Welcome!

Workshop 2
People Living with Dementia
Communication skills – 1st steps

Aims and purpose of the workshop

• Aim. - To highlight communication strategies for those working with people living with dementia
• To highlight the impact of dementia upon the communication skills of participants living with dementia.
• To share practical strategies for improving communication with participants living with dementia.
• To know where to access further information.

Alzheimer’s - then and now!

• Alois Alzheimer (1864 – 1916) “discovered” AD in 1911
• Auguste Deter (patient 1901 – 1906)

“Government spends less on researching the disease than the cost of building one mile of motorway!” (£30 million)
2% of MRC budget, ¼ of that spent on cancer
(Lib Dem Conference 2009)

Reflection on your current experience/practice

Identify the key factors about dementia that affect your teaching in OEP/PSI/EFS
Can you prioritise 3 from your group?

Information processing - two things at once
What is dementia?
Characterised as:
• Global and generalised cognitive impairment, conditions that are progressive and irreversible (nerve cell death)
• ‘umbrella’ term to describe a syndrome – the nature in which nerve cell death occurs – there are different types of dementia E.g. ‘Cortical’ and ‘Subcortical’ dementia
• Different types present differently although there may be common features
  
Dementia is not “normal ageing”

Cortical and subcortical dementia

Cortical
• Outer layers of brain (cortex)
• Main problems: memory, recall of words, aphasia
• E.g.s. Alzheimer’s, frontotemporal,

Subcortical
• Inner layers of the brain (below the cortex)
• Main problems: personality, slowing down of thought processes
• Memory and language largely unaffected
• E.g.s. Huntington’s, Parkinson’s, MS

Different parts of the brain

Different mental activities take place in different parts of the brain. Positron emission tomography (PET) scans can measure this activity. Chemicals tagged with a tracer “light up” activated regions shown in red and yellow.

Alzheimer’s Disease

The common face - 60% of dementias

Beta amyloid plaques
dense deposits of protein accumulates outside and around nerve cells

Neurofibrillary tangles
twisted fibers that build up inside the nerve cell

Alzheimer’s disease
• Most common of dementias (60%+)
• Nerve cell death: amyloid plaques and neurofibrillary tangles (tau)
• Hippocampus in temporal lobe extremely vulnerable

Alzheimer’s variant - 1
Progressive visuospatial
• Posterior cortical atrophy (Terry Pratchett)
• Disease restricted to back of the brain
• Memory loss not as obvious in early stages
• Visual problems (occipital lobe)
• Object and face recognition (object agnosia, prosopagnosia)
Alzheimer’s variant - 2
Progressive aphasic (linguistic)
Left temporal lobe atrophy (wasting away)
• Non fluent aphasia (most common) – problems with word production, can understand others
• Fluent aphasia – can speak fluently but can’t make sense. Can’t understand others

Vascular dementia
• Second most common (20%) and affects more men than women
• Common cause: stroke or vascular event
• Not a single disease, but different vascular causes e.g.
  • stroke (single infarct)
  • mini-strokes (multi-infarct)
  • TIA’s (Transient Ischaemic Attack) sub-cortical vascular dementia - damage to tiny blood vessels that lie deep in the brain
• Progress may be a series of “steps”

Strong link to lifestyle factors, BP, cholesterol, type 2 diabetes, physical inactivity

Episodic Memory
• Inability to learn and/or retain new information
• Memory for events – time, place, emotions, contextual knowledge e.g. I had eggs for breakfast
• Forming new memories, (I had a cup of tea) rapid forgetting (sit to stand)
• Poor orientation (how far away is that chair, where am I?)

Semantic Memory
• Memory for facts, meanings, ideas, tastes, smells
• Symptoms: word finding difficulties, reduced vocabulary (can’t explain)
• Reduction in content and meaning of words (backwards, sideways, fast, faster)
• Loss of general knowledge e.g. Eggs have shells, they are laid by chickens and can be boiled, scrambled, poached or fried

Attention/executive function
• Attention problems - early as poor concentration and being easily distracted
• As disease progresses – inability to co-ordinate and sequence activity, (learned purposive tasks e.g. doing up a button, cooking with recipe, driving, getting dressed, in fact becoming a learner all over again)

Dementia – a syndrome
There are different
• Types of dementia
• Parts of the brain that are affected
• Presentations although there may be common features
• Rates of progression through stages

Once you’ve met a person with dementia, you’ve met a person with dementia”
People living with dementia – what review level evidence do we have?

- Exercise training increases fitness, physical function, cognitive function and positive behaviour in people with dementia (Heyn 2004)
- Sustained walking benefits mood and improve quality of sleep (Eggermont @ Scherder 2006)
  - But at least 30 mins per day to benefit mood
  - Several times a week for improved sleep
- Walking in 1 – 1 reduces aggressive behaviours and agitation
  (Cohen Mansfield 2001)
- Impact on ADLs in Care settings requires sustained programme
  (Cohen Mansfield 2001)
- But Cochrane (2008) equivocal - power and design
  (Recruitment and adherence, ethical consent, exclusion)

Dementia and falls

- Only 48 / 25,000 papers on falls mention dementia
- Most PLWD are excluded from trials
- No benefit with multifactorial interventions
  (Shaw et al 2003 (BMJ), Jenson et al 2003 (JAGS))
- Evidence is emerging e.g. Reduction in falls and quality of life found for people with dementia from carer-directed home exercise program.
  (Megan L. Wraith 2008)
- “There is no reason to suppose that PLWD will not experience the same benefits as other people” (Close 2010)

What other evidence do we have?

3 – Seattle Protocols

- Exercise Interventions for Dementia and Cognitive Impairment: The Seattle Protocols
- Community dwelling individuals with cognitive impairment
- Decrease physical disability and delay disease progression
  - Initiating physical activity participation
  - Behavioural strategies
  - Encouraging walking and community-based activities
  - Engagement interpersonal support

Communication behaviour

In any one of your OEP/PSI/EFS classes, what communication behaviours/activities are used by you and participants?

Verbal and non verbal communication

15 – 25% of communication is verbal

75 – 85% of communication is non verbal

Communication challenges

Instructor

Non verbal

Participant

???

Impaired by dementia or by (ab)normal ageing?
Communication challenges

What do we need to know?
How much do we have access to?
How much of this information can we find out?
Who could help us?

- Hearing loss and visual impairment - confounding factors in later life
- Concentration and distractions (internal/external)
- Environment (light, colour, sounds)
- Medication, (timing short and long term)
- Pain, discomfort, and agitation
- Other conditions e.g. infections, incontinence
- Mood and motivation – depression, apathy, purpose of?
- Emotional - frustration (with situations/tasks), anxious, aggressive or withdrawn

The type of dementia and the parts of the brain affected and the status/stage on the dementia journey

Practical applications

- Attracting attention/concentration
  - Initiating activity
  - The environment

The physical activity environment

- A safe place to be
- A good place to be
- A stimulating place to be

What do we want to achieve?

- Communication
  – For participation, achievement and success
  – Safety and enjoyment
- But what is that?
  – Effective performance
  – Improvement
  – A worthwhile experience
  – Satisfaction

Your or their priority?
And finally ..........

Further resources at
www.laterlifetraining.co.uk
LLT CPD training – dementia
Late Autumn 2011
Review – one thing to take away from this session
Evaluation forms

www.laterlifetraining.co.uk
Thank you for participating