dementia may be feeling/what their life is like?

Validation Therapy/Redirection[4]

The words "loved one" appears as this is copyright and to respect the copyright it is not changed; however, as you go through this information you can verbally adjust to work for the participants such as saying "client".
If you have a loved one or care for clients with Alzheimer's or dementia, then you know how difficult it can be to communicate with him or her. Maybe there are good or bad days. Maybe there are certain times of the day that are better or worse. The following are techniques that can be used to improve communication.

Learning Activity:
This activity should help with understanding validation and redirection. You can select your own activity or use the following:
1. After reviewing the information with participants, role-play validation and redirection.

Put Yourself in Their Shoes

Imagine, for a moment, that you are getting dressed for work. You've worked in the same office for thirty-five years, and today is like any other weekday. Perhaps you're having trouble tying your tie, which makes you wonder whether your daughter is home; she's great at fixing your tie. You call out her name. She comes into the room and asks where you're going. You tell her you've got 10 minutes to catch the train or you'll be late for work. Your daughter tells you that there is no train and you've been retired for 10 years; you have no job, but you do have dementia.

Reawakening a person to the fact that he or she has dementia used to be the social norm, even for caregivers. It was even considered a "gentle reminder" or "correction." However, we know better now. These small reminders shatter that person's reality, and repeated experiences can be psychologically damaging. Dementia affects the brain, but the person retains his or her humanness, and still has a mind, an ego and feelings that should be respected. It's cruel to force a person with dementia to accept aspects of reality that he or she cannot comprehend. So if, for example, your loved one is excited about a new job (that doesn't exist), it's better to offer congratulations than to correct him or her. Of course, this is sometimes easier said than done. The main coping skills you'll need to improve communication with your loved one are redirection and validation.

Redirection

People with dementia sometimes display behaviors that seem out of character or are far too emotional for a specific situation. Sometimes their behaviors are due to delusion or hallucination. Redirection techniques divert those individuals' attention away from the stressful event to something that is more pleasant. The following is an example:

> JOE [agitated]: I need to get to work. I'm going to miss my train!
> MARY: Okay, Dad, but I just made breakfast. How about you eat with me first and then I'll drive you to the station. You'll make the train **and** get a good meal that way.

Obviously, techniques and their usefulness depend on what seems sensible in the situation. You'll need to be creative and experiment to see what works and what doesn't with your loved one.

A few pointers on redirection techniques:

- People with dementia pick up on body language. Be warm and open when redirecting, to reduce stress levels and/or tension.
- Ask pointed questions. Try to get to the bottom of any unexplained behavior. It will make it easier to redirect if you understand the context.

Validation Therapy

Validation therapy, first conceived of by Naomi Feil (MS, ACSW), runs the fine line between bluntly explaining reality and simply allowing a person with dementia to believe what he or she wants. Validation therapy often integrates redirection techniques, but it is not solely about moving an individual's attention from one thing to another; it is also about validating feelings and emotions.

Validation therapy is based on the idea that a person with dementia may be sorting through past issues (albeit somewhat disguised) in the present. Some may even retreat to the past significantly, to restore a balanced feeling, especially if his or her present memory has begun to fail. Proponents of validation therapy say that allowing the dementia patient some measure of control will aid in self-worth and will reduce the occurrence of negative behaviors.

A few pointers on validation therapy:

- Try to understand **why** your loved one is behaving a certain way; what's the trigger or underlying concern? Then figure out a way to address it. So, for example, if your loved one is hoarding or hiding items, ask what he or she is fearful of losing. Give a "safe box" that can be used to store those items.
- Don't get caught up in whether or not something makes sense. A person with dementia may not be able to piece everything together, but their emotions are still valid. In fact, their distress or anxiety can be amplified when they aren't being understood. Accept that your loved one's emotions have more validity then the logic that leads to them.
- Ask specific questions about how certain actions or situations make your loved one feel. After you receive an explanation of those feelings, validate them with phrases that show your support, such as, "I'd be upset too, if that happened to me" or "I understand why you feel that way."
- Allow your loved one a graceful exit and be mindful of his or her ego!

Ask: Have you had experience with clients hallucinating or demonstrating delusion?

Do: Read the following and encourage brief discussion:

Hallucinations and Delusions

People with dementia sometimes experience delusions and/or hallucinations. Hallucinations can involve any of the five senses - a person with dementia may see, hear, smell, taste or feel something that isn't there. Dementia affects the brain, and as a result, people who suffer from this disease can experience delusions that stem from distorted ideas and false beliefs.

Some people understand that their minds are playing tricks on them, even in the midst of experiencing a delusion or hallucination. Others are completely absorbed in the experience and believe that it is really occurring. Whatever the case, understand that these experiences can be quite vivid and upsetting. Ask simple questions to determine whether the experience is causing any anxiety and take it from there. Instead of trying to talk your loved one "out of it," try redirecting his or her attention, and make sure that he or she knows you are trying to help.
[4]source: https://www.caring.com/articles/validation-therapy-and-redirection-for-dementia

There are *"Ten Tips for Communicating with a Person with Dementia"* that provide some practical strategies for dealing with the troubling behavior problems and communication difficulties often encountered when caring for a person with dementia.

Do: Review the Ten Tips with the group; encourage brief discussion:

Ten Tips for Communicating with a Person with Dementia

We aren't born knowing how to communicate with a person with dementia—but we can learn. Improving your communication skills will help make caregiving less stressful and will likely improve the quality of your relationship with your loved one. Good communication skills will also enhance your ability to handle the difficult behavior you may encounter as you care for a person with a dementing illness.

1. **Set a positive mood for interaction.** Your attitude and body language communicate your feelings and thoughts more strongly than your words do. Set a positive mood by speaking to your loved one in a pleasant and respectful manner. Use facial expressions, tone of voice, and physical touch to help convey your message and show your feelings of affection.

2. **Get the person's attention.** Limit distractions and noise—turn off the radio or TV, close the curtains or shut the door, or move to quieter surroundings. Before speaking, make sure you have her attention; address her by name, identify yourself by name and relation, and use nonverbal cues and touch to help keep her focused. If she is seated, get down to her level and maintain eye contact.

3. **State your message clearly.** Use simple words and sentences. Speak slowly, distinctly, and in a reassuring tone. Refrain from raising your voice higher or louder; instead, pitch your voice lower. If she doesn't understand the first time, use the same wording to repeat your message or question. If she still doesn't understand, wait a few minutes and rephrase the question. Use the names of people and places instead of pronouns (he, she, they) or abbreviations.

4. **Ask simple, answerable questions.** Ask one question at a time; those with yes or no answers work best. Refrain from asking open-ended questions or giving too many choices. For example, ask, *“Would you like to wear your white shirt or your blue shirt?”* Better still, show her the choices—visual prompts and cues also help clarify your question and can guide her response.

5. **Listen with your ears, eyes, and heart.** Be patient in waiting for your loved one’s reply. If she is struggling for an answer, it’s okay to suggest words. Watch for nonverbal cues and body language, and respond appropriately. *Always strive to listen for the meaning and feelings that underlie the words.*

6. **Break down activities into a series of steps.** This makes many tasks much more manageable. You can encourage your loved one to do what he can, gently remind him of steps he tends to forget, and assist with steps he’s no longer able to accomplish on his own. Using visual cues, such as showing him with your hand where to place the dinner plate, can be very helpful.

7. **When the going gets tough, distract and redirect.** If your loved one becomes upset or agitated, try changing the subject or the environment. For example, ask him for help or suggest going for a walk. *It is important to connect with the person on a feeling level, before you redirect.* You might say, *“I see you’re feeling sad—I’m sorry you’re upset. Let’s go get something to eat.”*

8. **Respond with affection and reassurance.** People with dementia often feel confused, anxious, and unsure of themselves. Further, they often get reality confused and may recall things that never really occurred. *Avoid trying to convince them they are wrong.* Stay focused on the feelings they are demonstrating (which are real) and respond with verbal and physical expressions of comfort, support, and reassurance. Sometimes holding hands, touching, hugging, and praise will get the person to respond when all else fails.

9. **Remember the good old days.** Remembering the past is often a soothing and affirming activity. Many people with dementia may not remember what happened 45 minutes ago, but they can clearly recall their lives 45 years earlier. Therefore, *avoid asking questions that rely on short-term memory*, such as asking the person what they had for lunch. Instead, try asking general questions about the person’s distant past—this information is more likely to be retained.

10. **Maintain your sense of humor.** *Use humor whenever possible, though not at the person's expense.* People with dementia tend to retain their social skills and are usually delighted to laugh along with you.

[5] source: https://www.caregiver.org/caregivers-guide-understanding-dementia-behaviors

(415) 434-3388 | (800) 445-8106; website: www.caregiver.org; email: info@caregiver.org
FCA CareJourney: www.caregiver.org/carejourney
Family Care Navigator: www.caregiver.org/family-care-navigator

Family Caregiver Alliance (FCA) seeks to improve the quality of life for caregivers through education, services, research, and advocacy. Through its National Center on Caregiving, FCA offers information on current social, public policy, and caregiving issues and provides assistance in the development of public and private programs for caregivers. For residents of the greater San Francisco Bay Area, FCA provides direct support services for caregivers of those with Alzheimer’s disease, stroke, traumatic brain injury, Parkinson’s, and other debilitating health conditions that strike adults.

When working with individuals with dementia remember to be patient, use your self-control plan. Don't take it personally - be empathetic. The person with dementia is not doing "things" on purpose - it is not their choice but rather the illness taking over.

NOTE to PART Trainers:
If you are only teaching PART Basic then Skills Training is not included. Continue with the balance of the PART program.

If you are teaching PART Intermediate or Advanced, include the following when teaching the dementia enhancement with skills. The last page of this enhancement could be copied and provided to your participants as it is not included in the participant handout.

PART techniques

PART has practical skills that can be utilized to respectfully break a hold or grip and even to temporarily manually restrain a dementia client when required. The three PART techniques I will demonstrate are slightly modified for the PART Dementia Enhancement and should be used with the dementia client.

NOTE: When teaching PART Intermediate techniques with the dementia enhancement, use the information on the next page for the three techniques noted. Ensure you demonstrate, allow for adequate practice time and the required return demonstration.

The following skills/techniques are aligned with the PART breakaway/evasion techniques. These techniques can be done respectfully and not cause injury to the client or the worker. The dementia client may not be intentionally violent or assaultive; it may be their reaction to a situation.

You match the level of your response with the level of aggression posed - you don't exceed it; you don't use excessive force.

Do not over react. Use your self-control plan.

Get your client's attention – this can be achieved by a light touch or tap for example, on their hand if they're grabbing you.

Use your calm voice, such as "Betty, let go".

Practice – perfect practice makes perfect. Following training, practice all modules to keep what you've learned in the forefront. Practice with your co-workers to help keep everyone safe.

Pinch Release (Capture)

Assaultive individual pinches your arm.

- move toward point of capture, pushes free hand down on assaultive individual's fingers which will release capture and moves through the scratch and out of the way.

Scratch Response (Capture)

Assaultive individual is scratching your arm.

- move toward point of capture, pushes free hand down on assaultive individual's fingers which will release capture and moves through the scratch and out of the way.

PART's **Two Person Escort** technique may result in using too much force with the dementia client. Staff may require adjusting their alignment to the client by positioning themselves at either side of the client. This alignment would provide the ability for staff to guide the client.

Differences in staff height relative to the client is considered (as pictured) and staff may need to adjust their hand placement.