Dementia Companion

Guide for Additional Caregivers in Nursing Care

Simone Schmidt
Martina Döbele

Springer

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ISBN 978-3-662-67041-5 ISBN 978-3-662-67042-2 (eBook)
https://doi.org/10.1007/978-3-662-67042-2

This book is a translation of the original German edition "Demenzbegleiter" by Schmidt, Simone, published by Springer-Verlag GmbH, DE in 2019. The translation was done with the help of an artificial intelligence machine translation tool. A subsequent human revision was done primarily in terms of content, so that the book will read stylistically differently from a conventional translation. Springer Nature works continuously to further the development of tools for the production of books and on the related technologies to support the authors.

This Springer imprint is published by the registered company Springer-Verlag GmbH, DE, part of Springer Nature.
The registered company address is: Heidelberger Platz 3, 14197 Berlin, Germany

Foreword

In 2007, I was diagnosed with a brain tumor. In the hospital, my roommate was an elderly man who suffered from dementia. Until then, I did not even know what dementia meant. He left the room and did not come back for hours, unless I brought him back. At night, he stood in front of my bed and scolded, what I was doing in his apartment.

That was the moment when I told myself: If I get well again, I want to help other people.

After a year, my tumor was gone. So I quit my old job after over 30 years and did a four-month training at the DAA as a nursing assistant/dementia caregiver, which I completed with special success. This was followed by a one-month internship at the old and nursing home "Luisenheim in Düsseldorf". The home manager Mr. Kuhlmann and the nursing service manager Mrs. Wittig liked my open way of dealing with the seniors very much. So I got a full-time job.

Meanwhile, I work together with 3 other colleagues. This book was very helpful to us in our work: I built our first sensory mobile for little money, with which we can entertain our bedridden residents with 10-minute activations. On my laptop, I have loaded many old hits, operettas and funny stories. Wednesday evening, then, as part of the night café, my request concert takes place. With a glass of wine or juice, the residents look forward to a great evening.

Through my work, my attitude towards age, illness and farewell, but also to my own activity, has changed. I wish all readers of this book these or similar experiences.

Michael Lenden
Düsseldorf

Preface

» "Time for care"

This was the title of the article in the German Medical Journal in June 2012 about dementia companions in the care and support of seniors. Although the various professional groups, the public and the media expressed themselves predominantly negatively and rejectingly when the care staff directive was published, it has proven in practice that additional care has become a success story. A scientific evaluation commissioned by the GKV-Spitzenverband confirmed the high satisfaction of the participants.

From our point of view, the critical attitude was not justified even then, because the accompaniment of a person with dementia is learnable. In the directive on the qualifications and tasks of additional care staff published in August 2008, the requirements for dementia companions were fundamentally defined.

Requirements for care staff

- A positive attitude towards sick, disabled and elderly people
- Social competence and communication skills
- Observation and perception skills
- Empathy and relationship skills
- The willingness and ability to communicate non-verbally
- Imagination, creativity and flexibility
- Composure in dealing with behavioral peculiarities resulting from dementia and mental illnesses or intellectual disabilities
- Psychological stability, ability to reflect on one's own actions, ability to set boundaries
- Ability to accompany and guide individuals or groups of people with dementia, mental illnesses or intellectual disabilities with dignity
- Teamwork skills
- Reliability

Our concern remains to equip the future dementia companions with these necessary knowledge and skills through this book, so that they can fulfill their important and beautiful task with joy and creativity. We wish all those affected and their relatives such a companion who walks a part of the way with them.

» "What you tell me, I forget.
What you show me, I remember.
What you let me do, I understand."
Confucius

We thank Ms. Sarah Busch, our "companion" at Springer Verlag, who always supports us competently. We thank Ms. Ulrike Niesel for the prudent project management, who has accompanied us for many years.

Ms. Barbara Lengricht, who accompanied us with heart and commitment in the first edition, made this book possible. We would also like to thank her warmly.

We owe great thanks to our friends and colleagues, but especially to our families, for their understanding, support and tolerance.

Martina Döbele
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Mörlenbach
Ladenburg
Summer 2019

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Service Part

List of Abbreviations

AEDL	Activities and existential experiences of life
BEBP	Federal Association of European Care and Nursing Staff e. V.
BGB	Civil Code
BMI	Body mass index
BT	Occupational therapy
CMAI	Cohen-Mansfield Agitation Inventory or Cohen-Mansfield Scale
DCM	Dementia Care Mapping
DNQP	German Network for Quality Development in Nursing
ESBL	Extended-spectrum beta-lactamase
GG	Basic Law
GKV	statutory health insurance
GPS	Global Positioning System
HIV	Human Immunodeficiency Virus
HL	Home Management
HWL	Housekeeping Management
ICD	International Classification of Diseases
IFSG	Infection Protection Act
KDA	German Foundation for the Care of the Elderly
MDA	Mobile Digital Assistant
MDE	Mobile Data Acquisition
MDS	Medical Service of the Peak Associations
MMST	Mini Mental State Test
MNA	Mini Nutritional Assessment
MRE	Multiresistant Pathogens
MRSA	Methicillin resistant Staphylococcus aureus
NBA	New Assessment for Appraisal
PDL	Nursing Service Management
PEG	Percutaneous endoscopic gastrostomy
PSG	Care Support Act

SGB Social Code

SIS® Structured information collection according to the structure model

StGB Criminal Code

VA Validation user

WBL Residential area management

WHO World Health Organization

Dementia

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https://doi.org/10.1007/978-3-662-67042-2_1

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» The mind and the ability to use it are two different abilities. (Franz Grillparzer)

In Germany, more than 1.7 million people are currently suffering from dementia and about 300,000 new cases are added each year. Taking into account the demographic development, it becomes clear that the disease dementia poses an enormous challenge in the future, especially since the care and support of people with dementia requires basic knowledge and extensive experience and is associated with a huge amount of time in the course of the disease. In this chapter, the disease will be presented first. The knowledge of the different forms and causes of dementia, the resulting losses of cognitive abilities, the typical **symptoms** and the existing treatment options are prerequisites for an appropriate handling of the affected people. For each **symptom**, there are references to the respective chapters that deal with the resulting problems and the possible therapeutic **interventions** in the care of dementia patients.

1.1 Disease

In principle, one distinguishes between primary dementias, which are caused by a degeneration of the brain substance, and dementia-like **syndromes**, which occur on the basis of another disease, such as malnutrition, alcohol dependence, metabolic disorders or inflammatory diseases of the central nervous system.

Definition

Dementia
The term **dementia** comes from Latin and means translated "without mind". It does not mean a specific disease, but the occurrence of various signs of disease that involve a loss of mental abilities.

Dementia-like syndrome
The World Health Organization WHO defines a dementia-like **syndrome** as an "acquired global impairment of higher brain functions including memory, the ability to solve everyday problems, the execution of **sensomotor** and social skills, language and communication as well as the control of **emotional** reactions without pronounced impairment of consciousness."

1.1.1 Forms of Dementia

The most well-known form of dementia is Alzheimer's disease. It was first described by Alois Alzheimer (1864–1915), a German psychiatrist and neuropathologist (Fig. 1.1), who met the patient Auguste Deter in 1901 in Frankfurt, at the "Municipal Institution for the Insane and Epileptic"

Fig. 1.1 Alois Alzheimer

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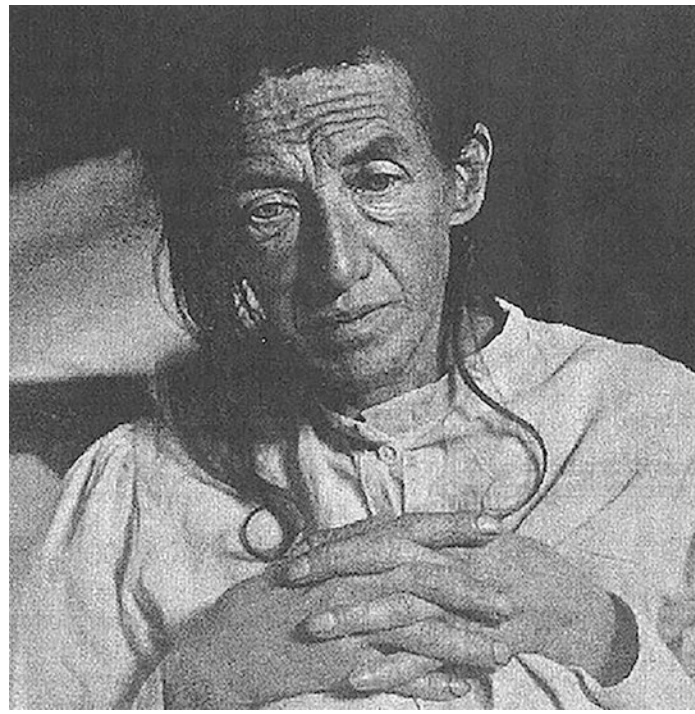

Fig. 1.2 The 51-year-old Auguste Deter

(Fig. 1.2). She was brought by her husband, because she could no longer manage the household and showed noticeable behavioral changes.

Alois Alzheimer already described in 1901 in his notes the typical course of conversation with people with dementia.

In a conversation record of Alzheimer with Auguste Deter, typical features of dementia are recognizable.

- "What is your name?"
- "Auguste."
- "Surname?"
- "Auguste."
- "What is your husband's name?"—Auguste Deter hesitates, finally answers:
- "I think…Auguste."
- "Your husband?"
- "Oh, I see."
- "How old are you?"
- "51."
- "Where do you live?"
- "Oh, you have been to our place before."
- "Are you married?"
- "Oh, I am so confused."
- "Where are you here?"

- "Here and everywhere, here and now, you must not take anything amiss from me."
- "Where are you here?"
- "There we will live."
- "Where is your bed?"
- "Where should it be?"

Alzheimer was surprised by these symptoms, as the patient was only 51 years old. After her death, he examined her brain and found the deposits typical of Alzheimer's disease, called plaques.

In contrast to age-related dementia, Alzheimer's disease occurs before the age of sixty and is therefore also referred to as the **presenile** form. The dementia of the Alzheimer type, i.e. the presenile and the senile form, account for up to 70% of the dementias. About 20% of the affected people suffer from a **vascular** dementia, i.e. a dementia caused by circulatory disorders, the rest are distributed among mixed forms of these diseases and dementia syndromes of various causes.

Vascular dementia is caused by many small, sometimes unnoticed strokes. This leads to a reduced blood flow to certain brain areas.

Risk factors for vascular dementia

- Significantly elevated blood fats (cholesterol)
- Smoking
- Diabetes (diabetes mellitus)
- High blood pressure
- Obesity (adiposity)
- Lack of exercise

It should be borne in mind in this context that these risk factors have had an impact over a long period of time. They are important for the prevention of the disease, but not in the advanced stage.

1.1.1.1 Classification of Dementia According to ICD-10

The International Classification of Diseases ICD-10 distinguishes the following dementia diagnoses:

- Dementia of the Alzheimer type: early onset/with delirium/with delusion/with depressive mood
- Dementia of the Alzheimer type: late onset/with delirium/with delusion/with depressive mood (together about 70%)
- Vascular dementia/with delirium/with delusion/with depressive mood (~20%)
- Dementia due to an **HIV infection**
- Dementia due to a **Parkinson's disease**
- Dementia due to a **Creutzfeldt-Jacob disease** and due to other diseases of the brain

Often, however, the disease is not sufficiently diagnosed, the affected person eventually gets the general diagnosis of "dementia". For the treatment and the use of different methods in the care, however, it is advantageous if the cause and the stage of the disease have been examined more closely.

The distinction of dementia from **physiological** degradation processes in old age and from other diseases with similar symptoms is important for the treatment and for the interaction with the affected persons.

1.1.1.2 Severity Levels

When warning signs occur, a visit to a memory clinic is helpful.

In the case of the different forms of dementia, it is often a matter of diseases that start insidiously and progress over a period of several years. Only a few forms of dementia, such as the demential syndromes in various metabolic disorders, are completely **reversible,** that is, the disease symptoms regress when the underlying disease is treated.

At first, there are nonspecific warning signs, but they are usually not consciously perceived by either the affected persons themselves or their environment.

Warning signs

- Forgetfulness with impact on work: Most people forget names or dates now and then. If these incidents accumulate and also unexplained states of confusion occur, this can be a sign of a decrease in memory performance.
- Difficulties with familiar actions: People who have a lot to do are sometimes distracted and forget e.g. the pot on the stove. People with dementia may not only forget the pot on the stove, but also that they cooked.
- Language problems: Most people sometimes have difficulties finding the right words. People with dementia often can't remember simple words, instead they use inappropriate filler words. This makes the sentences hard to understand.
- Spatial and temporal orientation problems: Many people occasionally forget e.g. weekdays or get lost in an unfamiliar environment. People with dementia may find themselves in their own street and not know where they are, how they got there and how to get back home.
- Impaired judgment: Not always do people choose the appropriate clothing for the weather. The clothing chosen by people with dementia is sometimes completely inappropriate. They wear e.g. a bathrobe when shopping or several blouses on a hot summer day on top of each other.

- Problems with **abstract** thinking: For many people, it is a challenge to manage an account. People with dementia often can neither sort numbers nor perform simple calculations.
- Leaving objects behind: Now and then almost everyone leaves the key or the wallet behind. However, people with dementia may put objects in completely inappropriate places, such as an iron in the refrigerator or a watch in the sugar bowl. Afterwards, they don't remember where they put the objects.
- Mood and behavioral changes: Mood changes occur in all people. People with dementia can fluctuate very abruptly in their mood, often without any apparent reason.
- Personality changes: In old age, the personality of many people changes a little. In people with dementia, a very pronounced personality change can occur suddenly or over a longer period of time. Someone who is normally friendly, for example, becomes unexpectedly angry, jealous or anxious.
- Loss of initiative: People do not work continuously with the same motivation. People with dementia sometimes lose the momentum in their work and the interest in their hobbies completely, without finding joy in new tasks.

In the further course, the typical signs of dementia occur with increasing severity (Table 1.1).

1.1.2 Symptoms

The function of the brain consists of the reception, transmission, processing and storage of stimuli by the nerve cells. If there are changes in these processes, important tasks of the brain are difficult or impossible.

Depending on the severity and cause of the disease, the various subareas of the mind can be impaired. This results in typical signs of the disease, which can be detected by a precise observation of the patient.

When observing the symptoms, the differentiation of the individual functions of the mind is important.

Subareas of the mind

- Consciousness
- Attention, perceptual ability
- Concentration
- Thinking ability
- Language comprehension and language production
- **Association**
- Responsiveness

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Table 1.1 Severity of dementia

Severity	Cognition	Lifestyle	Disturbances of drive and affect	MMST*-Score (max. 30 points) *Mini-Mental-Status-Test (Appendix 2)
Mild "Forgetfulness stage"	Complicated daily tasks or leisure activities cannot be performed (anymore)	The independent lifestyle is limited, but an independent life is still possible	Lack of spontaneity, depression, lack of drive, irritability, mood instability	Below 23–24
Moderate "Stage of confusion"	Only simple activities are maintained; others are no longer performed completely or inappropriately	An independent life is no longer possible; patients depend on foreign help, an independent lifestyle is partly still possible	Restlessness, outbursts of anger, aggressive behaviors	Below 20
Severe "Stage of helplessness"	Thought processes can no longer be communicated comprehensibly	The independent lifestyle is completely abolished	Restlessness, fidgeting, screaming, disturbances of the day-night rhythm	Below 10

- Impulse control
- Loss of judgment
- Loss of reality—living in a subjective world
- Memory: short- and long-term memory
- Orientation ability
- Emotion and **Intuition**

The precise observation and documentation of the individual disease symptoms that result from the cognitive impairments is important both for the assessment of the course and for the interaction with the affected persons (▶ Chap. 3). In addition, the observation of the symptoms is helpful in formulating the care planning (▶ Chap. 5).

▶ Example

A 93-year-old demented patient developed the feeling that the nursing staff had something against her and therefore only spoke the bare minimum. She complained that they would whisper about her in her presence. After the **ENT doctor** had rinsed her ears, the symptoms immediately disappeared.

A 90-year-old demented patient suffered from a pronounced cataract with a significant loss of vision. Since she saw small animals everywhere, she did not want to eat anymore. After an eye operation, the problem was solved. ◀

All staff involved in the care of the person with dementia should record their observations and exchange them regularly in team meetings.

The decline of vision and hearing in old age worsens the symptoms.

Practical tip

For the dementia companion, it is therefore useful to always have a notebook ready, in which he records daily peculiarities, abnormalities and behavioral changes, as they otherwise quickly fade from memory.

In particular, attention should be paid to behavioral abnormalities that are unpleasant or stressful for the person with dementia or his environment. Also, the change of abilities or typical reactions is of interest. The dementia companion spends a significant part of the daily routine with the affected person in a manageable environment and can therefore assess the behavior and mood of the demented person unhindered.

By reversing the relationship between reason and emotion, the demented person can no longer **rationally** justify or make decisions in the course of the disease, he rather decides "from the gut".

The more pronounced the physical and mental decline, the greater the proportion of emotion and intuition (◘ Fig. 1.3).

The most important task in the care of people with dementia is to detect feelings and moods, in order to be able to establish appropriate contact with the affected person. The basic prerequisite for this is a pronounced empathy and the ability to reflect on one's own behavior (► Chap. 3).

1.1.2.1 Consequences of the Symptoms

Due to the above-mentioned **cognitive** deficits, there are impairments in the area of thinking and in the area of behavior. Depending on the stage of the disease, the affected persons recognize that they have lost certain abilities and develop strategies to hide the signs of the disease. At the beginning of the disease, it is usually very easy to conceal the symptoms by using general phrases, such as: "That can happen to anyone", or: "You know what I meant". In the further course, they "invent" answers to questions or deduce the correct answer from the context.

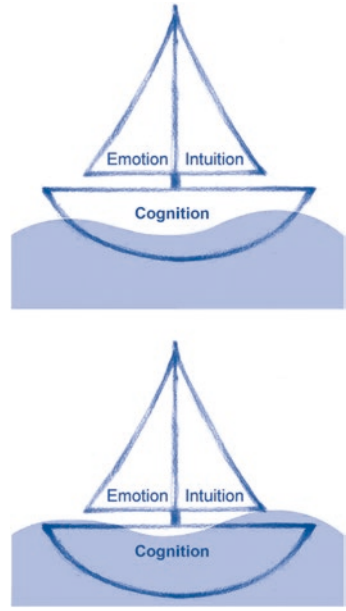

Fig. 1.3 Reason and emotion

A stressful problem for the affected persons is the phase of the disease in which the deficits progress and are still perceived by the patient as a deficit. In this phase, mood swings predominate, ranging from anxious, insecure and clueless to desperate and depressed.

In the case of severe dementia, physical symptoms eventually occur, which ultimately lead to complete helplessness and **need for care**.

Impairment of thinking processes

- Word-finding difficulties
- Memory problems, initially with short-term memory, later also with long-term memory
- **Disorientation**
- Loss of **abstract thinking** and judgment with misinterpretation of situations or persons
- Delusions and hallucinations
- Confabulations

Confabulating means telling objectively false stories (Latin "fabula": story, fairy tale) to cover up memory problems.

▶ Example

Mrs. Maier wanders aimlessly along the corridor, although her nursing staff Mrs. Lehmann has asked her several times to have lunch in the dining room. She addresses her:

Mrs. Lehmann: "Mrs. Maier, where are you coming from, don't you want to come to eat?"
Mrs. Maier: "Yes, yes, I just had to finish something."
Mrs. Lehmann: "What did you do?"
Mrs. Maier: "Oh, that was really very important, my mother got a visit and I had to help her with the preparations. You can imagine what that means: making beds, baking cakes, dusting, yes, yes, you always have something to do. Now I'm really glad that we finished everything in time, my sister is no great help there. Well, she was always a bit special, spends more time in front of the mirror than at work. But my mother knows that she can rely on me." ◀

The disturbances of thinking often manifest themselves in the form of misunderstandings, which lead to conflicts in the social environment of the affected person.

In the case of **orientation**, four different areas are distinguished, which are considered separately when orientation disorders occur.

Orientation ability
- Temporal orientation
- Spatial orientation
- Orientation to the situation
- Orientation to the person

In a severe case of disorientation, all four areas can be affected.

▶ Example

An example of a complete orientation disorder are people who no longer recognize themselves in the mirror and therefore have a lively conversation with their mirror image. ◀

The most important therapeutic measures for dealing with impairments of thinking are described in the chapter "Dealing with People with Dementia" (▶ Chap. 3).

Impairments of behavior
- **Agitation,**Restlessness
- Sleep disturbances
- Possibly reversal of the day-night rhythm
- Verbal or physical aggressive behavior
- Wandering, running away or towards tendencies
- Orientation disorders
- States of excitement, delirious behavior
- Loss of reality

- "Facade" behavior, meaning the person affected tries to maintain a facade
- Depressive moods

The chapters "Dealing with People with Dementia" (▶ Chap. 3) and "Care" (▶ Chap. 6) deal with the possible measures for behavioral disorders, taking into account an appropriate approach.

Physical symptoms

- Lack of drive
- Gait disturbances with tendency to fall
- Further **motor** disorders
- Swallowing difficulties with malnutrition
- Urinary and fecal incontinence

In the final stage, the affected person often lies in a fetal position in bed, can no longer communicate and is dependent on help in all areas.

The possible nursing measures are described in the chapter "Care and Documentation" (▶ Chap. 5).

An assessment of the behavioral problems is possible with the Cohen-Mansfield Agitation Inventory CMAI. This is completed by experts and presented in the appendix for better understanding (Appendix 1). An assessment of the well-being is also possible with the Heidelberg Instrument for Measuring the Quality of Life of People with Dementia H.I.L.DE.

1.1.3 Diagnosis and Differential Diagnosis

Only by a more precise Diagnosis using imaging techniques and various test procedures can the Dementia be differentiated from other clinical pictures. First, the clinical picture is collected for the Diagnosis, whereby especially the cognitive impairments are examined.

Imaging techniques, especially the **Computed tomography** and the **Magnetic resonance imaging,** allow a more accurate examination of the cause. In the case of Alzheimer's disease, a precise diagnosis can often only be made in an advanced stage or after death by examining the brain. The diagnosis is therefore a diagnosis of exclusion and also serves to monitor the course of the disease.

The most important test procedures, which also allow a statement about the progression of the disease, are the Mini Mental State Test MMST (Appendix 2) and the Clock test

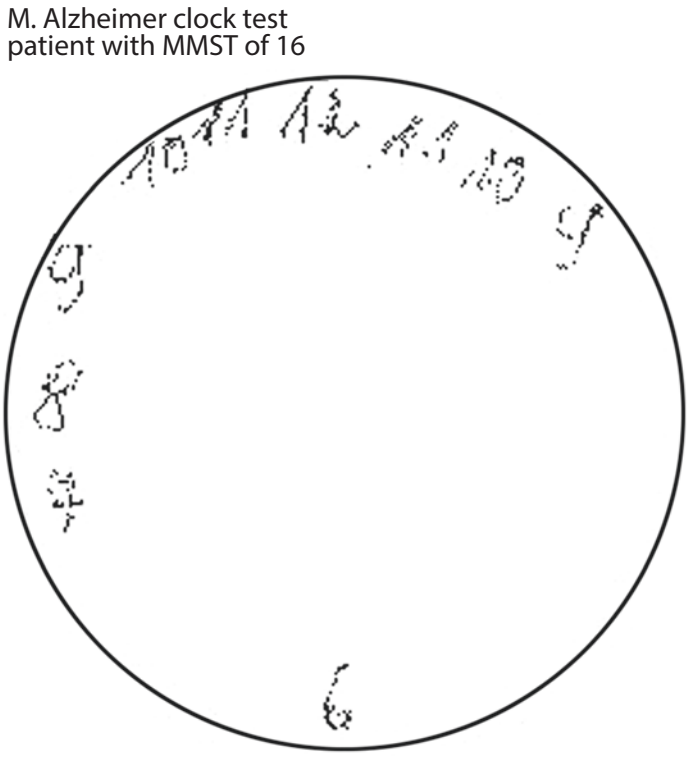

Fig. 1.4 Clock test

(Fig. 1.4). Both can be performed at any time and with little time expenditure. In the clock test according to Shulman, the person concerned is asked to draw a clock and enter a certain time. Points are awarded for the result according to fixed criteria. To perform the tests, a **gerontopsychiatric** expertise is necessary, but for a better understanding both tests are presented.

A disease that has similar symptoms and therefore has to be excluded in the diagnosis is the Depression.

In depressive disorders, dementia-like symptoms can occur and vice versa. The exact distinction is, however, especially important for the pharmacological treatment.

In depression, a so-called "Pseudodementia" can occur, which causes similar symptoms, but completely disappears after the depressive episode subsides.

1.1.4 Prognosis

As already described, the dementia syndrome is completely reversible due to an organic cause. All other forms of the disease, however, are not curable and lead to complete helpless-

ness with need for care and ultimately to the death of the person concerned over months to years.

Some very rare, hereditary forms of the disease have a rapidly progressive course.

1.1.5 Treatment

Medications, psychological and psychosocial methods as well as interventions that are oriented towards behavior therapy are used.

1.1.5.1 Medicinal Treatment

A medication of dementia serves to slow down the course of the disease and can be used for a mild to moderate dementia. Depending on the preparation, the progression of the disease is delayed by 3 to 6 months and there is a stabilization of brain functions.

Side effects are nausea and vomiting, drop in blood pressure and dizziness as well as, especially at the beginning of the treatment, restlessness and sleep disorders. An effect can only be assessed after at least 2 weeks of intake.

The symptomatic treatment for restlessness, agitation, anxiety and delusional symptoms consists of administering medications that have a **sedative** effect.

The so-called neuroleptics are most frequently used, which, however, have to be dosed very carefully in older people, as there can be serious side effects. With decreasing metabolic function in old age, there can be an increase of the active substance in the blood, a so-called accumulation.

It is assumed that older patients need only about half the dose due to the declining liver or kidney function.

Possible side effects of neuroleptics

- Fatigue
- Drop in blood pressure
- Rapid heartbeat
- Dry mouth or salivation
- Increased risk of falling
- Reduced pain sensation
- Swallowing difficulties
- Changes in appetite
- Depressive mood
- Parkinson-like symptoms
- Tongue spasms
- Eye spasms
- Restlessness

As a serious late consequence, finally, so-called tardive dyskinesia can occur with the classical neuroleptics. These are involuntary movements of the body and the facial muscles. In the worst case, they persist for life or have to be treated with medication for years.

Practical tip

In the daily contact with the affected person, it is important to pay attention to corresponding indications and to exchange these observations in the team.

Other serious side effects are the **delirium** or the **malignant** neuroleptic syndrome, an intolerance reaction to the medication, which represents a life-threatening condition.

The treatment of agitation or sleep disorders in dementia with benzodiazepines, i.e. Valium-like sedatives, can lead to paradoxical reactions. The affected people then become restless or euphoric. Another reason why benzodiazepines are prescribed with caution is the risk of respiratory disturbances and the high addictive potential of these substances.

1.1.5.2 Non-pharmacological Treatment

Over the last decades, several research results were obtained and based on them, several therapeutic interventions were developed, which are only listed here. A more detailed description is given in chapter "Dealing with people with dementia" (▶ chap. 3) as well as in chapter "Care" (▶ chap. 6).

Possible treatment strategies

- Assessment of the behavioral disorder (Assessment)
- Activation and occupation
- Biographical work, memory album
- Day structuring
- Milieu therapeutic interventions
- Person-centered interventions e.g.:
- Reality orientation training or reality orientation support
- Memory training
- Everyday training
- Use of animals
- Music therapy
- Aromatherapy
- Validation
- **Snoezelen**
- Dementia Care Mapping DCM

The possibilities of the individual measures are described in the chapter "Care" (▶ Chap. 6).

1.1.5.3 Prevention

Scientifically proven at the moment is only the Prevention against vascular dementia, which consists in avoiding risk factors.

For dementia of the Alzheimer type, new strategies of prevention are continuously taken up in the media, whose effectiveness for the individual is not verifiable and which are therefore not listed in detail here.

Practical tip

A generally healthy lifestyle with balanced nutrition, regular exercise and mental activity is certainly useful in **prevention**.

1.1.5.4 Complications

The most significant Complication of the various forms of dementia is Delirium.

Delirium

The term delirium (delir) comes from the Greek "leros": madness, nonsense and from the Latin "delirare": to be insane. In principle, it is a disturbance of consciousness.

Delirium Delir is an acute or insidious disturbance of consciousness with reduced concentration, impairments of memory and orientation, and perceptual disturbances in the sense of hallucinations, which cause great restlessness and anxiety. In contrast to dementia and depression, consciousness is reduced in delirium.

Practical tip

Typical for delirium are fidgety movements of the hands.

Delirium is always an emergency!

Delirium can be triggered by a variety of causes.

Causes of delirium

- Fever
- Lack of oxygen
- After surgery

- Infections, e.g. urinary tract infections, pneumonia
- Heart failure, anemia
- Disturbances of fluid and electrolyte balance
- Alcohol withdrawal
- **Medication intoxication**
- Metabolic disorders

Delirium is an urgent medical condition, as it poses a life-threatening situation for the affected person. There is a risk of cardiovascular failure due to the stress.

Important and often difficult is the timely recognition of delirium, so that a hospital admission and a drug treatment can be initiated.

Mental Disorders

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https://doi.org/10.1007/978-3-662-67042-2_2

» You can run away from what is behind you, but what is inside you, that catches up with you. (African proverb)

Some psychiatric disorders resemble the symptoms of dementia. The patients suffer partly from limitations of **everyday competence** and need supervision, support and guidance. For this reason, all persons with impaired everyday competence were included by the legislator in the group to be cared for. In order to adequately care for persons with impaired everyday competence due to mental disorders, the caregiver must have comprehensive knowledge of the causes and effects of these diseases. Therefore, this chapter describes in more detail the psychoses, depression and mental retardation.

2.1 Psychosis

The terms "psychosis" and "neurosis" need to be distinguished.

The term "psychosis" is an umbrella term that stands for a group of mental disorders. It is often used synonymously with the term schizophrenia.

Definition

Psychosis
Psychosis comes from the Greek and consists of the word *Psyche,* meaning mind, soul and the ending *-ose,* which indicates a morbid condition. The term psychosis would therefore be translated as "mental or emotional illness".

Neurosis
The psychosis needs to be distinguished from the term Neurosis. This also comes from the Greek, composed of the words *Neuron,* nerve and the ending *-ose.* In contrast to psychosis, neurosis is understood as a milder mental disorder that is caused by **traumatic** or negative experiences and leads to fears, compulsions, mood swings, disturbances of social behavior and **panic**.

Unlike psychosis, the patient clearly perceives the disorder as a disease that requires treatment.

2.1.1 Classification of Psychoses

One basically distinguishes between organic and non-organic psychoses, whereby an organic psychosis is characterized by a detectable brain disease.

Organic psychoses

- Due to brain diseases, e.g. dementia, tumor
- Due to brain injuries, e.g. traumatic brain injury
- Due to inflammations of the brain, e.g. herpes encephalitis
- Due to exogenously administered substances, e.g. medications, drugs

Non-organic psychoses

- Psychoses of the schizophrenic spectrum: Due to the diversity of the symptoms observed here, this formulation is nowadays usually used instead of the term schizophrenia.
- Affective psychoses: These include the alternation between **mania** and depression and often also simple, severe depressions.
- Mixed forms: The so-called schizoaffective psychoses.

2.1.2 Symptoms of Psychosis

The main symptoms of psychosis are paranoia (paranoid symptoms) and **hallucinations.**

Other symptoms are self-disturbances, i.e. the feeling of being influenced by other people or the feeling that others can read one's thoughts. In addition, there are disturbances of the thought process, such as thought blocking, delusional experiences or thought withdrawal.

2.1.2.1 Paranoid Symptoms

The paranoid symptoms, i.e. the feeling of being persecuted or threatened, often lead to the patient trying to escape this situation by, for example, barricading himself in his apartment for days or hiding in the forest.

► Example

In the case of delusions of persecution, those affected often feel persecuted by people with whom they have regular contact in everyday life, such as relatives, colleagues or neighbors. Some patients feel persecuted by secret services or the mafia, others have the feeling that all people want to harm them and are after them. ◄

The experiences that the affected people report lead to massive fears, up to and including fear of death.

The presence of self- or other-aggressive behavior may necessitate closed confinement.

In the worst case, these symptoms lead to suicide attempts or even suicide. In addition, delusions of persecution can trigger the occurrence of other-aggressive behavior, if the affected people try to defend themselves against their "persecutors".

2.1.2.2 Hallucinations

There are different qualities of hallucinations:

- Auditory hallucinations
- Visual hallucinations
- Olfactory hallucinations
- Body misperceptions

▪ Auditory Hallucinations

Auditory hallucinations are the perception of noises that do not exist in reality. Some patients hear music or other noises that do not cause stress or threat, but most hear voices that insult, threaten or urge them to do something.

So-called imperative voices command the affected person what to do, occasionally they even urge the patient to commit suicide. Often they are also voices that forbid the affected person to talk to other people about their problem, or even threaten to punish them for it. For this reason, it is sometimes difficult to notice auditory hallucinations. However, in the observation of the patient, one can often see that he is having "self-talk" or looking anxiously in a certain direction. Occasionally, the patients also hear voices that speak to them from the television or the radio.

▪ Optical hallucinations

Optical hallucinations are the seeing of objects or persons that do not exist. Here too, there can be a feeling of threat up to mortal fear. Especially when the affected person sees persons who want to harm him or her, or animals that want to attack him or her, massive fears are triggered.

▶ Example

Patients report, for example, that they have seen the devil, who is after them, or that there is a hearse outside their door, in which they are to be picked up. ◀

▪ Olfactory hallucinations

This form of hallucination is rather rare. The affected persons usually smell unpleasant odors and feel impaired by them. There can be a danger if it is about threatening rumors, such as a gas smell.

Body misperceptions

This form of hallucination also occurs rather rarely and only occasionally leads to self- or other-endangering behavior.

► Example

The affected persons report, for example, that they can no longer feel certain body parts or that their body temperature is **abnormal**. As tormenting are body hallucinations in the form of tingling or small animals that are on the skin. Occasionally, it can be observed that the patients shower very hot for hours to kill the animals. ◄

Any form of paranoid-hallucinatory psychosis is an unimaginable torment for the affected person.

This symptoms are triggered by a disturbance of the neurotransmitters. These are substances that transmit nerve impulses in the brain from one nerve cell to the next. An important role seems to be played by the neurotransmitter dopamine. However, it is assumed that a certain predisposition for the disease must be present, as a hereditary component was also found.

It is also suspected that in the presence of a vulnerability, i.e. susceptibility, the psychosis is triggered by stress.

This can be both negative stress, such as the death of a close person, the loss of a job, a divorce, a failed exam, etc., as well as positive stress, such as a wedding, the birth of a child or similar events.

2.1.3 Treatment and Care

The therapy is complicated by the symptom of lacking insight into the illness.

The treatment consists firstly of the Administration of drugs that act specifically against the psychotic symptoms, so-called Neuroleptics or Antipsychotics (► Chap. 1). These substances interfere with the brain metabolism and inhibit the transmission of the neurotransmitter dopamine.

Since the affected people feel persecuted and assume that someone wants to harm them, the administration of medication is usually difficult. In this case, anxiolytic drugs are often given additionally.

Examples of neuroleptics and antipsychotics

- Haloperidol
- Melperone
- Pipamperone
- Melperone
- Risperidone
- Olanzapine
- Clozapine

Because the pharmacological treatment is the only effective therapy, a regular intake of medication must be ensured or, in extreme cases, a forced medication must be carried out.

The task of nursing and care is – besides the administration of medication – the observation of the affected person, the support in everyday life and the establishment of a trusting relationship, so that the patient finds the opportunity to talk about his problems and learns to cope with the illness.

In the conversation with the patient, it is important to perceive signs of psychotic symptoms, to communicate this to the patient, to convey to him that one understands these signs of illness as a burden, without reinforcing him in his reality.

It is impossible to talk the patient out of his delusional experience, but one must not confirm them either by "playing along".

2.2 Depression

Depression is one of the most common psychiatric disorders. In Germany alone, about 20% of the population suffer from depression at least once in their lives.

Depression

The term depression comes from the Latin word "deprimare": to press down, and describes the depressed, sad mood of the person affected. However, there are also other symptoms.

2.2.1 Symptoms of Depression

Women are more often affected than men.

The classic symptoms of depression result from various factors, whose interaction usually leads to typical signs of illness gradually. The cause is an imbalance of different neurotransmitters in the brain, where especially a **norepinephrine**- and **serotonin** deficiency can be observed. In addition, there are acute stressors, such as the loss of an important person, the loss of work or the move to a nursing home.

Symptoms

- Depressed, hopeless, dejected mood
- Lack of motivation, tiredness, exhaustion

- Withdrawal, preferably to bed, with social isolation
- Feeling of "numbness"
- Inner emptiness
- Impairment of concentration and decision-making ability
- **Loss of libido**
- Loss of appetite, usually with weight loss
- Sleep disorders
- Inner restlessness
- Tendency to ruminate
- Anxiety
- Suicidal thoughts
- Feelings of guilt
- Physical weakness and neglect

Often, one can observe a so-called morning low in depressed people. This means that the mood and the drive are particularly impaired in the early morning and improve during the course of the day.

For the affected person, it is a big problem that the environment does not perceive the illness as such.

Also typical is the seasonal depression. It is also called winter- or light deficiency depression and usually begins at the end of September. The symptoms often disappear on their own in spring.

The influence of light on the mood is also used therapeutically in light therapy.

2.2.2 Treatment and Dealing with Depressive people

The pharmacological treatment with antidepressants is the most important therapeutic approach.

Antidepressants

- Doxepin
- Amitriptyline
- Nortriptyline
- Mirtazapine
- Citalopram
- Fluoxetine
- Sertraline
- Venlafaxine

In addition, behavioral or psychodynamic methods are used. Supportively, it is important to pay attention to an accepting and activating interaction with the depressive person and thereby mobilize his or her resources.

Neither should one overwhelm the affected person with activism, nor should one ignore his or her tendencies to withdraw. Moreover, one must watch out for suicidal thoughts, as at the beginning of the treatment only the drive improves, but the mood is still bad.

The activation begins cautiously with the joint planning of a daily structure with the simplest requirements that the patient can meet. Gradually, group activities and occupational offers are added.

The environment of a depressive person tends to either pity the patient or trivialize his or her problems.

Practical tip

The first step of care is the establishment of a relationship with the right measure of closeness and distance and taking into account an appropriate communication. Neither a demanding behavior, such as with statements like: "Now don't let yourself go!", nor a belittling behavior with statements like: "It will get better!", is helpful for the affected person.

2.3 Mental Disability

The term "mental disability" is actually not very common anymore, but is used both in everyday language and in the guideline of the umbrella organization of statutory health insurance for the qualification of additional care staff.

The condition is rather referred to as mental retardation, as intellectual defect or as learning disability in the medical-nursing language.

2.3.1 Symptoms of Mental Retardation

The typical signs of intellectual disability are cognitive limitations in all subareas of thinking (▶ Sect. 1.1.2).

To varying degrees, the affect, i.e. the emotional life, is also altered and there are behavioral problems and mental disorders.

Degrees of severity of intellectual disability according to the International Classification

- Mild mental disability (mild intellectual disability, formerly debility) The intelligence quotient (IQ) is between 50 and 69. The affected persons have difficulties in school

and reach an intelligence age of 9 to under 12 years as adults. Many adults can work, maintain good social relationships and contribute to society.

- Moderate mental disability (also moderate intellectual disability, formerly imbecility) The intelligence quotient (IQ) is between 35 and 49. This corresponds to an intelligence age of 6 to under 9 years in adults. There are significant developmental delays in childhood. However, most affected persons can achieve a certain degree of independence and acquire sufficient communication skills and education. Adults need varying degrees of support in daily life and at work.
- Severe mental disability (also severe intellectual disability, formerly imbecility) The intelligence quotient (IQ) is between 20 and 34. This corresponds to an intelligence age of 3 to under 6 years in adults. Since the affected persons cannot learn to read and write and cannot attend a general education school, they need support to receive a life-practical education; continuous support is necessary.
- Profound mental disability (also profound intellectual disability, formerly idiocy) The intelligence quotient (IQ) is below 20, this corresponds to an intelligence age of under 3 years in adults. Their own care, **continence,** communication and mobility are highly impaired.
- Dissociated intelligenceThere is a significant discrepancy of at least 15 IQ points, e.g. between verbal IQ and performance IQ.
- Other mental disability (also other intellectual disability) This category should only be used if the assessment of intellectual disability using the usual methods is particularly difficult or impossible due to accompanying sensory or physical impairments, such as blindness, deafness, severe behavioral disorders or physical disabilities.
- Unspecified mental disability (also unspecified intellectual disability) The information is not sufficient to classify the intellectual disability into one of the above categories.

2.3.2 Treatment Options

The cure of a mental disability or a mental retardation is usually not possible, as it is a congenital defect. However, through targeted support, a self-reliant life can be achieved. Special education and remedial education measures are used.

Depending on the severity and manifestation, different therapeutic measures are used.

The support usually starts in kindergarten and focuses on acquiring intellectual skills, thereby improving everyday competence.

The support of a daily structure, the guidance in everyday activities and the accompaniment in leisure activities are the basis of the therapy.

Guiding principles of therapy

- Adult-oriented orientation: Adults who suffer from a mental disability must not be treated like a child.
- Subject-centeredness: The therapy should pay attention to the person, their wishes must be respected.
- I-Thou-Relation: Every therapy should be seen as a partnership and not as a compulsion.
- Emancipatory principle: The person should develop independently into a self-confident person; just like any other person, he has his place in society.
- Assistance and cooperation: The way to independence is the goal.
- Holistic-integrative principle: The mentally disabled person must be seen as a "unit".
- Principle of developmental appropriateness; the orientation to the human being is in the foreground: In a pleasant situation for the person, he should be encouraged to make learning progress.
- Proximity to life and active learning: The person should experience both the everyday household chores and the reality of life outside the living environment in the natural habitat.
- "Letting be" and trust in the resources: Not only learning and improving the skills and abilities should be in the foreground, but also the purposeless and self-determined life; the person must be given the opportunity to discover his own life.

In order to meet all these requirements, it is crucial for the caregiver to constantly reflect on his own behavior.

Dealing with People with Dementia

Contents

S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_3

» We have to talk to each other, not against each other. (Anthony Yeboah)

The communication with people with dementia, the daily interaction and the resulting situations are a great challenge for the dementia companion. Again and again one feels that one reaches the limits of one's patience, that one has trouble understanding the affected person, or that he or she expresses wishes that one cannot or does not want to fulfill. The basis of the work and occupation with people with dementia or changed behavior is on the one hand the empathy and communication skills, on the other hand however the ability to perceive, analyze and change one's own behavior if necessary. In this chapter, basic knowledge on the topic of communication is imparted, followed by a section on the avoidance of conflicts, on basic rules of **interaction** and on important behaviors when dealing with people with dementia.

3.1 Communication

Communication

The term communication comes from the Latin "communicare": to share, to communicate, to participate, and means a communal action, in which ideas, thoughts, knowledge, experiences and insights are exchanged.

"One cannot not communicate", said the Austrian communication scientist and philosopher Paul Watzlawick and meant by that, that people also exchange information and send signals through other behaviors than speaking.

This is especially observable in people who are impaired in their communication ability and therefore communicate through other channels, for example through facial expressions and gestures.

For the companion, it is therefore essential to know and respect the normal communication and the changed communication in dementia.

Communication involves the exchange of information between sender and receiver, using language, gestures and facial expressions, writing or images.

The most common communication model, which was developed by Stuart Hall in 1970, defines communication as the transmission of information from a sender to a receiver. This model was further developed and refined in communication psychology.

In the working world, the communication can be examined more closely under consideration of the communication model by Schulz von Thun (Fig. 3.1). In this model, the four sides of the conversation process are examined more closely.

Under consideration of the four aspects content, appeal, relationship and self-disclosure, simple but effective basic rules of communication can be derived. The basic idea of this model included that the message fulfills other functions besides the transmission of a certain content. The model can be transferred to everyday situations.

► Example

A married couple is driving in a car. The husband on the passenger seat says to his wife: "There is a parking lot over there". The message is immediately understandable in terms of content. A possible appeal would be: "Come on, we're late!" The relationship aspect of the message could be: "If only I had driven myself!" Finally, the self-disclosure aspect of this message could be the husband's thought: "Women just can't drive!" ◄

A everyday example from communication with people with dementia shows that communication is made more difficult by the impairments of brain function:

► Example

The caregiver wants to motivate a person with dementia to participate in an activity and addresses him with the words: "Would you like to play with us?". Content-wise, this message is also immediately understandable, a possible appeal would be: "Now come on, the others are waiting for us to start." The relationship

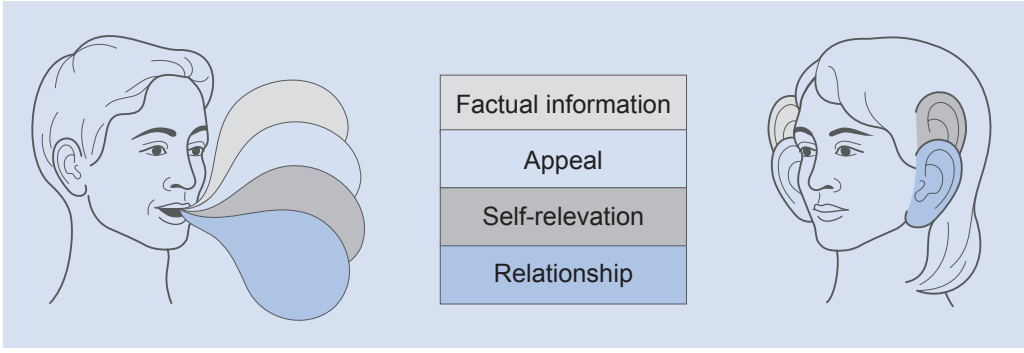


Fig. 3.1 Communication model by Schulz von Thun

aspect of the message would be, for example: "We always have to wait for you!" A possible self-disclosure aspect of this message would be: "I always have to do the same thing here." ◀

From the perspective of the person affected, the message may not be clear in terms of content. The person addressed wonders about the offer, as he sees himself as an adult who has no time for such things. The appeal, however, can be intuitively felt. The person with dementia feels that the caregiver is impatiently waiting for something, and reacts either with guilt or aggression. Both possible reactions also affect the self-disclosure aspect of the message.

To achieve smooth communication, one should consider various basic rules.

Basic rules ofCommunication

1. Be factual
2. Speak clearly
3. Listen attentively and analyze
4. Listen actively
5. Address feelings directly
6. Send I-messages
7. Say your own opinion
8. Clarify intentions and goals
9. Argue convincingly

These basic rules must be taken into account when dealing with people with dementia, but they must be adapted to the situation and to individual communication skills.

3.2 Communication with People with Dementia

Communication with patients is particularly difficult when they suffer from cognitive deficits, such as in the context of dementia. Depending on the severity of the disease, basic rules in the conversation with people with dementia should be considered.

Communication with dementia patients

- Use short sentences
- Speak slowly and clearly
- Do not use "childish" language
- Use "yes" or "no" questions
- Adjust the volume, do not shout
- Do not make sentences unnecessarily complicated
- Support words with facial expressions and gestures

- Do not give any hints in the conversation that the patient is not taken seriously
- Do not communicate with relatives over the patient's head

However, communication with the person with dementia begins already with the contact initiation.

> The person affected must first have the opportunity to see the person who is addressing him, possibly to recognize and classify him. Therefore, one must always address the person with dementia from the front and first establish eye contact.

Addressing from the side or even from behind is irritating for the person affected and is either ignored or leads to defensive reactions.

> The patient must then have enough time to look at and classify the interlocutor. This can take a few seconds to several minutes depending on the severity of the disease.

Communication with the person affected is the basis of any interaction and must therefore always take place very consciously. If communication problems occur, one should therefore answer the questions below.

3.2.1 Communication Problems

A communication problem occurs repeatedly in communication with the person affected. These are unavoidable, but a closer look at the situation can help to prevent misunderstandings.

At least two people are involved in a communication problem.

Not only the behavior of the person with dementia should be considered, the cause of the communication problem can also be found in the communication partner. At regular intervals and in acute problems, the following questions can help to **analyze** the problem.

Questions for analyzing the communication problem

- Did I express myself unclearly?
- Did I overburden the person I care for?
- Did I speak loud enough?
- Was my choice of words understandable?
- Did I give the person enough time to think?
- Has the person's performance decreased?
- Are there other causes for the misunderstanding, such as limitations of hearing or vision?

- Was the noise level of the environment too loud?
- Was the person with dementia distracted by other factors?
- Was the moment inappropriate?
- Was the topic uninteresting for the person?

The answer to these questions enables an appropriate interaction and thus a successful dealing with the person with dementia.

The following table lists factors that affect the communication with the person and therefore need to be paid special attention to (◘ Table 3.1).

The targeted use of signal or key words will be described in more detail later (▶ Sect. 3.4.4). When caring for and engaging people with dementia, phrases or proverbs can also be used (▶ Chap. 6).

◘ Table 3.1 Factors influencing communication

Factor	Meaning
Native language	People with **migration background** can express themselves better in their native language during the course of the disease
Dialect	With increasing loss of cognitive ability, the originally learned dialect comes to the fore; also, specific dialect expressions are used more frequently
Word choice	The language changes over the decades, the affected person increasingly resorts to "old" words, e.g. "Abort" instead of "Toilet" Words can have a signaling effect that triggers an emotional reaction in the affected person; such "signal words" can be used deliberately
Rate of speech	The speech tempo of both interlocutors is crucial for understanding; it also gives an indication of the current attention and concentration of the person with dementia, for example when long response latencies occur or he loses the thread in the middle of the sentence
Volume	The volume of both interlocutors is also important for communication: Very loud speaking can be frightening, very quiet speaking is exhausting for the interlocutor or can be a sign of insecurity and depression
Lack of speech ability	Often, people with dementia can understand the spoken word, but they have difficulty with speech production. This quickly creates the impression that the person does not want to speak, or even the feeling among other people with dementia or relatives that the person "does not talk to everyone"

3.3 Interaction

Communication influences the everyday interaction with the cognitively impaired person and is the basis of interaction.

Interaction

Interaction comes from the Latin words "inter": between, and "agere": act and refers to the mutual influence of actors or systems. The human being as a social being is continuously in interaction with other persons and thereby also acquires a position in a social structure.

The person with dementia, the mentally ill or the intellectually disabled has also taken on a social role through interactions in the course of his or her life. Due to a possible need for care or increasing dependence in the course of the disease, he or she may not be able to maintain this role.

The loss or change of a social position can be very painful for the person concerned.

The interaction with the affected persons is strongly influenced by the attitude of the caregiver. The emotional attitude towards the cared-for persons can be intuitively perceived.

Especially for people with dementia, who have spent most of their adult lives in an independent and competent way, it is humiliating when they suddenly feel that they need support and have to take on a dependent role.

3.4 Dealing with People with Dementia

The way of dealing with the affected persons is influenced by various factors that one should always be aware of.

3.4.1 Attitude

The attitude towards dementia in general and the affected person in particular depends on one's own life experience and the inner attitude towards life, illness, age and death.

This attitude is often intuitively sensed by the affected person and causes corresponding reactions. An open-minded approach can facilitate the access to the person, a rejecting or insecure attitude often causes a distant behaviour or even an open rejection.

In order to better reflect on one's own attitude, it is useful to answer the following questions.

Questions about one's ownAttitude

- What value does life have for me?
- What attitude do I have towards age and illness?
- Are there people with illnesses, especially with dementia, in my private environment?
- Am I afraid of developing dementia myself?
- Can I approach other people openly?
- Am I willing to establish a relationship with the affected people?
- Can I talk about difficult or embarrassing topics?
- Can I listen actively?

The inner attitude is usually unconscious and can be better perceived by answering the previous questions. In addition, one should try to put oneself in the shoes of the person with dementia and think about how one would feel in their position.

3.4.2 Getting to Know

At the beginning of the care and support, it is important to get to know each individual affected person.

Practical tip

The dementia companion should always take notes, because personal characteristics and elements from the **biography** already show up at the first contact, which are useful in the course of the support. However, it is not advisable to write this down on site, as writing can irritate the person with dementia. Since the person is unknown to him, he may feel like being interrogated.

If relatives are reachable, they should be involved in the conversation.

The task of the dementia companion is in this context the observation and the information collection.

If possible, the conversation takes place in the room or in the outpatient area in the apartment of the person concerned. There he feels safe and secure and is surrounded by his personal belongings, which are both suitable as a topic of conversation and provide clues to previous interests, hobbies, preferences and important reference persons (▶ Sect. 3.5).

When getting to know each other, the care worker should be aware that the person with dementia is no longer able to get to know a stranger in a short contact. The care worker

must not expect that the person with dementia will recognize her at the next meeting.

> Many affected people are, however, able to store people they have met several times. This ability should never be directly tested, as it is hurtful for the person with dementia if he cannot answer questions like: "Who am I?" or: "What is my name?"

When getting to know someone, the following procedure can be helpful:

- Ask the responsible nursing staff about any special features in dealing with the affected person.
- Make yourself known by knocking on the door.
- Ask if you may enter.
- Approach the person slowly.
- Get on eye level, even with sitting or lying persons.
- Make eye contact.
- Observe the reaction, especially the facial expression.
- Greet the person politely and with the correct time of day, such as "Good morning" or "Good afternoon".
- Introduce yourself with your name and point out that you do not know each other.
- Speak clearly, politely and at an appropriate pace.
- Pause between sentences, in which you observe the reaction of the person; if the person seems overwhelmed or frightened, give them more time or leave the situation.
- Explain the reason for your visit and give the person the opportunity to respond.
- Try to start a conversation.
- If you notice that the person no longer wants to talk to you, initiate the end of the conversation.
- Say goodbye and express your pleasure at seeing them again.

The getting to know process must be aborted if the person with dementia reacts negatively or if they are clearly overwhelmed by the situation, for example if they have just slept or dozed and are therefore impaired in their attention.

Special features in dealing with the affected person, which should be asked before making contact with the reference persons or the reference nursing staff, are diverse.

Possible special features

- Limitations of vision or hearing.
- Limitations of communication, for example, the person affected can only say "yes" or "no" or only nod or shake their head.

- The person affected only responds to being addressed by their first name or surname.
- The person affected answers with a delay.
- The person affected does not answer at all, but understands everything.
- The person affected communicates only with certain people, for example, only with women or only with men.

3.4.3 Nonverbal Communication

In all contacts with people with dementia or mental changes, nonverbal communication is of enormous importance. This includes the **facial expressions** and the **gestures,** but also touches play a big role.

3.4.3.1 Facial Expressions

Observing changes in facial expressions is especially important in moderate dementia.

For people with impaired cognitive function, facial expressions are often a mirror of their emotional state. Especially in moderate dementia, the person affected begins to live in their own, closed-off world. However, they send out unconscious signals that show the environment what feelings they experience.

As the disease progresses, the facial expressions may also be affected and cannot be easily assessed. In severe dementia, the people affected are usually facially rigid, so that no emotion can be read from their facial expression.

3.4.3.2 Gestures

These changes also affect the gestures and body language of the patients. Initially, losses of language function can still be well expressed by gestures and postures, but in the course of the disease, this ability is lost. Nevertheless, it is important to observe the gestures, as the people affected still express unpleasant feelings, especially pain, through their body posture for a longer period of time (▶ Sect. 5.4.11).

A bent body posture or a so-called protective posture, in which certain body parts are no longer moved, must always be considered as an expression of pain.

3.4.3.3 Touches

Touches are always an important element in dealing with people in need of care. Here too, it must be considered that the touch can be pleasant or unpleasant for both interaction partners.

Touches must never take place unannounced or unprepared in people with dementia or mental changes.

Demented people often cannot classify the person standing in front of them and feel threatened when a stranger touches them unannounced. Everyday and socially accepted body contacts, such as shaking hands to greet or patting someone approvingly on the shoulder, are usually tolerated.

Some people with dementia react defensively or even aggressively when they are touched unprepared.

However, unwanted body contacts often lead to defensive reactions by the affected person, which manifest themselves in screaming, hitting or running away. This includes, for example, the unpredictable hugging or stroking of the face.

Body contacts that are far from the trunk are better tolerated than those that are close to the trunk!

In all physical contacts, the dementia companion must always consider that the measures are not perceived as a threat by the affected person.

► Example

For example, holding the wrist to prevent a fall during a walk can be perceived as completely normal by the companion, whereas the affected person thinks he is being taken away by the police.

Hugging can trigger the feeling of a sexual assault in some affected people, especially in female people with dementia. Here, biographical experiences must be taken into account, as especially the war generation has had corresponding experiences (► Sect. 3.5).

Male residents can also feel sexually harassed: A resident of a nursing home complained that these "indecent ladies" always came to him at night, he had not ordered them at all. In fact, the staff put a urine bottle on him several times at night. To avoid waking the resident, only a night light was turned on.

Of course, the opposite case can also occur, when the caregiver or other patients feel harassed by the sick person. Demented, mentally ill or mentally handicapped people sometimes lose any social inhibition and become verbally or physically intrusive. If this behavior cannot be stopped by a clear rejection or if it occurs repeatedly, the contact between the persons should be avoided if possible. ◄

However, most affected people perceive desired touches as pleasant, soothing and comforting. Therefore, touches can also be used therapeutically.

Female patients also know these massages from their past in connection with a manicure or pedicure.

The offer of a hand, back or foot massage has a relaxing, calming and emotionally balancing effect on many affected

people. Especially for those whose sensory perception is severely impaired and who therefore can hardly have stimulating sensory experiences, the massage of individual body parts as well as the rhythmic tapping, especially of the back, is a positive stimulus transmission.

People who are limited in their mobility or in the processing of sensory stimuli often react with behaviors that are a burden for their environment. This can lead to the permanent repetition of single words or phrases, to incessant calling or screaming, or to the ritualized performance of recurring actions.

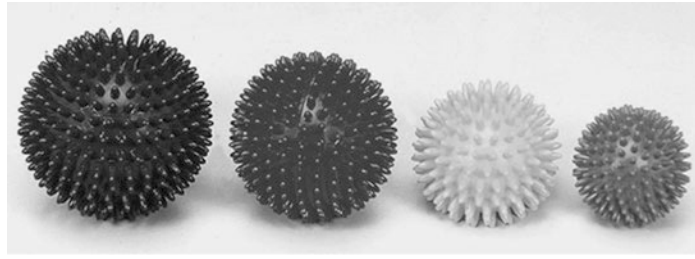
► Example

Behaviors that occur due to lack of sensory impressions are often misinterpreted. For example, one can find affected people who wipe imaginary crumbs from the table with their hand. These people are then seen as particularly clean and tidy. Other people with dementia repeatedly call "help, help" or for a specific person. When one offers them help, they are usually surprised and cannot answer what they need help with. ◄

These stressful behaviors can usually be interrupted at least temporarily by rhythmically tapping the back or by massages with so-called "hedgehog balls" (◘ Fig. 3.2).

3.4.4 Verbal Communication

In connection with verbal communication, a variety of possible peculiarities, disturbances and limitations due to the disease patterns occur. In connection with communication, the topic of "language" has already been described (► Sect. 3.2.1), at this point the effects of changes in verbal communication are discussed, as well as the possibilities of the dementia companion to react to them.



◘ **Fig. 3.2** "Hedgehog ball". (With kind permission: Jakobs GmbH)

3.4.4.1 Word Finding Difficulties

Word finding difficulties can distort the content of a message so that it is no longer recognizable.

Especially at the beginning of the disease, word finding difficulties occasionally occur, which can increase in the further course. In the initial stage, these are perceived as relatively normal, as soon as the word finding difficulties increase, however, the affected person often feels that this is not normal and suffers from the problem. With a further progression of the process, it becomes increasingly difficult for the communication partner to understand the content. This "non-understanding" is also stressful for the person with dementia.

Relatives, caregivers, nursing staff and dementia companions tend to want to help the person affected and to supplement the missing word for him. This can be helpful for the person with dementia, but it can also lead to anger and aggression.

> The correct response to a word-finding disorder must be tried out on a case-by-case basis and may change over the course of the disease.

In this context, it is important for the dementia companion to observe the extent of the disorder and the reaction of the affected person to possible offers of help. The following example shows different possible reactions.

► Example

Mrs. Müller walks nervously up and down the corridor. She is approached by a passing person:

Possibility 1
"Mrs. Müller, why are you so nervous?"
"I can't find my … uh, what's it called, … my nose anymore."
"Your nose?"
"Do you think I'm stupid, I'm not looking for my nose, that's outrageous, making fun of an old woman."

Possibility 2
"Ah, good that you come by, I've been looking for my … thing … all the time, well, my nose."
"You probably mean your key."
"No, that's nonsense, I have it here in my bag."

Possibility 3
"Mrs. Müller, why are you so nervous?"
"I can't find my … uh, what's it called, … my nose anymore."
"I can help you look for it."
"Oh really, that's very kind of you."

"Have you already looked in your room?"
"No, not yet, that's a good idea, I probably left my handbag on the … well, what's it called, forgotten."
"That could well be." ◄

The reaction to word-finding disorders requires tact and succeeds the better the more one knows the affected person.

3.4.4.2 Interpretation of Communication

The same applies to the interpretation of communication. Even if the spoken word is understood clearly, the content of what is said sometimes remains hidden. The sentences are not comprehensible in terms of content and therefore appear confused.

Examples ofcommunication problems

- The person speaks sentence fragments or single words
- Swearing
- Whining
- Whispering
- Mumbling
- Screaming
- Constant repetitions of the same contents

The most complicated variant of these communication problems is silence, the "non-answer", the ignoring and the walking away.

For the interpretation of what is said, precise knowledge of the person, their character, their deficits and their biography are useful.

The dementia companion is forced in all these cases to interpret the communication problem and to react according to his or her assumption.

At the beginning of the activity, the companion is not so familiar with the persons and their peculiarities. Therefore, different possibilities of interpretation should be shown at this point.

Possibilities of interpretation

- The person affected is ashamed of his or her deficits.
- The person affected tries to cover up the deficits.
- The person affected is very afraid.
- The person affected wants to leave the unpleasant situation.
- The person affected wants to blame someone else for his or her problems.
- The person affected does not perceive his or her deficits and does not want to be made aware of them.

- The person affected repeats statements or actions automatically to calm himself or herself down, his or her deficits are not conscious to him or her.

Taking into account all possible interpretations, it becomes clear that it is always unpleasant and hurtful for those affected to be pointed out their deficits and behavioral abnormalities.

A strategy to respond to communication problems is active listening. In doing so, the contents of what has been said are picked up and repeated. The listener thereby signals that he or she has listened attentively to the speaker and has taken in what has been said.

To better understand, examples of active listening are presented here.

When caring for people with dementia, the speaker also gets the opportunity to rethink what has been said by actively listening.

▶ Example

Mrs. Müller – Oh, I feel so bad. I feel so bad. I feel so bad.

Companion – You feel bad?

Mrs. Müller – I feel so bad, you can't imagine. I feel so bad.

Companion – I can imagine how bad you feel. Can you tell me why?

Mrs. Müller – I feel so bad, I'm so scared.

Companion – So you are afraid.

Mrs. Müller – Yes, I feel so bad.

Companion – Why are you so scared?

Mrs. Müller – "Oh, if you knew, I feel so bad."

Companion – Because you are afraid.

Mrs. Müller – That's true, I'm so afraid. I feel so bad.

Companion – What are you afraid of?

Mrs. Müller – Somehow of everything.

Companion – You are afraid of everything, maybe it will help you if I stay with you a little bit?

Mrs. Müller – That would be nice.

Companion – I won't leave you alone.

Mrs. Müller – That's good. ◀

3.4.4.3 Form of Address "Sie" or "Du"

The Duzen address on a first name basis is usually not allowed in dealing with patients or residents. Even people with dementia should always be addressed by their family names,

in order to maintain a professional distance to, which is also necessary for mutual respect.

However, there are exceptions in the advanced stage of dementia or for people with a mental disability.

► Example

People with dementia sometimes do not respond at all to their last name. This happens especially with women who are in an earlier phase of life due to the disease. Here it happens that the affected people do not remember having married, and therefore cannot relate to their married name at all. Some then react more to their maiden name, if it is known, other people with dementia react in principle only when they are addressed by their first name. ◄

In this context, the consent of the relatives should always be obtained.

Also in facilities for mentally disabled people, the residents are often addressed by their first names.

However, forms of address that have a childish character, such as "sweetie", "cutie" or "darling", must always be avoided. This applies especially to people who suffer from a mental illness. A childish language must always be avoided!

3.4.4.4 "We Don't Talk About That"

In all areas of dementia care, there are topics that are addressed by the people affected and that are considered unpleasant or even embarrassing by relatives, co-residents, caregivers or support staff. Unpleasant situations arise when people with dementia use swear words, curses, expletives or foul language or insult individuals directly.

Practical tip

An insult by a cognitively impaired person should always be viewed with a professional distance and not taken personally. The correct way to react is to ignore it.

Insults sometimes also lead to conflicts and disputes within a group of people affected.

Even more unpleasant is the situation when the person with dementia behaves freely and sexually uninhibited towards staff or co-residents. The cause of such behavior is not easy to fathom, but for the protection of the person affected, such behavior must not be ignored.

Physical assaults must be stopped immediately. If the person affected behaves only without distance towards one person, this person should avoid contact if possible. If the

person affected behaves generally uninhibited, he must be removed from the situation for his own protection.

Normally, it is helpful to distract him and accompany him to his room or to temporarily remove him from the group by other activities, such as a walk. In no case should the behavior give rise to scolding, punishing or ridiculing the person with dementia.

3.4.4.5 Conflicts

Again and again, conflicts, misunderstandings and disputes arise in dealing with people with dementia, mentally ill or mentally handicapped. These arise whenever one of the interlocutors feels misunderstood or pressured.

With cognitively impaired people, such feelings can arise quickly, especially when they do not recognize the person or the situation.

Conflicts in a group can often be solved by distracting activities.

► Example

The dementia companion wants to prepare a sausage salad with a group and distributes the tasks to the individual participants. He asks a participant if she would like to cut some cucumbers. The participant does not understand the question, but does not want to embarrass herself in front of the group and declines. The dementia companion then repeats the question several times, whereupon the participant becomes angry and wants to leave the room. ◄

If a person affected has declined an offer, the dementia companion should accept this and give the participant the opportunity to observe what is happening. Often this creates interest and the person being cared for decides spontaneously to participate after all.

3.4.4.6 Truth or Lie?

Dealing with people with dementia confronts the dementia companion again and again with the question of whether an affected person always gets told the truth or whether it is occasionally better for him to lie to him.

In principle, it is assumed that no one can be lied to in the health care system.

Exceptions arise in dealing with people with dementia when the affected person suffers greatly from the truth and relives it again and again.

► **Example**

Mrs. Schneider is desperately looking for her mother. She addresses the dementia companion who has arrived: "Have you by any chance seen my mother, I have been looking for her for so long."

The dementia companion replies: "But Mrs. Schneider, your mother must have been dead for many years, you are already 87, your mother would be well over 100 years old." Mrs. Schneider then bursts into tears. ◄

In the early stage of dementia, the affected person can clearly recognize when he is being lied to. Lying then leads to a loss of trust. Even in later stages, the affected persons sometimes intuitively sense that a person is not telling them the truth. The decision must therefore always be made on a case-by-case basis. This strategy can also change in the course of the disease.

Pretending false facts also corresponds to a lie in principle. For example, a few years ago, non-functional bus stops were used to occupy people with dementia. However, waiting in itself is not a pleasant or meaningful activity, even if the affected persons may come into conversation with other "waiters" at the bus stop.

In a Swiss nursing home, a railway compartment was even faithfully reconstructed, in which a monitor is installed in the window, showing a train ride. This kind of "deception" may evoke positive memories for some people with dementia, for example of a nice holiday trip.

3.4.4.7 Coercion and Violence

In contact with the affected persons, situations can arise again and again in which the dementia companion or other persons consciously or unconsciously exert pressure on the person with dementia. This can occur in everyday life due to stress or thoughtlessness, but it can also happen that the caregiver is disappointed, angry or annoyed and therefore reacts inappropriately.

For a better understanding, various examples from all areas are given here, which can be considered as coercion or violence against the affected persons.

Examples of violence

- Patronizing
- Forcing communication
- Ignoring questions or requests
- Loud talking
- Scolding

- Disinterest
- Compulsive positioning, forced mobilization
- Restraint
- Withholding medical or therapeutic treatment
- Taking away aids
- Forcing personal hygiene
- Using "bibs" and plastic dishes
- Forcing food or fluid intake
- Feeding food
- Too few toilet visits
- Psychotropic drugs without the patient's knowledge
- Occupational offers are not age-appropriate
- Using informal or wrong address

With increasing professional experience, the dementia companion will repeatedly encounter such situations.

It is important to perceive situations in which coercion or violence threatens and to avoid them accordingly.

3.4.4.8 Signal- or Key Words

Communication with people with dementia can be guided in a certain direction by using signal or key words. If one notices that an affected person reacts positively or negatively to a specific word, one can use this knowledge to influence moods.

► Example 1

Mrs. Wagner is an open-minded, cooperative lady who suffers from dementia. She enjoys attention and affection and likes to participate in activities. However, when she is asked if she would like to go for a walk, she bursts into tears. The dementia companion observes that Mrs. Wagner likes to go outside when the word "walk" is not used, for example when she is asked if she wants to come to the garden. When a long-time friend of Mrs. Wagner comes to visit, he asks her about it. She explains that Mrs. Wagner was harassed by a neighbor as a teenager on a walk and that is why she reacts so violently to the word. ◄

► Example 2

Mr. Schuster suffers from an advanced dementia and speaks only short sentences or single words. He keeps asking everyone around him where Rosa is. Neither relatives nor acquaintances can associate anything with the name. However, the family finally finds a package of love letters signed with the name Rosa when clearing out the apartment. It seems to be the first great

love of Mr. Schuster. The next day, Mr. Schuster is very agitated and calls out: "Help, help". One of the staff members says to him: "Mr. Schuster, I have greetings from Rosa for you." This calms Mr. Schuster down immediately and he smiles all over his face. ◄

These examples clearly illustrate the importance of key or signal words for dementia care. However, it is more difficult to find out which events have played a special role in the life of the affected person.

The collection of the biography is essential for this.

3.5 Biography

As soon as a behavior is explainable, it is no longer necessarily perceived as disturbing.

The **biography** is one of the most important elements in dealing with people with dementia. The more the dementia companion knows about the experiences and events of the person being cared for, the better he can communicate with him and react to conspicuous behaviors. Here, one distinguishes between the external and the internal biography.

3.5.1 External Biography

The external biography includes mainly social data and concrete events from the life of a person. In this chapter, the biography of Albert Einstein was chosen as an example, who was not affected by dementia, but whose biography is well suited to illustrate the difference between external and internal biography.

► **Example**

External biography

Albert Einstein (Fig. 3.3) was born on March 14, 1879 as the first child of the Jewish couple Hermann and Pauline Einstein, née Koch, in Ulm. When Albert's grandmother saw him for the first time, she is said to have kept saying: "Much too fat! Much too fat!" But despite all fears, the development of young Albert was normal. In November 1881 Albert's sister Maria - called Maja - was born. Shortly afterwards the Einstein family moved to Munich, where Albert first attended elementary school and then the Luitpold-Gymnasium there. He was a "mediocre" student, who was already very interested in natural sciences and mathematics. He did not like the teaching at the gymnasium, as it was conducted under strict discipline and the compulsion to

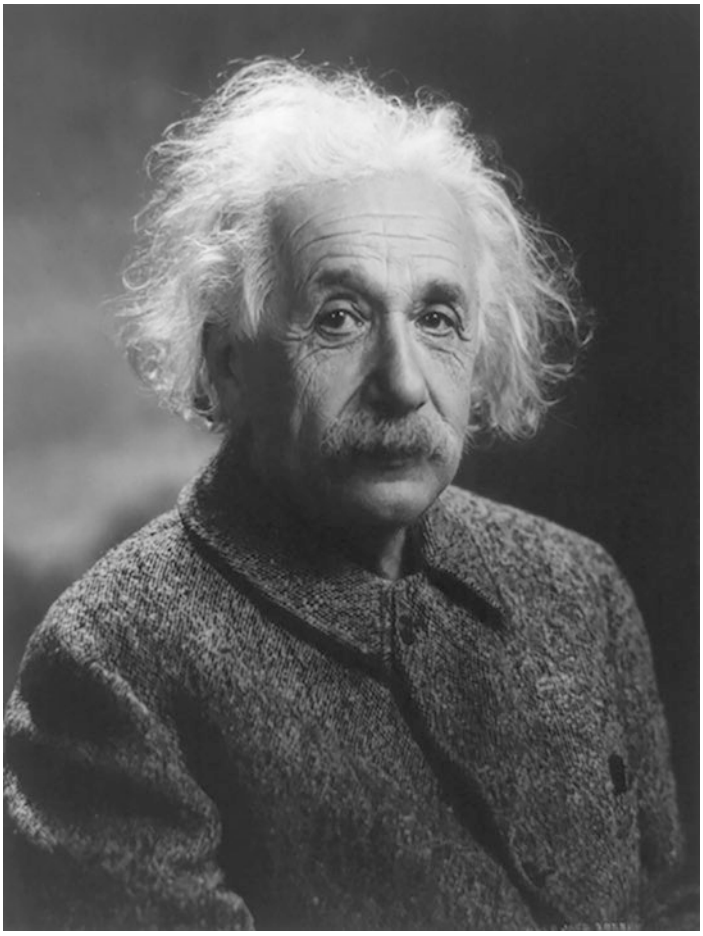


Fig. 3.3 Albert Einstein. (© Photo by O J Turner, Princeton, 1947)

learn. At the age of 15 he left school without a diploma and followed his family to Milan, where they had settled in the meantime.

To make up for the missed school diploma, he attended the cantonal school in Aarau in Switzerland from 1895. There he graduated from high school (Matur) a year later and began studying in Zurich in 1896. His study goal was the diploma of a specialist teacher for mathematics and physics. In July 1900 he successfully completed his studies. He moved to Bern and got a job at the patent office there. In his spare time he worked in the field of theoretical physics. In 1905 he published some very important scientific papers. One of them deals with the groundbreaking special theory of relativity. In 1903 he married his fellow student Mileva Maric. A year later Einstein's first son Hans Albert was born, in 1910 his second son Eduard. In 1909 he became

professor of theoretical physics at the University of Zurich. He followed professorships in Prague and then again in Zurich. In 1914 Einstein was called to Berlin to work there scientifically. In the same year the First World War broke out.
After Einstein had separated from his wife Mileva, he married his cousin Elsa Löwenthal in 1919. In the years 1909 to 1916 Albert Einstein worked on a generalization of the special theory of relativity, the general theory of relativity. He received the Nobel Prize for Physics for the year 1921. Due to the political conditions and the events associated with them in Nazi Germany, Einstein left Germany in December 1932. He never set foot on German soil again. From 1933 on Einstein lived with his family in Princeton, America. At the "Institute for Advanced Study" there he found ideal working conditions. In December 1936 Einstein's wife Elsa died. In 1939 the Second World War broke out. Fearing that work on atomic bombs was being done in Germany, he wrote a letter to Franklin D. Roosevelt, the president of the United States of America, to alert him to the possibility of nuclear weapons. In 1946 he made the proposal of a world government, in which he saw the only possibility for a lasting peace. Einstein spent the last years of his life withdrawn in Princeton. Until the end he worked on a new theory, the unified field theory, which remained unsuccessful. Albert Einstein died on April 18, 1955 at the age of 76. (With kind permission of H-J Küpper, ► http://www.einstein-website.de). ◄

The external biography provides important clues to the internal biography.

The more information about the external biography can be collected, the easier it is to explore behaviors.

It is difficult to collect information from people with cognitive impairments. Usually, the relatives are interviewed for support. However, it happens again and again that an affected person does not want to provide information about his or her biography and neither do the relatives.

The refusal to reveal personal things must then be accepted. However, if biographical information becomes known in the conversation, it should be added to the biography sheet (► Chap. 5).

It is advantageous to also orient oneself to the AEDL (► Chap. 5) when creating the biography, in order not to omit important information. Especially the consideration of life habits, preferences and dislikes in the areas of personal hygiene, nutrition, mobility and occupation influence the well-being and quality of life to a high degree.

Practical tip

If one tries to fill out a biography sheet for one's own parents or grandparents, one will notice how difficult this is. Although one usually knows one's parents very well, one often does not know what they did decades ago. It is even more difficult if one does not know a parent. "Family secrets" and conflicts make it even more difficult.

3.5.2 Internal Biography

From the information of the external biography, it can now be deduced how the affected person has processed the events of his or her life. The coping with life experiences and the meaning of these experiences correspond to the internal biography.

The more one can learn about the internal biography, i.e. the processing of experiences, the easier it is to understand behaviors and attitudes. It is therefore important to always consider what significance positive and negative life events have. To explore this, it is useful to obtain further information by asking specific questions and by talking to the affected person and his or her relatives.

It is not useful to interpret things into the biography that are not verifiable.

The questions for assessing the internal biography are based on different areas of life.

Possible questions for the internal biography

- What influence do political events, education, religion and morality have?
- How did the person concerned cope with the experiences?
- What feelings did he develop in the process, such as pride, joy, hopelessness, despair or guilt?
- How important were other people in this context?
- What attitude to life, death, illness, old age, disability and need for care resulted from this?
- Is the person concerned satisfied and happy with this development?
- Are there events that the person concerned has not yet processed?
- Is the processing of these events still possible?

In the following section, these questions are applied to the possible inner biography of Albert Einstein, in order to show possible interpretations, which are purely fictional, however, as they cannot be verified in conversation with Albert Einstein or his family. The explanations are only intended to show how information can be used.

► **Example**

Possible inner biography of Albert Einstein

Looking first at the childhood, it is noticeable that the family changed their place of residence frequently. The resulting insight would be the question of where Albert Einstein could have felt at home. The grandmother, who found the grandson much too fat, is also mentioned. What kind of relationship developed from this? Some information also concerns the school time of Albert Einstein. In the natural sciences, he is described as a good student, in the linguistic field as rather bad. How did he perceive this talent and failure, did he react defiantly and rebelliously or did he feel proud of his good achievements.

Many information concern the Jewish origin of Albert Einstein. In this context, it would be important to find out whether he suffered from it in the course of his life, for example when he was attacked because of it and left his homeland. The meaning of the statement that he never set foot on German soil again could be fear or anger, but also the feeling of having found a new home.

Albert Einstein married twice. How was the marriage received by the family? What significance did the founding of his own family have for him, how did he cope with the separation, what contacts existed after the separation to the ex-wife and the children? What kind of relationship existed to the second wife?

What significance did his scientific successes have? Was he proud of his achievements, e.g. the Nobel Prize? How did he deal with failures? In this context, the question of the atomic bomb also arises. Did Einstein develop feelings of guilt for his invention afterwards? ◄

In the inner biography, the relationships with parents, siblings, friends and acquaintances, colleagues and the entire social environment also always play a role. What reference persons did the person concerned have, with whom did he have a close or a tense relationship? Are there people with whom conflicts could never be resolved?

Geographical and historical knowledge are always advantageous for the interpretation of the inner biography.

This may provide clues to ongoing worries or unresolved problems, to feelings of guilt that continue to torment the person concerned and, of course, to positive events that make people happy even in old age.

If one looks at frequent behaviors of people with dementia, one can often find the trigger for this behavior in the external and internal biography and then react accordingly. The following section presents some examples of this.

► Example

Many people with dementia are restless and repeatedly express that they have to go home. People who had to leave their homeland because of war experiences often search for their home or for their father and mother.

War experiences also influence behavior when they cause fears or feelings of guilt. People who were in concentration camps, for example, have a completely different association with the word "shower". People who killed others as soldiers suffer from nightmares for part of their lives. Many do not want to talk about it and react negatively or even aggressively to the topic of the past.

People who were on the run during the war and had to suffer hunger have a conscious attitude towards food. Often they hoard it in their room, so that they never have to suffer hunger again and nothing spoils. Similar fears concern clothing, many people with dementia think they do not have enough to wear. Sometimes they also feel robbed when clothes are removed.

Religious upbringing, politeness, diligence, order and discipline, rituals and moral values also play a big role for many people with dementia. Some affected people, for example, sit in front of the filled plate and do not touch it, if no table prayer was said beforehand. ◄

An individual care of people with dementia is only possible if the inner biography is understood and respected.

Practical tip

The generation project—history writing from below is an internet platform where anyone interested can publish stories and events from the past. The essays are arranged by year and provide a good insight into the reality of the older generation (► www.generationenprojekt.de).

The biography of the people being cared for should always be considered in the team, as each employee has a different view of the person concerned and gains different information. A regular exchange of all participants should therefore take place, but important information must be passed on quickly (► Chap. 11).

3.6 Communication Games

Book tip "Biography work" by Monika Specht-Tomann (Springer Verlag, Berlin 2009)

The knowledge about communication can be used specifically for activation and occupation in dementia care. In this section, some communication games are presented. Further possibilities of occupation are included in the chapter "Care" (► Chap. 6).

The planning of care possibilities can be completely spontaneous, for example, if the participants express that they want to play a certain game. However, there is also the possibility of carrying out a project on a topic that interests the people affected or that is suitable for the season and therefore contributes to temporal orientation.

Therefore, communication games are presented here that can be prepared as a project on the topic "We go on vacation".

Example: We go on vacation

Game 1
The participants tell freely where they would like to go on vacation or where they used to go on vacation. Afterwards, each participant can draw a picture of it.

Game 2
The group leader has brought an old suitcase full of old objects that are related to the topic of vacation, such as straw hat, sunglasses, maps, picture books, bathing suit, postcards, walking stick. The participants can now take out objects and tell in turn why they chose this object. The group leader should start, so that the participants understand the game better.

Game 3
Each participant can now take away objects and pack them in the suitcase. He explains to the others what he is taking with him. The next participant repeats what the predecessor has packed and can now pack his own object.

Game 4
The suitcase is covered with a cloth, the participants can feel and guess which object is in the suitcase. However, the participants must have seen the objects beforehand.

Game 5
The group leader reads travel memories. The participants can then also tell about their most beautiful trip. The group

leader can ask supportive questions: "Who accompanied you, what did you like best?" If a participant never traveled, he can tell why this was not possible.

Conclusion
Together, a "vacation week" is planned. Since the possibilities to travel are only given in exceptional cases in stationary facilities, the vacation can also take place in the facility. For this purpose, suggestions are collected, what the participants would like to do on vacation or have done in the past. For example, a wellness day, a hiking day, a sports or swimming pool day, a museum or culture day, a rest day. During the vacation, vacation pictures can be taken and postcards can be sent to the family or to the participants themselves.

Age-Related Diseases

Contents

S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_4

» Aging people are like museums: It is not the facade that matters, but the treasures inside. (Jeanne Moreau)

In our society, there are many diseases that only manifest themselves in old age. The immune system is weakened in old age, which favors infections. The cardiovascular system is often burdened by high blood pressure, the back and joints ache and the vision deteriorates. In the future, diseases such as heart attack, stroke, diabetes and pneumonia will continue to increase sharply. Many of the diseases and infirmities can lead to the need for care and bedriddenness.

Age-related diseases are diseases that, although not only, but much more frequently occur in older people.

4.1 Diabetes Mellitus

Diabetes mellitus is the most common metabolic disorder, affecting millions of people. One form of diabetes begins in adolescence (type 1 diabetes), but it only accounts for about 5% of all diabetics. A second form (type 2 diabetes, also called age-related diabetes), is much more common (about 50 million in Europe) and begins later, around the age of 40.

Due to the increase in obesity and a higher life expectancy, the disease is increasing worldwide and thus also the probability of illness in old age.

4.1.1 Clinical Picture

Diabetes mellitus leads to permanently elevated blood sugar levels, which in turn cause secondary diseases mainly affecting the eyes, kidneys, nervous system, heart, brain and blood vessels.

Through our food we take in sugar in various forms, e.g. as starch. During the digestive process, the starch is broken down into glucose and then transported into the blood. The blood sugar level rises and **insulin** is released to regulate the blood sugar level. Insulin enables the entry of glucose into the body cells, where it can be converted into energy. This lowers the sugar level in the blood again. A healthy body keeps the sugar level constant in this way. In type 1 and 2 diabetes, this principle is disturbed in different ways.

4.1.1.1 Type 1-Diabetes

Type 1 diabetes is caused by a lack of the hormone insulin. Body's own defense substances (antibodies) start—usually already in childhood or adolescence—to destroy insulin-producing cells in the pancreas, until finally no insulin can be released anymore.

4.1.1.2 Type 2-Diabetes

As described above, this type of diabetes is much more common than type 1 diabetes. Here, too, there is a lack of insulin, which usually increases slowly. Usually, insulin is still released, but this is not enough or can no longer work properly due to changes in the body cells.

Causes of type 2 diabetes

- "Exhaustion" of the insulin-producing cells due to years of overproduction of insulin
- Insulin resistance: The body cells react too little or not at all to insulin
- Genetic predisposition (increased cases of diabetes in the family)

Factors that promote type 2 diabetes:

- Obesity
- High blood pressure
- Elevated blood lipids
- Lack of exercise

▪ Complications

▪▪ Diabetic microangiopathy

Persistently elevated blood sugar levels damage the small blood vessels of the body.

Organs particularly frequently affected by circulatory disorders

- Retina of the eye with visual disturbances up to blindness
- Kidneys with the consequence of kidney damage up to kidney failure; as a result of kidney damage, high blood pressure can develop.

▪▪ Diabetic neuropathy

Likewise, persistently elevated blood sugar levels damage the small nerves of the body, which in turn leads to sensory disturbances (e.g. burning pain in the feet, change in temperature perception).

Diabetic foot

Circulatory disorders and nerve damage to the feet lead to open, poorly healing wounds and ulcers (diabetic **gangrene**). Sometimes this can even make an amputation of the foot necessary. Even small injuries (e.g. when cutting toenails) can cause long-lasting complaints.

Diabetic macroangiopathy

Persistently elevated blood sugar levels accelerate to a considerable extent the **arteriosclerosis** (arterial calcification) of the larger blood vessels. If high blood lipid levels, high blood pressure and obesity are added, the risk of e.g. heart attack and stroke increases.

4.1.2 Diagnosis and Treatment

The disease can be diagnosed by blood sugar and urine sugar tests. Diabetes mellitus is present when the values for blood sugar (fasting) are at least 100 mg/dl or more.

The treatment depends on whether type 1 or type 2 diabetes is present (insulin treatment and/or medications such as oral antidiabetics). The goal of treatment is a balanced blood sugar level. Often, type 2 diabetes is associated with an unhealthy diet with overweight and obesity. Therefore, a change in lifestyle is part of any diabetes treatment.

Lifestyle habits that should be changed

- Reduction of excess weight
- Physical activity
- Healthy, carbohydrate-reduced diet (whole foods)

Vascular dementia is caused by arteriosclerotic vascular changes in the brain.

A cure for the disease is not possible. By maintaining a consistent blood sugar control combined with adherence to the therapy, especially the appropriate diet, a diabetic can lead a symptom-free life without developing complications with the resulting late effects (such as vascular damage).

Despite optimal adjustment of the blood sugar level, hypoglycemia or hyperglycemia may occur. The diabetic, his or her relatives and caregivers should be aware of the symptoms in an emergency.

4.1.3 Hyperglycemia (Hyperglycemia)

Too high blood sugar levels can cause a life-threatening situation: the diabetic **coma**. The body tries to excrete the

excess sugar with the urine through the kidney. This leads to dehydration due to the high fluid loss. The symptoms usually develop over hours to days.

Symptoms of hyperglycemia

- Increasing strong thirst
- Strong urge to urinate
- Dry, often also reddened skin and mucous membranes
- Fatigue, drowsiness
- Visual disturbances
- Weakness
- Possibly acetone smell of the breath (reminiscent of rotten apples or nail polish)
- **Impairment of consciousness** up to unconsciousness

Practical tip

In daily contact with the person affected, it is important to pay attention to corresponding signs and to report these observations as soon as possible to a nursing professional. In case of suspicion of hyperglycemia, he or she will first determine the blood sugar level (Fig. 4.1) and contact the family doctor if the values are above 280 mg/dl.

Fig. 4.1 Measuring blood sugar

4.1.4 Hypoglycemia (Hypoglycemia)

When blood sugar levels are below 50 mg/dl, this is called hypoglycemia. The cause can be a too low carbohydrate intake, too much insulin or excessive physical exertion. Untreated hypoglycemia can lead to unconsciousness.

Symptoms of hypoglycemia

- Feeling of weakness, trembling, unsteady gait
- Lack of strength
- Sweating (all over the body)
- Slurred speech
- Difficulty concentrating (confusion)
- Coordination problems (the person may suddenly appear drunk)
- Mood swings (some people become **aggressive,** others hyperactive and silly)
- **Impaired consciousness**

Always take carbohydrates (e.g. glucose) with you on walks with diabetics!

To distinguish these symptoms in a person with dementia from his or her dementia, one must know and observe him or her very well. If hypoglycemia is suspected due to the symptoms described above and the person is still conscious, a nursing professional should be informed immediately or, if one is alone, carbohydrates should be administered immediately.

Immediate measures for hypoglycemia

- 20 g of glucose (or 4 tablets of Dextro-Energen) or
- 8 pieces of sugar cubes or
- 200 ml of fruit juice or cola

After that, the blood sugar level must be measured soon.

Never give liquids to an unconscious person!

In case of unconsciousness, call the emergency doctor immediately, clear the airways if necessary, put the person in the recovery position and cover him or her (► Chap. 9).

4.2 Degenerative Diseases of the Musculoskeletal System

4.2.1 Joint Wear (Osteoarthritis)

Osteoarthritis is a joint damage that is often caused by overloading. Degenerative changes can be detected in more than 80% of all people from the age of 70.

Osteoarthritis begins with a breakdown of the joint cartilage, which is supposed to protect the bone from shocks or high stress. Due to an imbalance between stress and resilience, this cartilage gradually wears away until the bone is partially or even completely exposed. The now unprotected bone tries to compensate for this overload by forming increased bone substance. This remodeling process of the bone with nodular thickening and deformations leads to a destruction of the joint surface. An increasing functional impairment of the joint is the consequence. In addition, the cartilage wear or abrasion causes recurrent swelling and effusions in the joint as well as inflammation of the synovial membrane.

Osteoarthritis can occur in any joint of the body. However, the hip and knee joints are most commonly affected, as these joints are most stressed by the own body weight.

4.2.1.1 Causes

Many causes can lead to osteoarthritis

- Hereditary disorder of the cartilage
- Congenital malposition of joints (e.g. X-leg position)
- Injuries (e.g. bone fractures, ligament injuries)
- Metabolic disorders (e.g. diabetes, gout)
- Joint inflammation
- Obesity

4.2.1.2 Symptoms

Symptoms of osteoarthritis are pain in the affected joints. Especially in cold and damp weather, the sufferers complain that these increase. Also stress, such as going down stairs, is very painful. Typical is also the so-called start-up pain. In the morning when getting up or after a long rest, the first movements are painful. However, this improves after a few meters, when the joint is "warmed up". Another symptom is the stiffness of the joint (limited mobility).

People with osteoarthritis have to "warm up" again after a long period of rest.

If an inflammation occurs, the joint is red and warm (activated osteoarthritis). In addition, a joint effusion can occur.

4.2.1.3 Diagnosis and Treatment

Although the diagnosis can already be made based on the medical history or, in the case of damage to the knee and hip joints, based on the gait pattern, osteoarthritis is mainly diagnosed by X-ray. In this, the doctor can recognize the typical changes in the joint.

The main goal of treatment is pain relief by administering medication (analgesics).

Further treatment goals

- Relieve symptoms (e.g. by cold and heat treatments)
- Improve mobility and walking performance (e.g. physiotherapy, orthopedic therapy)
- Prevent the progression of joint wear and tear (e.g. by strengthening muscles)
- Maintain or improve the overall quality of life of the affected person

Exercise and dancing in a group promotes the mobility of the joints.

Sport and movement has a beneficial influence in many ways, even if one suffers from osteoarthritis. However, the following applies: Affected people should move a lot without putting too much strain on the joints.

4.2.2 Osteoporosis (Bone Loss)

Osteoporosis is a disorder in bone metabolism, whereby the bone mass decreases beyond the normal level and thus the bone structure changes. Affected are mainly people in higher age.

From birth to about the 30th year of life, the bone skeleton is constantly built up and remodeled. The maximum bone mass is reached at about the 35th year of life. After that, bone resorption predominates. This remodeling process (build-up and breakdown of bones) takes place continuously, the bone is constantly renewed. The sex hormones (estrogen, testosterone) control (among other factors, such as vitamin D) the bone remodeling, regulate the uptake of calcium into the bone tissue and slow down the bone resorption. In old age, the hormone balance changes, the bone breakdown process intensifies, bone mass is lost and the risk of bone fracture increases.

4.2.2.1 Causes and Symptoms

The female hormone **estrogen** protects women from bone loss. In menopause, the estrogen level drops and the age-related bone loss accelerates. After the age of 60, one in three women suffers from osteoporosis. Women are therefore disproportionately affected by osteoporosis.

Testosterone protects men in a similar way as the female hormone estrogen. Since men do not have classic menopause, the hormone production declines much later and osteoporosis develops only around the age of 70.

Risk factors

- Family history
- Too little exercise

- Underweight
- Wrong diet (e.g. low in calcium and vitamin D)

Due to the reduction of bone substance, the tissue structure of the bone deteriorates, loss of stability and elasticity is the consequence. The symptoms of osteoporosis start slowly, for example with back pain. As the disease progresses, the bones become prone to fractures. Hip, femoral neck, forearm and spine are often affected by fractures. In advanced stages, fractures occur even without falling events, the bones collapse, muscle tension occurs. The affected people suffer from pain and limited mobility, which, if it progresses, often results in admission to a nursing home.

4.2.2.2 Diagnosis and Treatment

With different methods, such as X-ray examination, bone density measurement, computed tomography or **ultrasound measurement,** one can diagnose osteoporosis. Typical to observe is also the change in the posture of the affected persons, such as the hunchback also called "widow's hump" and the loss of body height (Fig. 4.2).

Goals of treatment

- Pain relief, e.g. by medication and/or physiotherapy (massages, heat applications and much more)
- Preservation of joint mobility and muscle strength (e.g. by active movement, especially in daylight)
- Maintenance of the best possible posture
- In addition to the measures described above, a change or adaptation of the lifestyle (e.g. the diet with balanced mixed food and high calcium content, abstention from nicotine and alcohol) of the affected persons is required

An increase in mobility can reduce the risk of falling.

4.3 Cardiovascular Diseases

The cardiovascular system supplies the body with all important nutrients and oxygen. The heart is the pump in this system and ensures that within one minute the entire blood of the human being (approx. 5–6 L) flows through the entire organism once. In light activity, the heart of an adult beats about 60–80 times/minute.

The heart consists of a left and a right half (Fig. 4.3). Each of the halves is again divided into a small atrium and a larger chamber. The blood is pumped through the pulmonary artery into the lungs by the right ventricle. In the total circulation of the blood, the lungs are one of the most important

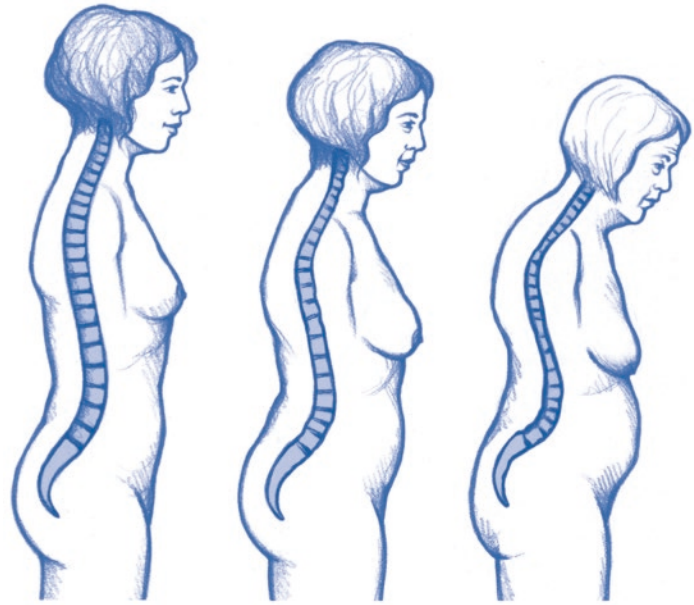


Fig. 4.2 Hunchback

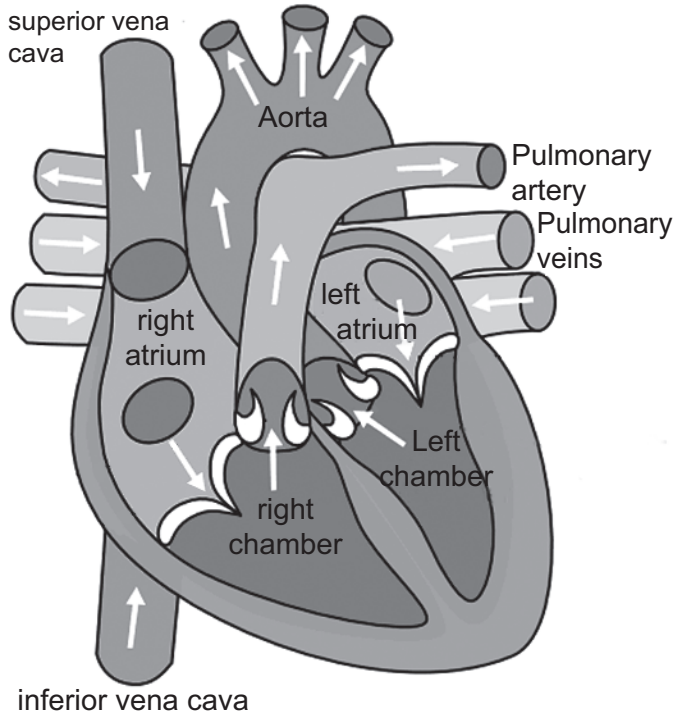


Fig. 4.3 The heart

stations, because here the uptake of oxygen and the release of **carbon dioxide** take place. The now oxygen-rich blood reaches the left ventricle via the pulmonary vein. Here the pulmonary circulation ends and the systemic circulation begins. The oxygen-enriched blood reaches the left ventricle via the left atrium. By contracting (contraction) of the ventricle, the blood is pumped through the aorta into the body. The blood is transported in the blood vessels.

- Blood vessels that lead to the heart are called veins.
- Blood vessels that lead away from the heart are called arteries.

The further the blood vessels are from the heart, the more branched they become and the smaller their diameter becomes. In the smallest vessels, a constant metabolism takes place, nutrients and oxygen are supplied to the tissue, waste products and carbon dioxide are transported away. The now oxygen-poor blood is transported back to the heart in the veins. When the blood reaches the right ventricle via the right atrium, the large systemic circulation ends.

4.3.1 Heart Diseases

Lack of exercise, high blood pressure, obesity, diabetes, lipid metabolism disorders or stress can lead to a heart disease becoming noticeable in old age (e.g. arrhythmias, coronary heart disease). The affected persons can be easily fatigued and short of breath, and also suffer from pain attacks behind the breastbone during physical exertion.

Before any planned activity, clarify how resilient the person is!

4.3.2 The Blood Pressure

To maintain the blood circulation, a certain pressure must be present. It is generated by the ejection force of the heart. The pressure of the flowing blood on the arterial walls is called blood pressure. The blood pressure is given in two values. In a healthy adult, the blood pressure at rest is about 120/80 **mmHg,** whereby blood pressure fluctuations during the day are normal.

4.3.2.1 Low Blood Pressure (Hypotension)

Long bed rest and/or fluid loss (sweating, diarrhea) can cause low blood pressure.

Low blood pressure is defined as values below 100/60 mmHg. Many people have low blood pressure, which does not cause them any discomfort. In others, circulatory problems occur, for example, after standing for a long time or changing position suddenly (quickly straightening up). Typical complaints that are then reported are dizziness or "blackening" in front of the eyes. Sweating, cold feet and hands, as well as fatigue and lack of motivation can also indicate low blood pressure.

4.3.2.2 High Blood Pressure (Hypertension)

High blood pressure is the most important risk factor for a stroke.

When the normal blood pressure limit at rest is permanently exceeded with values above 140/90 mmHg, this is called high blood pressure. Many people do not notice that their blood pressure is elevated and thus it can gradually damage the blood vessels. Various causes and risk factors can trigger high blood pressure, usually several causes come together.

Possible causes of high blood pressure

- Influencable factors, such as smoking, obesity, high blood lipids, lack of exercise
- Increased age
- Diseases, such as heart and kidney diseases, diabetes mellitus

Affected people often show a red face and complain of head pressure ("The feeling as if the head is bursting"), dizziness and/or ringing in the ears, have nosebleeds or sweating.

Diagnosis and treatment

High blood pressure can be diagnosed by regular blood pressure measurement (usually long-term measurements over 24 hours) (Fig. 4.4). A single high blood pressure value does not prove a high blood pressure disease.

The goal of treatment is to prevent vascular damage—such as arteriosclerosis.

Possible consequences of vascular damage

- Heart attack
- Stroke
- Renal insufficiency (chronic kidney failure)

The treatment is initially started with the change of lifestyle habits.

Fig. 4.4 Measuring blood pressure

Change of lifestyle habits
- Sufficient exercise in fresh air
- Balanced diet with little alcohol and restriction of salt intake
- Weight reduction
- Abstinence from nicotine
- Relaxation exercises

Only if the change of lifestyle habits is not enough (the implementation is rather difficult for seniors), additional medications (antihypertensives) are used.

As part of the care, always motivate to exercise more in fresh air!

4.3.3 Stroke (Apoplexy)

The stroke—a bolt from the blue—affects hundreds of thousands of people in Germany every year. It is an acute disease of the blood vessels in the **central nervous system.** Due to the occlusion of an artery (70–80% of all strokes) or due to a bleeding into the brain tissue (15–25%), there is a lack of oxygen supply to individual brain regions. It can be announced by sudden warning signs.

Pay attention to sudden paralysis or weakness in body parts when caring for someone!

Possible warning signals
- Very severe headache
- Visual disturbances
- Dizziness with gait disorders

- Numbness
- Paralysis
- Weakness in the face (e.g. drooping corner of the mouth), arm, leg or the whole half of the body

Stroke is the most common cause of permanent disability in Germany.

Caution with sudden stroke symptoms: Stroke is an emergency and every minute counts. A nursing professional must be informed quickly and immediately make an emergency call (► Chap. 9).

4.3.3.1 Consequences of Stroke

Strokes not only lead to paralysis, but also increase the risk of developing dementia.

Depending on which area of the brain is affected and to what extent, the symptoms after a stroke vary. The consequences can range from visible physical disabilities to impairments of mental abilities or disturbances of behavior and experience. For the affected people, the consequences of the stroke mean a significant restriction, which can affect the following areas and require an adjustment of the previous life.

- **Limitations in physical functions**
  - Hemiplegia means the paralysis of one side of the body
  - Spasticity, which means an uncontrolled muscle activity that pulls the head, trunk and limbs into unwanted and non-functional positions
  - Different sensations in both halves of the body. This means that the symmetry and thus the physical balance are disturbed
  - Chewing and swallowing difficulties hinder the intake of food
  - The affected people suffer from **urinary and fecal incontinence**

The hemiplegic person may not perceive his or her affected side, but still feel pain!

- **Sensory disturbances**
  - Numbness up to total loss of sensation (risk of injury!)
  - Impaired heat-cold sensation
  - Hypersensitivity
  - Pain (e.g. shoulder pain)

- **Limitations of mental abilities**
  - Often a language disorder hinders the contact with the environment (► Chap. 5)
  - Neglect of the affected side (Neglect)
  - Attention and concentration disorders
  - Perception and vision disorders

- **Change in behavior**
  - Lack of motivation
  - Irritability

- **Change in experience**
  - Often affected people suffer from mood swings **(depression)**
  - They are afraid of falling or of having another stroke

4.3.3.2 Treatment and Care After Stroke

The focus of the treatment is on rapid mobilisation (promotion and preservation of mobility) and the start of a self-help training (Fig. 4.5). It is important that the entire therapy, care and support are based on a consistent concept. A frequently used concept is the **Bobath concept**. Ask in the facility which concept is used.

Fig. 4.5 Walking with hemiplegia

Care and Documentation

Contents

S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_5

» Planning begins with thinking about what you want. (Ekkehard Kappler)

The starting points of professional care are the personal needs, habits and social contacts as well as the individual care problems and the remaining self-care abilities of a person. For this, all information is needed that is required for the promotion, support and care of a person. Within the framework of the care process, a care history with biography and a care plan are therefore created.

5.1 Care Process

The care process is a written, structured preparation and planning of the care service. A fixed sequence of different steps ensures that instead of a spontaneous arbitrary care, a planned and comprehensible care is created. The care service becomes transparent for all participants.

In principle, the care process is a systematic action model based on the problem-solving process. The care process is divided into several phases.

5.1.1 Phase 1: The Information Collection

Without information collection, there is no planned care!

The basis or foundation for the care plan is the information collection or care history.

In addition to the initial interview, instruments of the care history include observations and information from close persons (relatives and friends) or other persons involved in the care and support. The aim is to capture the current state of the person in need of care. The collected information forms the foundation of the further care planning (◘ Fig. 5.1).

Usually, this data collection in the form of the Care history is oriented to the AEDL according to Prof. M. Krohwinkel. In addition to the care history, a **risk assessment** must be carried out. Of particular importance here is also the beginning of the biographical work (▶ Chap. 3).

The care history must be continuously updated according to the development of the care process.

Practical tip

Observations and findings that are made during the care should be passed on to the responsible nursing staff for supplementing the care history and the biography!

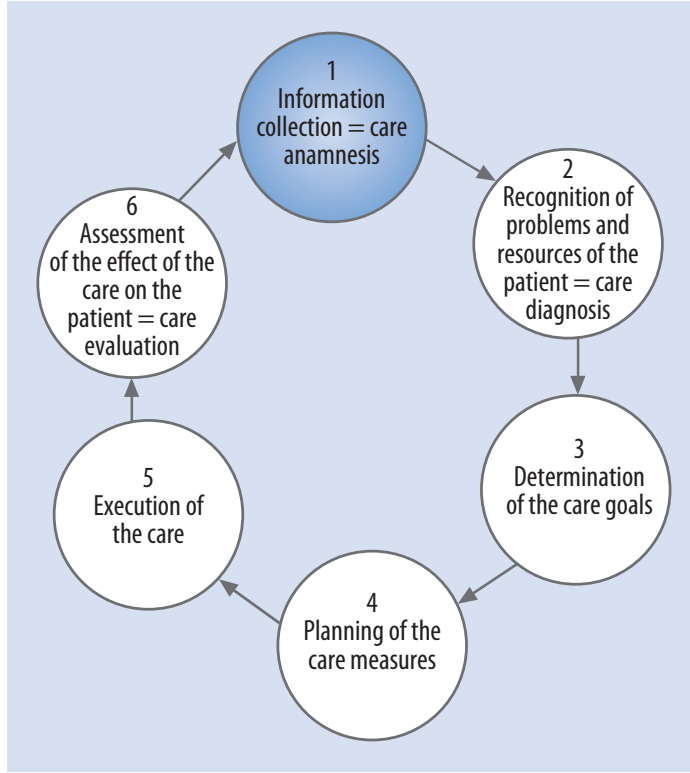


Fig. 5.1 Phase 1: Information collection

5.1.2 Phase 2: Recognizing Resources and Care Problems

After completing the nursing assessment, the second phase of the nursing process follows. The collected information has made resources and existing nursing problems clear (Fig. 5.2). In the nursing plan, the resources of the person in need of care should be used and promoted, his limitations considered and his needs met.

5.1.2.1 Resources – Promoting and Maintaining Independence

In nursing, resources are skills and possibilities that the person in need of care has and can use to take care of himself.

By considering the resources, nursing has an activating effect!

It is a characteristic of professional nursing to skillfully support the person in need of care in coping with his problems

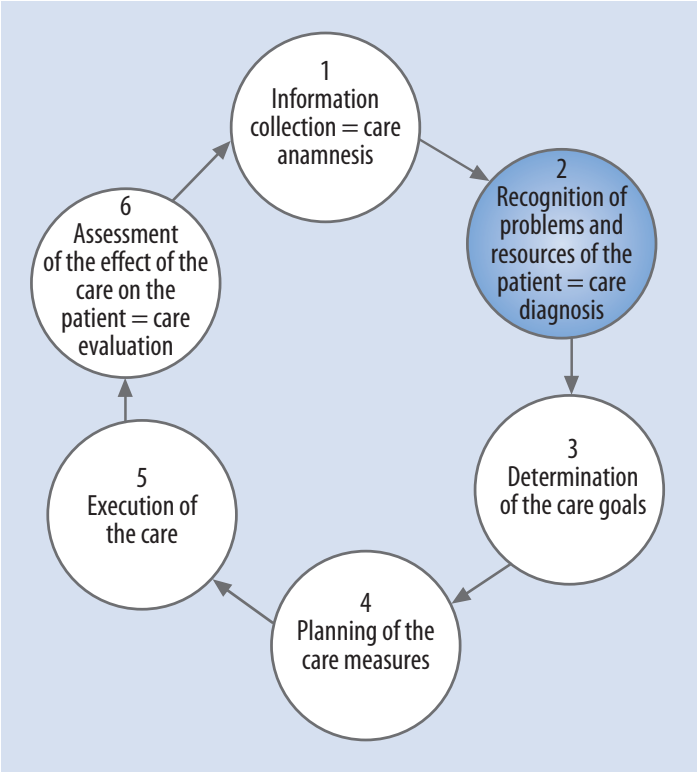


Fig. 5.2 Phase 2: Recognizing resources and nursing problems

himself, so that he can remain/become autonomous as far as possible. The use of resources increases his self-esteem.

Characteristics of resources

- Resources are the person in need of care's helping sources.
- Resources are individually different and must be recorded and supplemented continuously.
- Resources have a positive influence on the recovery process in case of illness.
- Resources help the person in need of care to achieve the greatest possible independence.

It should be noted that resources change. An evaluation of the nursing plan must therefore always include a review of the nursing assessment and the resources.

Within the scope of care, resources must be considered and promoted. The nursing plan provides information on this. This can be discussed with the responsible nursing specialist.

5.1.2.2 Care Problems

A care problem is an impairment in a life area that the person in need of care cannot compensate himself, that limits his independence and burdens him.

If the person in need of care cannot cope with this impairment alone (by his own strength) and therefore needs nursing help, then a care problem exists. Example: A person cannot stand up from the chair without support (= need for help) due to weakness.

Existing problems are also relevant for the care, support is required by the companion (e.g. when getting up from the chair, when eating).

If new problems occur during the care, they should be reported immediately to the responsible nursing staff!

5.1.3 Phase 3: Determination of the Care Goals

In phase 3, the care goals belonging to the respective care problems are now determined (Fig. 5.3).

A care goal refers to a specific care problem and describes the desired outcome that the person in need of care and/or his relatives/the care team want to achieve in a defined period of time.

The care goal indicates the direction of the planned measures and is at the same time a criterion and standard to assess the effectiveness of the planned measures. There are 3 types of care goals.

5.1.3.1 Maintenance Goals

The targeted care makes an important contribution to the preservation and promotion of abilities.

Maintenance goals are often used in elderly care, when realistically no improvement of the condition is possible anymore (e.g. in advanced dementia). The person in need of care should not suffer any additional impairments. The focus is therefore on the preservation and promotion of the resources (e.g. "Continues to eat meals at the table.").

5.1.3.2 Rehabilitation Goals

Rehabilitation goals concern the improvement of the current condition, e.g. improved mobility, independent eating and drinking. There are care goals that can only be achieved after a long period of time (long-term goals). For individual steps

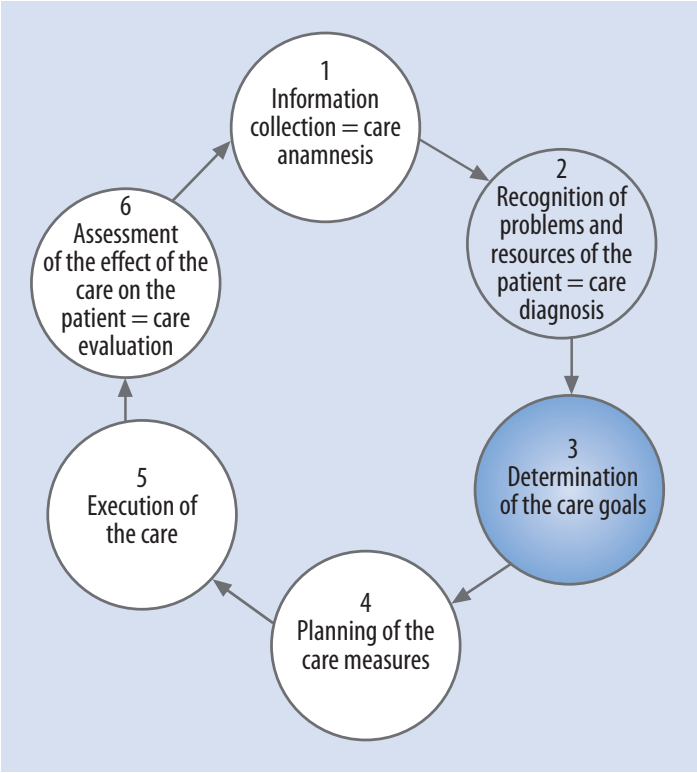


Fig. 5.3 Phase 3: Determination of the care goals

that are necessary to achieve the long-term goal, short-term goals are described.

5.1.3.3 Coping Goals

Coping goals serve to cope with the situation. Examples of this are coping with changed living conditions.

Conversations during care help the person in need of care to cope with his or her changed living conditions or unresolved events in life.

Reasons for changed living conditions

- Moving into a home
- Permanent disability after a fall or stroke
- Death of the life partner
- Beginning dementia (stage 1)

5.1.4 Phase 4: Planning of Care Measures

In phase 4, the care measures (or care interventions, nursing services) are now determined, which logically result from the set care goals (Fig. 5.4).

Nursing services must be coordinated with household and care services.

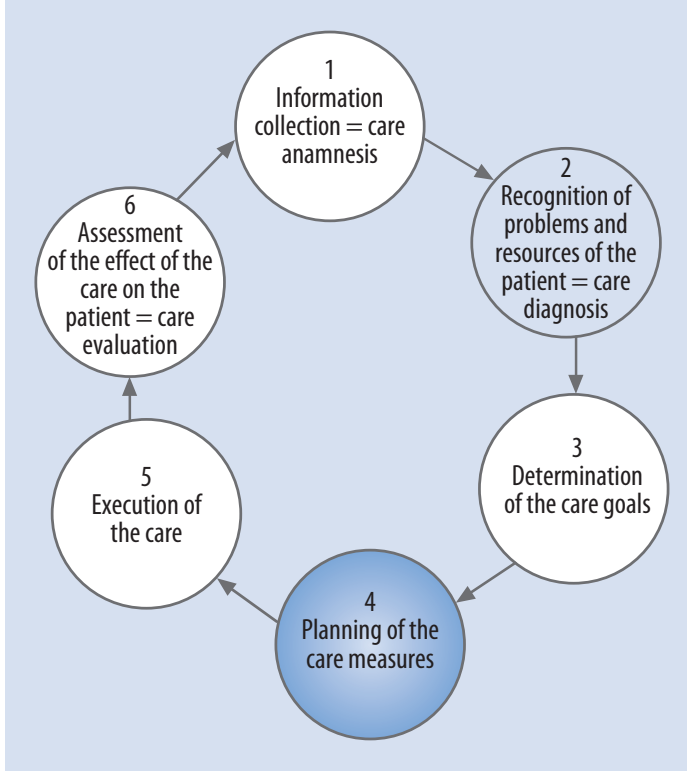


Fig. 5.4 Phase 4: Planning of care measures

Care measures are instructions for action that describe what, when, how and with what and how often something is done.

Within the care planning, the measures are formulated in a way that guides action for everyone. In this context, individual care flow plans have proven to be useful. Each care measure must correspond to the current nursing professional knowledge and can refer to care standards.

5.1.4.1 Care Standard

Care standards are binding specifications that are adopted and implemented by superiors. They define a certain quality level of care by measurable criteria.

Practical tip

In this context, special concepts and standards of the facility for people with dementia should be asked for, e.g. KDA quality manual "Living with Dementia", DCM (▶ Chap. 6).

5.1.5 Implementation of Care

In phase 5, the planned care measures are carried out. They are usually discussed in the team and must then be performed by all staff in the same form (■ Fig. 5.5).

> Nursing measures that become necessary during the care must also be carried out by the companion according to the care plan. Companions should be instructed by the nursing staff on how to do this!

5.1.5.1 The Nursing Report

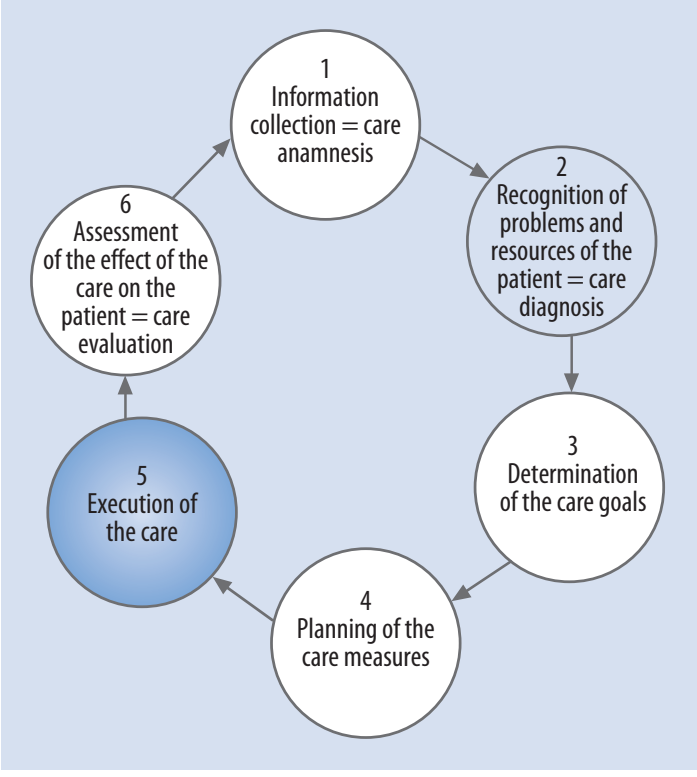
The nursing report (also called report sheet) is kept by all those involved in the care and supply. In it, as much as necessary, but as little as possible, is documented. The entries are generally concise, but precise.

The more hazardous a situation is, the higher the level of detail of the documentation.

▪ Functions of the nursing report

The care plan itself does not provide information about the effect of the nursing interventions and the well-being of the

The nursing report is the mirror of the care and support provided.



■ **Fig. 5.5** Phase 5: Implementation of care

person in need of care. However, this information is indispensable for providing qualified care. The assessment is done daily and documented in the nursing report.

Goals of the nursing report

1. Evaluate care: Were the goals achieved?
2. Describe the course: Has the condition improved, worsened?
3. Identify problems: Have new problems arisen or are no longer present?
4. Present the current condition and feelings of the person in need of care: How does he tolerate the care, support and therapy?

Documentation in the care report

The task of the dementia companion is the timely documentation of special features in the care report.

The care report contains the following information

- Changes
- Feelings
- Reactions to nursing measures
- Deviations from the planned measures
- Current events, such as falls
- Physical and mental conditions, such as pain, joy, fear

5.1.6 Evaluation (Evaluation)

With phase 6, the evaluation and review of the care provided begins. It is the feedback mechanism of the nursing process cycle and thus the decisive step to trigger a new process (Fig. 5.6).

The evaluation of the care also takes place during the course of the nursing process for all nursing actions (see nursing report)

Since the nursing process now starts again at the first step, all steps have to be reworked in the evaluation, i.e., the nursing history, the problems and resources, the goal formulation, the planning of measures and the implementation of the care are evaluated.

Practical tip

The nursing process provides important information (e.g. on age-related diseases, ▶ Chap. 4) for the care. The dementia companion should be introduced to the entire nursing process planning and the nursing documentation of the facility and coordinate where he can make his entries.

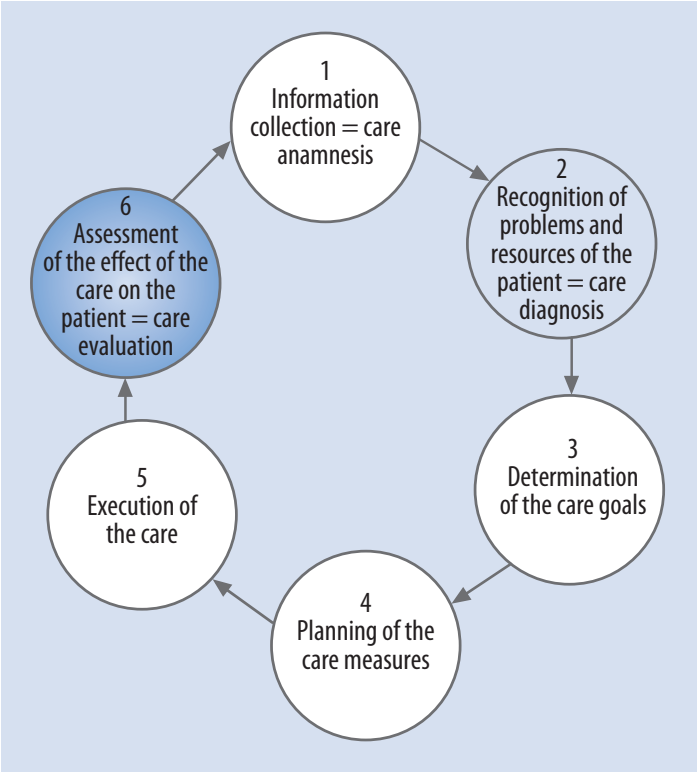


Fig. 5.6 Phase 6: Evaluation (assessment)

5.2 Nursing Documentation

The **nursing documentation** is the decisive factor for proving a correct, conscientious, professional and appropriate care that takes into account the current scientific findings and the activation of the person in need of care. It thus offers a high degree of legal certainty, if it is kept regularly and properly.

5.2.1 Structure of the Nursing Documentation

In the nursing documentation, there are standard forms that have to be kept for every person in need of care, and special forms that are only needed if necessary.

Standard forms

- Master sheet
- Nursing assessment

- Risk assessment (e.g. assessment tools for fall and pressure ulcer risk, malnutrition)
- Biography
- Nursing planning
  - Problem description and abilities
  - Goals
  - Planned measures
  - Evaluation
  - Nursing report
- Performance record/Implementation record
- Order form
- Transfer form

Special forms

- Monitoring or vital signs form
- Positioning plan with positioning protocol
- Nutrition plan with nutrition protocol
- Fluid plan with drinking protocol or balance sheet
- Micturition protocol
- Wound documentation
- Pain history with pain progression control
- Documentation of deprivation of liberty or approved coercive measures
- Consultation form
- Care protocol (Appendix 3)

5.2.2 Content-Related Criteria

The entries should be understandable for all those involved in the care, support, provision and treatment. A generally accepted nursing-medical terminology is used.

Principles of the entries

- Comprehensibility
- Completeness
- Continuous documentation
- Orientation to the nursing process or the care plan
- Value neutral formulation
- Concrete formulation

Statements of the person in need of care are documented as a quote if necessary. Interpretations and evaluations of his subjective statements should be avoided.

5.2.3 Formal Criteria

The documentation in care planning and care report for paper documentation must be "document-proof", i.e. with ballpoint pen (no felt-tip pens).

Principles of documentation
- Readability
- Clarity
- Provided with date and signature (hand sign)
- Without blank lines

Document-proof means that the following is prohibited
- Use Tipp-Ex®
- Write with pencil
- Cover, erase or make illegible written text

If a mistake has been made, corrections must be made in such a way that the original remains legible, i.e., cross out the entry horizontally, make the correction with hand sign and time.

If an entry has been forgotten, then the following applies: make up the entry on the following day and mark the entry as a correction.

As part of digitalization, paper-based nursing documentation in many health care facilities is changing to digital documentation, e.g. by MDE/MDA devices in outpatient care or by tablets and touch screens in nursing homes, which is why some of the criteria mentioned above are no longer relevant for digital entries, e.g. the requirements for document-proofness.

5.3 Basic Knowledge of Nursing

The life of a human being takes place in different life phases: childhood, adolescence, adulthood, old age. The human being strives in each phase to perform certain, recurring activities (life activities) under the prevailing life situations and depending on self-reliance (or degree of dependence). People with dementia lose the ability to care for themselves—to perform their life activities themselves—as the disease progresses. Professional nursing focuses on this.

5.3.1 Activating Care

Activating care means involving the existing abilities of a person to perform his or her individual activities of daily living.

The existing self-care abilities should be maintained.

The basic idea of activating care is to enable the care-dependent person to live an independent and self-determined life and to provide them with assistance in such a way that they can exert the greatest possible influence on the design of their life. The goal is to achieve a high degree of independence from the caregiver.

Goals of activating care

- Maintain the emotional well-being of the care-dependent person by strengthening their self-esteem and conveying security
- Increase self-confidence in one's own abilities and possibilities
- Promote fine and gross motor skills by regularly performing movements and additionally by targeted exercises
- Stimulate sensory perception (which decreases with age) of nose, ears, mouth, skin and eyes in this way
- Preserve and activate mental abilities

5.3.2 Degrees of Independence

The degree of independence is crucial for promoting-rehabilitative and nursing activities, in order to specifically maintain individual abilities, and to reactivate those that have been lost, if possible. The abilities are divided into degrees in each area of the activities of daily living.

Degrees of independence

- Independent
- Predominantly independent
- Predominantly dependent
- Dependent

The degree of independence is recorded in the nursing assessment and the need for assistance is determined.

5.3.2.1 Independence

A person is independent when he can live all (or individual) life activities without restrictions (e.g. the person can move, his communication is unrestricted, he can react adequately to

external conditions and their changes). The person is also independent when the performance of the life activity is difficult, slowed down or can only be carried out by using an aid/care aid. The decisive factor is that he does not need any support from another person (◘ Fig. 5.7).

5.3.2.2 Predominant Independence

Predominant independence can be assumed when the person can perform the largest part of a life activity independently and only has a very low need for support from another person, such as

- Arranging objects (providing a washbasin, then washing himself, adjusting the insulin pen, then injecting himself) or other similar preparatory activities.
- Prompting to do something (possibly several times)
- Few handholds within an activity (e.g. only washing the back)

5.3.2.3 Predominant Dependence

Predominant dependence exists when the person can only perform a small part of the life activity independently. However, there are still enough resources available that he can participate. This is the case, for example, when a lot of help is

◘ **Fig. 5.7** Walking with a walker

needed (possibly in addition to aids) for getting up from the chair, the toilet or the bed (Fig. 5.8).

5.3.2.4 Dependence

A person is considered to be dependent if he or she constantly needs personal assistance in a life activity. There are hardly any or no resources available. This is the case, for example, if someone can no longer walk (Fig. 5.9).

5.3.3 The Need for Assistance

Nursing assistance becomes necessary when the person cannot solve, cope with or alleviate problems related to his or her life activities independently. The need for assistance is very individual. It is recorded as part of the care planning, forms of assistance (guidance, supervision, support, partial takeover, full takeover) are planned for the measures.

Nursing interventions

- Act for the person in need of care (partial or full takeover of life activities)
- Guide and lead him or her

Fig. 5.8 Getting up from the bed with help

Fig. 5.9 Movement only with personal assistance

- Provide an environment that is conducive to positive development
- Support him or her
- Instruct, advise, teach and promote the person in need of care and/or his or her reference persons

5.4 AEDL Structuring Model

Professional caregivers align their actions with the criteria of certain nursing theories. All nursing models view the human being in his or her wholeness with his or her resources and problems, depending on his or her environment. The model frequently used in geriatric care is the model of supportive process care, developed by Professor Monika Krohwinkel, in which the individual life history and the promotion of the abilities of the human being are in the focus. It provides a structure for capturing the life activities and habits of a person, the 13 activities and existential experiences of life (AEDL):

Overview AEDL according to Krohwinkel

1. Communicating
2. Moving
3. Maintaining vital functions of life
4. Caring for oneself
5. Eating and drinking
6. Eliminating
7. Dressing
8. Resting and sleeping
9. Engaging in activities
10. Feeling and behaving as a man or a woman
11. Providing a safe environment
12. Securing social areas of life
13. Dealing with existential experiences of life

The following describes nursing measures for each AEDL that are important in the context of care and should also be performed by the companion in addition to nursing.

5.4.1 Communicating

Speech disorders can be an early sign of dementia.

▶ Chap. 3 "Dealing with people with dementia" describes in detail basic rules of interaction with important behaviors of people with dementia in connection with verbal and non-verbal communication as well as communication disorders.

In addition, there is the area of sensory perception, such as hearing, seeing, feeling, tasting, smelling or touching. These areas can be limited due to physical or mental illnesses.

Measures that enable communication

- Checking the functionality and the use of aids, such as:
  - Glasses (a clean and functional pair of glasses is also important for fall prevention)
  - Hearing aids (a functional hearing aid is also important for fall prevention)
  - Dentures
- Basic rules for hearing impairment, such as:
  - Maintain eye contact
  - Speak slowly, clearly and calmly
  - Do not shout, as the person with dementia may be more startled
  - Provide adequate lighting for lip reading
  - Reduce background noise (e.g. turn off the radio)
  - Rephrase the sentence or term if it was not understood

- If necessary, use body signals, signs and symbols, gestures or signs, communication aids; necessary for people with insufficient speech (e.g. **aphasia** after stroke, deaf or deaf-mute people)

Practical tip

Helpful in connection with the care is the creation of a sense testament. Ask, if possible, the relatives:

- What did the person with dementia like to see, hear, smell, taste, touch?
- More on sensory stimuli in ▶ Chap. 6

5.4.2 Moving Around

Movement promotes thinking and reduces tension.

The movement patterns of people with dementia are different. Either they sit for a long time in one place or they wander restlessly. Activities can balance the lack of movement or the urge to move. These are described in detail in ▶ Chap. 6.

Movement promotion is also a prevention for the development of joint stiffness, so-called contractures, and for bedsores, also called decubitus. If necessary, the dementia companion will be informed by other professional groups about a risk and instructed for measures during the activity.

The movement ability of a person with dementia is only increasingly limited in the last phase of the disease. This does not apply, of course, if he also suffers from a disease that restricts his movement (such as stroke, arthritis, ▶ Chap. 4).

At first, there may be coordination and balance problems when walking, later the **movement coordination** when walking, sitting and standing is no longer possible. As soon as people are only limited in their ability to move themselves, they need to be supported in the following activities:

- When walking and standing
- When getting up and sitting down
- When positioning in bed

5.4.2.1 Support when Walking

- The companion stands slightly behind the person in need of care (on the paralyzed side for people with hemiplegia).
- He supports the pelvis of the person in need of care with his pelvis.
- He places one hand on the opposite side at the level of the pelvis on the back of the person in need of care.
- With the fingers of the other hand, he grasps the palm of the nearer arm.

5.4.2.2 Support when Getting up and Sitting Down

The support can vary greatly depending on the illness (e.g. according to **kinesthetics,** according to Bobath, as light support or as full takeover of the activity). In the context of the accompaniment, support may be necessary again and again (e.g. when the person being cared for needs to go to the toilet).

Practical tip

The caregiver should be instructed by the nursing professional for all people with limited mobility who he cares for, which aids are necessary (walking stick, walker, wheelchair) and how he has to provide the support when getting up and sitting down (◘ Fig. 5.10).

5.4.2.3 Positioning in Bed

Especially in the case of individual care, the person in need of care should be in a position that allows him to participate. For reading or playing, looking at pictures or, as shown in ◘ Fig. 5.11, for eating, the **upper body elevation position** is suitable.

It is important to ensure that the person being cared for does not slide towards the foot end. The position then quickly becomes uncomfortable and makes participation more difficult.

5.4.2.4 Fall Prevention

As described in ▶ Chap. 9, the risk of falling is increased in old age. The causes for this are manifold. The companion also has to consider fall prevention measures for all activities.

Fall prevention measures in the area of movement

- Suitable footwear, closed and slip-resistant (if necessary, slip-resistant socks with anti-slip knobs)
- Suitable walking aids (e.g. rollator)
- Accompaniment in case of gait insecurity and decreasing strength (support for walking above)

5.4.3 Maintaining Vital Functions of Life

The vital functions include the functions of the vital organs brain, heart, lung and kidney. Under the vital functions, the respiration, the circulation and thermoregulation are to be understood in this context, whose maintenance is supported

Fig. 5.10 Support when sitting

by sufficient exercise in the fresh air (walks). Problems arise when the maintenance of the vital functions causes discomfort, as can be the case with rapid fatigue (e.g. with cardiovascular diseases, ▶ Chap. 4).

Limitations in the vital functions must be taken into account in any planning of occupation, in order to avoid overexertion.

5.4.4 Care for Oneself

Caring for oneself is an expression of an individual body hygiene. In order to perform the body care, mental and physical abilities are necessary.

Well-groomed skin invites to be touched.

Fig. 5.11 Upper body elevation position

This life activity includes
- Washing, showering, bathing
- Caring for the skin, the nails and the intimate area
- Shaving, styling
- Brushing the teeth

Traditions, cultural and social conditions (smelling good) determine the respective requirements that people place on their "appearance". This also includes, for example:
- Washing the hands before cooking or after using the toilet
- Brushing the teeth after eating
- Styling before going for a walk/shopping

These habits are often learned early and internalized. Even if the person with dementia can no longer express or plan them, he is guided by them. Often the **visual**-spatial movement coordination of these simple activities is no longer or only partially possible. The companion can support in this area, if he demonstrates the activity step by step (1. turn on water, 2. wet hands, 3. soap, 4. wash hands under the water jet, 5. dry hands).

5.4.5 Eating and Drinking

The entire well-being of a person is positively influenced by a tasty and nicely arranged meal in a pleasant environment. How important a balanced diet is for the supply of vital energy to

the body is explained in ▶ Chap. 7. People with dementia have special nutritional problems. Even in the early stage of the disease, unwanted weight loss can occur. Due to the restlessness, constant movement and also stress, the basal metabolic rate increases and the person with dementia needs a high calorie intake (further causes ▶ Chap. 7).

As part of the care planning, an individual nutrition and fluid plan is therefore created for each person with dementia to ensure adequate energy, nutrient and fluid intake (calculation of energy requirements ▶ Chap. 7).

▶ Chapter 6 describes the benefits of cooking together for the affected people and shows examples for the implementation. ▶ Chapter 8 deals with what to consider when buying food. The following describes further measures that need to be considered when eating.

- **Promoting perception and orientation**
  - Distinct contrasts between tablecloth, plate and food
  - Components of the meal one after another (only one course at a time)
  - Use napkins as such, not as "bibs"

A clear table arrangement (◘ Fig. 5.12) facilitates orientation

- **Dealing with chewing- and swallowing problems**
  - Checking if the denture fits properly
  - Cutting food, if necessary, in front of the eyes of the person in need of care

◘ **Fig. 5.12** Clear table arrangement

- Largely avoiding pureed, mushy food; it does not stimulate the appetite and is also not necessary for a long time; rather cut off hard parts (e.g. bread crust)
- If soft, pureed food becomes necessary, then it should not have any hard parts (solid components are often sorted out)

Feeding

When serving food it should be noted that the mouth of a person belongs to the intimate body areas.

- Place the plate in front of the person with dementia (otherwise it can confuse him if the plate from which he is supposed to eat is with the companion)
- Serve food in a sitting position, preferably sit next to him and not in front of him
- Serve food rather with the spoon than with the fork (possibly the affected person believes that he is being stabbed)
- Serve food in bed in an upright body position (upper body elevation)
- Make eye contact, because the order and pace of food intake should be controlled by the person in need of care
- Encourage self-eating and drinking again and again (possibly by using appropriate aids such as plate edge elevation, cup with nose cutout, special cutlery, straws)

The amount of food and fluid intake must be recorded by the companion.

5.4.5.1 Swallowing Disorders (Dysphagia)

"Choking" or clearing one's throat can be signs of a swallowing disorder. The most dangerous consequence of ***dysphagia*** is ***aspiration.***

The physical changes often lead to the fact that the person affected can no longer speak properly and can no longer swallow properly as part of the dementia disease. The health consequences of the swallowing disorder can be serious. In addition to the malnutrition described several times, aspiration**pneumonia** (pneumonia due to swallowing e.g. food) may threaten.

Eating rules for swallowing disorders

- The person affected must assume an upright sitting position (good sitting and head posture).
- Distractions, such as TV or radio, should be turned off and a quiet relaxed atmosphere should be ensured (environment as low-stimulus as possible).
- Do not talk to the person with dementia during food intake.
- Only give small bites and sips (or let them eat themselves).
- Let them chew well, pay attention to mouth closure when chewing.
- The mouth must be empty before a new portion is taken, take breaks in between.

- Thicken liquid (e.g. with melting flakes, or with preparations intended for this purpose).
- Oral hygiene must be performed after each meal.

After eating, the person affected should preferably sit upright for 20 minutes, so that the last food residues are swallowed or residues in the esophagus do not enter the trachea.

5.4.6 Excretion

Excretion is one of the most intimate activities in our culture. Therefore, independence has a special value especially for this life activity. In the case of dementia, many factors can make going to the toilet difficult.

Factors that make using the toilet difficult

- The person cannot find the toilet.
- He forgets to pull down his clothes or cannot do it anymore.
- He may use unsuitable places for excretion, because he confuses them with the toilet.

Recognizing the urge to urinate

The restlessness of a person with dementia may hide the urge to urinate or defecate

- Temporarily keep a record of the person's excretions (micturition diary), possibly some "regularities" can be recognized; for example, if he wets himself always half an hour after taking a drink, this can be prevented by taking him to the toilet shortly before
- Pay attention to clear signals from the person with dementia, such as restlessness, fiddling with his clothes

5.4.6.1 Urinary Incontinence

Urinary incontinence often occurs with dementia. This is not always a bladder weakness, but can also be a side effect of the medication (acetylcholinesterase inhibitors) for Alzheimer's dementia. In the late stage, almost 80% of dementia patients are incontinent of urine. Urinary incontinence can be counteracted by increasing the fitness and improving the mobility of the person affected.

Further measures

- Always associate toilet visits with consistent events (e.g. after meals, before rest periods)
- Accompaniment to the toilet (dementia patients cannot always ask for it)
- Good lighting

- Easy to open clothing items (e.g. replacing buttons with Velcro)
- Pictogram on the toilet
- No diuretic drinks in the evening, such as beer (the nocturnal urge to urinate is a wake-up stimulus)

5.4.7 Dressing Oneself

With the onset of dementia, not only the willingness, but also the ability to perform certain everyday activities independently decreases.

Common difficulties

- Choosing clothes
- Changing clothes when dirty
- Dressing according to the season

Supportive measures

- Lay out clothing items so that dressing is not only easier (e.g. in the order of first underwear, then pants), but also can be done independently
- Use familiar clothing items, new clothing items can increase confusion
- Leave the usual (dis-)order (e.g. in the wardrobe)
- Remove dirty clothing discreetly

All remaining abilities should be maintained or built up by constant activation and repetition.

5.4.8 Resting and Sleeping

Many people with dementia have sleep disorders. With the onset of dusk, they become increasingly restless, as their perception deteriorates. They go to bed early, without falling asleep right away. The sleep is usually only shallow, as a result they wake up more often at night and wander around (deep sleep phase is often not reached). Sometimes the sleep-wake cycle is completely reversed and the people with dementia can no longer distinguish between day and night.

Wandering around at night can lead to accidents and injuries.

A nocturnal snack can relieve the restlessness (e.g. due to low blood sugar), finger food is especially suitable for this

Not all day-active people with dementia sleep better at night, not all people with dementia who doze a lot during the day

Fig. 5.13 Memory care: Looking at pictures together

lie awake at night. Therefore, it is important to find out the individual sleep and wake patterns.

Measures to prevent or reduce nocturnal wandering

- Put on daytime clothing in the morning (distinction between day and night clothing)
- Structure the daily routine clearly (e.g. fixed meal times)
- Walks in the afternoon
- Stay in bright rooms during the day, bright lighting at dusk, darkness at night
- If necessary, heat applications (e.g. a warm bath)
- Find out earlier sleep rituals (biography work)

5.4.9 Keeping Busy

▶ Chapter 6 "Care" (Fig. 5.13).

5.4.10 Feeling as a Man or Woman

The gender role of a human being is an essential feature of his or her personality. Femininity and masculinity are expressed not only in the physical appearance, but also through differences in thinking, feeling and acting. How a man feels and behaves as a man or a woman feels and behaves as a woman or expresses his/her gender role, is reflected in:

Whoever appears outwardly attractive and well-groomed, is attributed further positive characteristics by the environment.

- many forms of behavior,
- the initiation of relationships and
- the design of social relationships.

One can support people with dementia in a nursing way, by helping them to dress and groom themselves according to their gender.

Nursing support measures

- Support with shaving, application of aftershave, tying a tie
- Support with styling, applying makeup, coloring hair, painting nails, applying perfume
- Attention to fashionable clothing, jewelry

5.4.10.1 Intimate Sphere

The intimate sphere is the area of the human being that needs to be protected most from the intrusion of others. Violation of the intimate sphere is met with embarrassment and shame.

During many nursing actions (dressing/undressing, assistance with excretions, washing the intimate area), caregivers enter the intimate sphere, the usual thresholds of the feeling of shame are exceeded. First of all, care should be taken that these actions can be carried out independently as long as possible. If this is no longer possible, the dignity of the person concerned must be preserved.

Measures to preserve the dignity of the person concerned

- Knock before entering the room
- Close the toilet/bathroom doors when performing activities
- Pay attention to the intimate sphere in multi-bed rooms (e.g. dressing/undressing in the bathroom)
- Ask for consent for the nursing action
- Remain factual when helping with excretions (no baby talk like "pee-pee")
- Perform intimate activities quickly

Wherever possible, the wish for same-sex care should be respected.

5.4.11 Ensuring a Safe Environment

At all times, people strive to avoid threat or danger. To maintain an adequate level of security, they behave accordingly. They perform numerous actions that often happen unconsciously, as they are the everyday habits that convey security.

Everyday behaviors to maintain security

- Assessing hazardous situations
- Requesting help when needed
- General orientation and decision-making skills

Life is always associated with risks. A maximum of security cannot be offered. The risk increases when one wants to preserve one's own experience and activity spaces for people with dementia. Therefore, a reasonable compromise must be found, in which on the one hand as much security as possible is offered, on the other hand the patient retains many freedoms.

Tensions, uncertainty and stress are more likely to cause accidents. All measures that serve well-being and balance also avoid dangers.

Additional danger-avoiding measures

- Eliminate fall hazards (▶ Chaps. 8 and 9)
- Prevent burns (▶ Chaps. 8 and 9)
- Remove or lock away problematic things (e.g. matches, cigarettes, fragile objects, scissors, poisonous plants, buttons, glue spray, flower fertilizer, ▶ Chap. 8)
- Prevent running away (hide the front door behind a curtain, remove hat, walking stick, Chap. 10)
- Facilitate finding again (equip the person with important data, such as a sign or bracelet with name, address, phone number, ▶ Chap. 10)

Pain

Pain is a subjective sensory perception that, when acute, is a warning and guiding signal. Its intensity can range from unpleasant to unbearable and will prompt us to seek the cause by visiting a doctor. If the pain is chronic, it loses the character of a warning signal. In this case, it is treated today as an independent disease (Chronic pain syndrome).

People with advanced dementia often cannot indicate that they have severe pain or that and where something hurts them. Since they can no longer communicate properly, they often receive less pain medication than necessary. Therefore, it is important for all people who are involved in the care and support of people with advanced dementia to recognize possible pain conditions indirectly.

The task of nursing is to determine possible pain already at admission. For this purpose, relatives should also be asked whether the person affected suffered from a painful disease (such as osteoporosis) before the onset of dementia and whether he or she regularly took pain medication. Also,

in the course of nursing, even after starting pain therapy, the pain intensity must be assessed.

In everyday interaction with people with dementia, one can also receive clues about pain conditions or pain intensity during care. An important prerequisite here is a good perception and observation skills of the dementia companion. Conclusions about an increased pain symptomatology in people with dementia can be drawn from the changes in their behavior.

Indications of pain

- Deviations from usual behavior
- Changes in facial expression
- No participation in usual activities

If there are indications of pain, the situation can be checked more closely using a special Scale.

The ZOPA Zurich Observation Pain Assessment includes 13 items, which are presented here as an example of a possible pain scale.

ZOPA©: Observed behavioral characteristics

Vocalizations

- Moaning/Complaining
- Humming

Facial expression

- Distorted/tormented facial expression
- Stiff gaze
- Clenching teeth (biting tube)
- Squinting eyes
- Tearing

Body language

- Restlessness
- Massaging or touching a body part
- Tense muscles

Physiological indicators

- Changes in vital signs:
  - Blood pressure/Pulse
  - Breathing
- Changes in facial color
- Sweating/Redness

5.4.12 Securing Social Areas of Life

▶ Chapter 6 “Care”.

5.4.13 Dealing with Existential Experiences of Life Cope

This life activity finds its expression in the confrontation with the boundary questions of life, in the desire for goals and orientation and in the attempts to interpret one’s own existence. In doing so, existential experiences touch the core, the existence of the person. Experiences are not transferable and effects are not derivable, because experiences are made by each person for themselves. Existential experiences can be triggered by incisive events as well as by banal everyday events.

Whether existential experiences are stressful or blissful—they always touch the innermost of a person.

The experiences collected in life, which had positive or negative effects, not only affect the experience in similar situations, but are important for all situations in life. They can influence the satisfaction, the psychological well-being and the physical condition of the person. By including the acquired knowledge and experiences of the previous life, the well-being and self-confidence of the person can be positively influenced.

In the accompaniment and care of people, the biography is the key to their understanding.

Promoting experiences that caregivers and companions should deliberately reinforce

- The feeling of being something, being recognized
- The opportunity to communicate and be heard
- The opportunity to have a say and participate in decision-making
- The experience of reliability, honesty and security
- The experience of leading a meaningful existence and being able to pursue meaningful activities
- The opportunity to show one’s feelings and deal with one’s situation, without being rejected
- The feeling of being respected and respected as a human being (regardless of limitations)

5.4.13.1 Faith

Many people have coped with their lives because they have drawn strength from their religion. Religious customs, such as singing hymns or going to church on Sundays, are important for believers. Many people with dementia enjoy the atmospheric power, the calmness and solemnity of a worship service, the familiar rituals and the sensual possibilities of

experience (candles, music, incense). It makes sense to find out about this from the biography.

5.5 Care Documentation

Analogous to the nursing plan, a process-oriented plan is also created for the area of care and support. Information is collected, abilities and problems are identified, which are influenced by the dementia disease, goals are formulated, measures are planned, implemented and evaluated.

The care plan can be part of the nursing plan, but in most facilities separate forms are used, as the measure planning often refers to different AEDL.

> The dementia companion must know exactly which forms are provided for the paper documentation for the care or which access rights he needs for the IT-System If there are two separate plans for the areas of nursing and support from the companion, it must be ensured that all involved professional groups have the same information.

Information and continuous observation are an important factor for successful nursing and care. Therefore, precise guidelines should be defined for the information exchange.

Possible information exchange

- Handovers
- Team meeting
- Case discussion
- Flashlight meeting
- Nursing visit
- Quality circle

5.5.1 Structure of the Documentation

To present a comprehensive process, the care documentation must include the following points:

Care documentation

1. Care planning
2. Evaluation
3. Performance record
4. Care report

An example form for a care documentation is included in appendix 3.

5.5.2 Contents of the Care Documentation

Similar to the nursing planning, the formulation of the care planning also poses a problem for many dementia companions.

To find suitable formulations, it is helpful to take a closer look at the functions of the brain in ▶ Chap. 1. This makes problems and resources clearer.

Practical tip

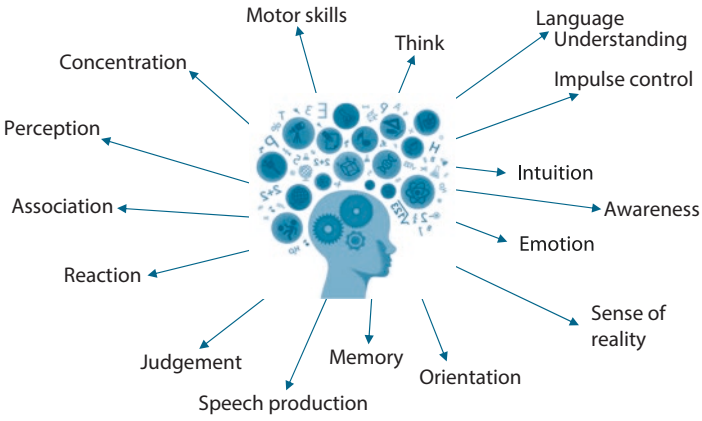
Create a list or a mind map with the tasks of the mind in ◘ Fig. 5.14.

Depending on these functions, abilities and problems can then be identified.

Practical tip

It is legitimate to describe only existing resources and abilities instead of problems, with the aim of preserving these abilities as long as possible.

To illustrate the content aspects of the care planning, the following table shows examples of possible problems, resources, goals and measures (◘ Table 5.1). In the fourth column, the planned date for the review is entered. In the care planning itself, the result of the evaluation should be recorded at this point.



◘ **Fig. 5.14** Mind map functions of the brain

Table 5.1 Examples of contents of a care plan

Resource, problem	Goals	Measures	Evaluation
Long-term memory is intact, short-term memory is impaired, resident is sad when he notices deficits	Short-term goal: Promote balanced mood through positive memories Long-term goal: Preserve the function of long-term memory	Create/look at memory album 1x/week Biography work 1x/week No memory training, as resident appears desperate during it	After 6 weeks
Orientation ability partially preserved: orientation to person given, situational and spatial orientation partly given, finds his way around the house, temporal orientation mostly not given	Long-term goal: Preserve existing orientation ability as long as possible Short-term goal: Accept temporal disorientation	Offer personal orientation aids Offer accompaniment whenever needed Offer information on temporal orientation whenever asked	After 2 weeks
Speech production preserved, speech comprehension impaired at times, long response latencies	Long-term goal: Maintain speech ability as much as possible	Participation in coffee afternoon 2x/month Individual care daily: conversations, reading aloud	After 4 weeks
Resident reacts tense to group conflicts, avoids situations in which he is confronted with several people	Long-term goal: Avoid social isolation Short-term goal: Enable integration into small groups (max. 3–4 people)	Care in small group 2x/week: validation group Individual care 4x/week: basal stimulation	After 1 week
Can eat independently Has trouble with the sequence of dishes at lunch	Maintain independent food intake	Daily participation in the dining group Serve food in a clear order	After 4 weeks

5

Ideally, short-term and long-term goals can be distinguished, but the most important thing is to consider whether the formulated goal was realistic and consistent with the wishes and needs of the person concerned.

The measures planned in the care plan are then transferred to the performance record and signed. If a measure could not take place, the care report should indicate why the planned measure was not carried out.

In addition, the care report contains information about observations and special features.

▶ Example

Mrs. Nowak could not participate in the baking group today, as she had vomited during the night and complained of nausea.

Mr. Jürgens played skat with great interest in the evening and was happy that he won several times.

Mrs. Wilkens cried loudly during the singing hour, but could not express why she was sad. She did not want to leave the group. The individual care for Mr. Heymann had to be aborted due to a state of agitation. The topic of conversation was his escape as a prisoner of war. The reference care staff was informed. ◄

Finally, the evaluation checks whether the planned measures were meaningful in view of the formulated goals. If necessary, new measures are planned or the goal is corrected. Also taken into account are new observations and information, the loss of resources, newly occurring or changed problems or problems that no longer exist.

Practical tip

The individual evaluation interval is based on the achievability of the short-term goals, if only a long-term goal was formulated, a review should take place at the latest after three months.

5.5.3 Documentation in the Outpatient Sector

In contrast to the inpatient sector, a guideline for documentation has not yet been clearly defined in outpatient care. Forms are used internally within the facility, which serve both to transmit information on goals and measures and to provide evidence of services for billing purposes.

As an example for outpatient care, the "Care Record Form" and the "Service Record" are attached in Appendix 4.

5.5.4 De-bureaucratized nursing documentation

In January 2015, the nationwide implementation of the new, de-bureaucratized documentation in nursing was started. At the suggestion of the Patient Representative of the Federal Government Karl-Josef Laumann, possibilities were sought to reduce the time required for documentation tasks and thus to have more time available for the care-dependent people.

The result is the structural model, which is based on a completely changed structure of the nursing documentation, so that, for example, the previous nursing history was replaced by the **Structured Information Collection SIS®**.

The structure of the SIS® is no longer oriented to the AEDL but to the modules of the New Assessment for Appraisal NAA for determining the need for care ► Chap. 10. In addition, the wishes of the person concerned are specifically asked and taken into account, which is especially important but also difficult for people with dementia.

Measures that are carried out "always like this" according to a standard or a procedure instruction no longer have to be planned separately and the risk assessment was also replaced by a risk matrix.

From the topics of the SIS®, a Measure Plan or a daily structure plan is created, which includes nursing measures, care services and the domestic supply. If these services are carried out exactly according to plan, no further documentation is required. Only in case of deviations from the planning, for example because the condition of the person concerned does not allow the planned measures or because they are not necessary, details are described in the nursing report.

► **Example**

Due to a feverish infection, Mrs. Müller cannot leave the bed and participate in the bingo afternoon. ◄

The SIS® is created by a trained specialist and is based on a scientific concept with the following topics.

Topics of the SIS®

1. Cognitive and communicative skills
2. Mobility and agility
3. Disease-related requirements and burdens
4. Self-care
5. Living in social relationships
6. Household management (outpatient) or living and domesticity (inpatient)

Further information on the structural model can be found on the websites of the project office for the implementation of Ein-STEP under ► www.Ein-STEP.de.

Care of People with Dementia

Contents

S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_6

» Variety is a good medicine for most ailments. (Christine of Sweden)

The main task of the dementia companion is to accompany, activate and provide meaningful occupation. A prerequisite for individual care is, in addition to the basic knowledge of the disease, a high degree of empathy and above all **creativity, flexibility** and patience. Therefore, this chapter presents various occupational offers and **therapeutic** interventions, in order to provide an overview of the diverse possibilities of dementia accompaniment. These are suggestions that can be expanded as desired.

6.1 Occupation

A successful accompaniment of people with dementia, mentally ill and intellectually disabled depends on various factors. In this context, a distinction is made between the requirements for the person of the dementia companion and the requirements for the measures he offers. The significance of the offers for the affected person must also be considered.

Requirements for the Dementia companion

- Open attitude towards the affected persons
- Appreciation
- Interest
- Knowledge of the underlying diseases
- Flexibility
- Patience
- Empathy
- Willingness to establish a relationship with the affected persons
- Ability to distance oneself sufficiently
- Communication skills
- Good observation skills
- Teamwork skills
- Willingness to accompany the affected persons possibly the last part of their life path

Requirements for the Care

- Offers are oriented to the needs of the affected persons
- Overload and underload must be avoided
- The interest and curiosity of the affected persons must be aroused
- The offers must be age-appropriate

- The temporal sequence is oriented to the individual participants
- The group size must be adjusted repeatedly
- In case of need, there are offers of individual care
- If necessary, a new offer must be made spontaneously
- No one has to participate, whoever wants can also just watch

Meaning for the affected person

- Variety
- Memories of the past
- Maintaining abilities
- Activation
- Increase of self-esteem
- Group experience
- Feeling of having a task
- Feeling of being useful

To achieve this, the dementia companion must plan and prepare the respective offers well.

The required materials should be sorted by topics in advance, so that sudden changes can be reacted to quickly. If possible, the participants are involved in the planning of the activities and their wishes are asked.

To achieve a varied design, the dementia companion should plan certain regular activities, which take place, for example, on recurring weekdays in small to medium-sized groups. In addition, changing activities in smaller groups or with individuals can be added at short notice according to individual needs.

Practical tip

It is advantageous for the participants if the regular activities are announced on a large board or a pinboard. Depending on the severity of the disease patterns, the information can be listed for one day or for a complete week.

A large blackboard is well suited, on which the date and the day of the week are also entered as orientation aids. Old shoe boxes, boxes, baskets or suitcases are excellent for sorting the necessary materials by topics or weekdays, so that they are always at hand.

6.2 Occupational Opportunities

This section presents various occupational opportunities. However, the individual areas of care are first listed in an overview. To achieve a rough structure, the listing is largely based on the AEDL (▶ Chap. 5). The order has been changed, because there are no or only few possibilities for some AEDL.

Overview AEDL according to Krohwinkel

1. Communicate
2. Move
3. Maintain vital functions of life
4. Take care of oneself
5. Eat and drink
6. Excrete
7. Dressing
8. Resting and sleeping
9. Keeping busy
10. Feeling and behaving as a man or a woman
11. Ensuring a safe environment
12. Securing social aspects of life
13. Dealing with existential experiences of life

6.2.1 Communication

This area of the AEDL has already been explained in detail in ▶ Chap. 3 "Dealing with people with dementia". In this chapter you will also find suggestions for communication games (▶ Sect. 3.6).

6.2.2 Movement

Movement is closely related to the losses of cognitive abilities, so that the deficits can ideally be delayed or stabilized by promoting movement.

Regular movement has a preventive effect on the development of dementia.

Scientific studies confirm that older people benefit from regular physical activities both physically and mentally. The associated positive effects for the cardiovascular system and for the blood circulation of the brain can even **prevent** the development of dementia or at least delay its course.

Even patients who already have limited mobility can participate in movement games.

Employment opportunities in the field of Movement

- Walks
- (Nordic) Walking
- Gymnastics
- Dancing, swaying, polonaise
- Chair dance or chair gymnastics
- Cycling on the ergometer or with special training devices (Fig. 6.1)
- Dumbbell training and balance exercises, which are also used for fall prevention
- Movement exercises with balls, hoops, scarves, balloons or parachutes
- Bowling
- Table football, table tennis
- Movement games with game consoles, e.g. Wii, Xbox, Playstation
- Swimming
- Hiking, forest walk
- Bicycle tours accompanied

Practical tip

Many people with dementia have a pronounced urge to move, which can be improved by targeted offers. However, the strain must be adapted to the physical condition of each individual affected.

Fig. 6.1 Training device Reck MOTOmed viva2. (With kind permission: RECK-Technik, Betzenweiler)

It is also important to consider the risk of falls and injuries as well as the risk of overexertion in patients with cardiovascular diseases. In the case of a walk, immediate help must always be called if the participant moves away from the group or does not want to go back. The most important phone numbers should be programmed in advance. Popular are movement offers in connection with music, such as dancing.

Special offers for fall prevention are carried out by physiotherapists.

Movement offers can be carried out at any time without much preparation. Short movement units are also useful between other activities that require the participants to pay attention and concentrate.

For all outdoor activities, the companion must always carry a mobile phone in case help is needed.

Most of the movement games listed here are well-known, therefore the game option with a parachute clothis explained (◘ Fig. 6.2) as an example.

◘ **Fig. 6.2** Swing cloth (With kind permission of the Pflegehäusl, Elisabeth Hankofer, 94447 Plattling)

► Example

Parachute games: The participants sit or stand in a circle. A parachute cloth or swing cloth is spread out in the middle. For smaller groups, a large sheet can be used instead. Each participant holds the cloth with both hands, so that it is stretched. Now balls, spheres, balls of wool or balloons can be moved back and forth on the cloth. The game is even more fun if music is playing, then the participants can also move in a circular direction with the cloth and perform a parachute dance. ◄

6.2.3 Eating and Drinking

Many older people suffer from loss of appetite.

Eating does not only mean food intake (► Chap. 7), eating is above all also a pleasure. When meals are prepared in large kitchens, with pureed food or diets, part of the pleasure is usually lost.

The selection, preparation and shared intake of meals can stimulate the appetite and be a valuable experience for the person with dementia.

Benefits of preparing meals together arise in terms of self-determination, the person can choose dishes themselves, on the enjoyment, the person has influence on the way of preparation, and on the success, if the food tasted good, the person will probably be praised.

6.2.3.1 Preparation

When choosing, it must be taken into account whether all participants can or are allowed to eat this food, such as diabetics or people with dental problems.

First, the group should choose together which dish will be prepared. The group leader collects suggestions from the participants, then it is decided together which food will be cooked.

Practical tip

It should be ensured that the preparation is not too complicated and does not take too long. Especially people with dementia are only able to concentrate and be active in phases.

Subsequently, a list of ingredients is created, which can also be used as a shopping list, if the participants are mobile. Otherwise, the ingredients can be obtained in consultation with the kitchen or with relatives.

6.2.3.2 Implementation

Now the companion distributes the tasks to the participants, taking into account their abilities and resilience. Each participant receives a task that is appropriate for him or her, such as peeling or cutting vegetables, stirring or supervising pots and setting the table. The companion must involve all participants in the activities if they wish, observe and guide them if necessary.

Of course, care must be taken to avoid the risk of injury when handling knives and other devices.

Practical tip

Just as important as cooking and eating together are the conversations and the exchange of cooking recipes, regional specialties and the table talk for the participants.

When handling food, **hygienic** basic rules must be observed.

Hygiene

- Surfaces and devices must be cleaned before use
- All participants must wash their hands before work
- All participants wear aprons
- The hair should be tied back if necessary
- Food must not be left open, it must always be covered
- Perishable food must be stored in a cool place, e.g. sausage salad, quark dishes or minced meat
- Prepared food should be consumed immediately
- The refrigerator must be cleaned and checked regularly
- After use, all surfaces must be disinfected and all devices must be cleaned

6.2.3.3 Follow-up

In addition to documenting the measure and observing the behavior of the participants, the kitchen must be cleaned and the measure evaluated after the meal. The group leader also documents the type and amount of food and drink consumed in a nutrition or intake protocol if necessary (► Chap. 5).

6.2.3.4 Food Intake in Dementia

Various factors of food intake can be altered by the underlying disease, so the companion must pay attention to some things during the meal.

Independence

The sequence of dishes must be timed so that the person with dementia is not overwhelmed. There must be breaks between the individual courses.

With increasing dementia, the affected persons may no longer be able to recognize the food and therefore do not start eating. It may be necessary to arrange the cutlery in the correct order or to give it directly into the hand of the person with dementia or to demonstrate the eating process itself, so that the person with dementia can imitate the movements.

People with dementia are often able to eat when they can observe others doing so. Eating in a group is therefore an important contribution to independence.

If several group participants need help with eating or drinking, the companion must involve additional caregivers or relatives in advance.

Table culture

For people with dementia who are served food, the plate must always be in front of the person with dementia, not in front of the person who is helping.

The food intake of people with dementia is strongly influenced by the accustomed table culture. The type of dishes and cutlery, the table decoration, the seating arrangement and the presence of bowls and ladles remind of the usual meal in the family and facilitate the recognition of the situation.

Rules of politeness: One does not eat before everyone has something on their plate, one eats everything up, one does not eat from other people's plates and one does not complain if the food did not taste good. The dementia companion must keep these learned rules in mind when a participant does not want to eat.

At this point, some photos are shown that illustrate the influence of table culture on food intake (Figs. 6.3, 6.4, 6.5 und 6.6).

Taste

For most people with dementia, the sense of taste also changes over time. Even if biographical knowledge must always be asked for in this context, it is possible that the person concerned suddenly rejects dishes that he liked to eat or vice versa eats dishes that he did not like before.

In general, the sense of taste decreases with age, so that older people often complain that food is not seasoned or too cold.

For people with dementia, it can be observed that sweet dishes are preferred. Unknown dishes, for example things that were not so widespread before, such as pizza or hamburgers, are rather avoided.

Fig. 6.3 Hospital food. (© Rainer Sturm/PIXELIO)

Fig. 6.4 "Normal food" with kind permission of the Haus Schwansen, Rieseby

Drinking

Due to a lack of thirst, older people mostly have problems taking in a sufficient amount of fluid. Under certain circumstances, the amount of fluid intake must be documented by all those involved in the care and support throughout the day (▶ Chap. 5).

At all measures of care, the participants should always be offered drinks as well.

Fig. 6.5 Old dishes. (© Günter Havlena/PIXELIO)

Fig. 6.6 Table culture. (© Harald Wanetschka/PIXELIO)

During the care time, the dementia companion must take over the documentation of the fluid and food intake.

People with dementia should be offered different drinks to find out what they like. Not everyone likes to drink water. Fruit juices, different teas, coffee, cocoa, milk, lemonades, malt beer, buttermilk and—after consultation—a glass of wine or beer should also be offered for dinner.

Activity possibilities in the area of Eating and drinking

- Breakfast buffet
- Brunch, e.g. fried eggs with bacon, soup
- Snacks, e.g. fruit salad, curd dishes, pudding
- Shared lunch
- Stews
- Regional dishes, e.g. white sausage with pretzels, steamed dumplings, lobscouse
- Coffee or tea time, e.g. cake, waffles and other pastries
- Dinner, e.g. sausage salad, potato salad, ham noodles
- Late meal, e.g. fruit, sandwich, soup
- Sandwiches, buffet in the evening
- Cookies at Christmas time, Christmas stollen
- Drinks, e.g. punch, hot milk with honey, hot chocolate
- Picnic
- Barbecue evening
- Finger Food (Fig. 6.7) and small snacks

This form of food can be eaten on the go and without cutlery and is therefore well accepted by many people with dementia.

6.2.4 Engaging

Engaging

Engaging means performing a meaningful activity, a task or a work, or shaping one's leisure time. The meaning corresponds to the term "acting" and includes an activity.

The human being is engaged throughout his life, in childhood with playing and learning, and afterwards with work and leisure activities. In old age, illness, disability and other limitations, the possibility of engaging may be impaired.

Various theories state that the most important occupation of aging is to **reflect** and process the experiences and experiences of life. That is why one often sees older people sitting idle for long stretches, sometimes with their eyes closed. When asked about it, they express satisfaction and decline offers of occupation, as they want to engage with their thoughts.

Demented people also process their past in thoughts, but they find it harder to orient themselves afterwards in the present. However, if the events to be coped with are traumatic, sad, threatening and frightening, it makes sense to distract the person with dementia by another occupation.

Fig. 6.7 Finger food. (© Brandt/Marke/PIXELIO)

Occupational opportunities in the area of "Engaging"

- Playing, e.g. board games, card games, games in the group
- Old toys, e.g. spinning tops, marbles, old dolls
- Therapy dolls (Fig. 6.8)

Fig. 6.8 Therapy doll. (With kind permission of Eelke Verschuur, ► www.elkee.de)

- Stuffed animals
- Crafting
- Painting
- Drawing
- Collages
- Reading aloud, e.g. newspaper, fairy tales, short stories
- Singing together, listening to music from the past, orchestra
- Reciting poems
- Completing proverbs
- Concentration games, puzzles
- Memory games
- Theater
- Biography-oriented activities
- Communication games (▶ Sect. 3.6)
- Everyday training
- Aromatherapy
- Music therapy
- Computer games for people with dementia
- Movies for people with dementia (◘ Fig. 6.11)

Therapy dolls are well suited for the care of people with dementia with communication disorders and fears.

6.2.4.1 Special Features of Dementia

To avoid overwhelming the person with dementia, the offers must be adapted to his individual abilities.

At the beginning of the disease, memory and concentration games are useful.

Book tip The book "Seniorenspielbuch" (Senior Game Book) by Ursula Stöhr, published by Springer Verlag, offers a variety of activities.

▪ Memory games

The most well-known memory games, such as Memory or similar memory games, are also enjoyed by people with cognitive deficits, as long as they do not feel overwhelmed. Memory training serves to activate, not to practice or learn, there must be no pressure to perform.

▶ Example

Also popular are circle games, in which each participant says something on a certain topic and the neighbor then repeats everything that has been said so far. For this, one can give different topics, for example the names of the participants or the answer to simple questions like "What does the baker need to bake bread?"

A variation would be the "sentence building", in which each participant extends the sentence by one word and previously says the complete sentence, or the "word game", in which compound words are formed and then a new word is formed

from the second part of the word, e.g. Haustür (house door)—Türschloss (door lock).

The so-called Kim games also train the memory: Different objects are looked at and then hidden under a cloth. The participants name in turn all the objects they could remember.

The hiding game is also a form of memory training in connection with concentration, and can be offered for demented people with special dolls that look at the wall. The "hiding doll" has to search and everyone can help. Whoever is found, can then hide the doll himself, which is then searched by everyone. ◀

For the memory and concentration training there are also special worksheets of different levels of difficulty.

Concentration games

The playful training and maintenance of **concentration** can be achieved, for example, by crossword puzzles or jigsaw puzzles. Also bingo, skill games, tangram, mikado and the like promote the ability to concentrate.

Biography-oriented activity

An important point of activity is the biography-oriented activity. The offers refer to the biography of the person concerned and pick up on previous knowledge and preferences. Since the old memory lasts longer, people with dementia can easily access such skills and are experts in this area, which increases self-esteem.

Well suited are former hobbies, but especially the former professional activity. It is easy to offer activities that are related to the former professional profile, both in the home and in the institutional setting.

▶ Example

For example, the seamstress can sew on buttons, the clerk can staple files at his desk, the housewife finds activities in cooking or folding laundry, the farmer is busy with gardening or animals and the director supervises everything professionally. ◀

When offering biography-oriented activities, the equipment used should ideally come from the time when the person concerned practiced his or her profession. Old desks, sewing machines, kitchen appliances, tools, washboards, toys etc. can be obtained by posting notices on the "bulletin board" or at flea markets (◘ Figs. 6.9, 6.10 und 6.11).

Fig. 6.9 Old dolls. (© Ernst Rose/PIXELIO)

Practical tip

Relatives often throw away old objects and are usually happy to provide them instead. Visiting flea markets is also a special experience for people with dementia.

By observing the reaction of the affected person when looking at old objects, one can easily determine what the person with dementia used to enjoy doing or which objects he or she recognizes, because he or she used to own them.

Everyday training

These objects can also be used for everyday training. Everyday tasks, such as from the areas of personal hygiene (▶ Chap. 5), household (▶ Chap. 8) or nutrition (▶ Chap. 7), are carried out together with the affected person.

Fig. 6.10 Old toys. (© Dieter Schütz/PIXELIO)

Fig. 6.11 Movies for people with dementia. With kind permission of "Ilses weite Welt", ► www.ilsesweitewelt.de

Training possibilities

- Dressing
- Making the bed
- Preparing meals
- Shopping
- Washing laundry
- Ironing
- Repairing something
- Gardening, harvesting fruit
- Making jam
- Riding a bike
- Tidying up or sorting things

The dementia companion should not take over the task for the person affected, but guide him and support him by showing the movements. Taking over the task is depressing, because the person affected then clearly perceives his deficits.

In the further course of the disease, the abilities and the time spans of endurance and concentration become shorter. The dementia companion should therefore use special measures, such as the 10-minute activation, in case of severe dementia.

10-minute activation

Activities from different areas are offered for a short interval of about 10 minutes. The necessary materials are prepared in different boxes and sorted by topic.

Practical tip

Well suited are shoe boxes covered with stickers, which are labeled with weekdays. The topics should be changed regularly. If the people affected want to deal with the materials for longer than 10 minutes, this is of course allowed. All participants can start a conversation through the stimulation by the material.

Topic areas for the10-minute activation

- Buttons, spools of thread
- Wool, pot holders
- Clothespins
- Postcards
- Photos
- Nails, screws
- Pens, chalk, small slate boards

- Small cans with spices
- Marbles
- Old furniture from the dollhouse
- Fabric handkerchiefs, cufflinks, ties
- Colorful beads, jewelry
- Hats
- Key ring, wallet
- Stamps
- Old coins and banknotes
- Old watches, alarm clocks
- Small animal figures
- Shells
- Chestnuts, nuts
- Christmas tree decorations
- Easter eggs
- Toy cars
- Old decorative items, knick-knacks
- Playing cards, game pieces, puzzle pieces
- Small perfume bottles
- Railway carriages

The task of the dementia companion is to make sure that objects are not swallowed.

The participants can look at, touch, **associate** mostly past times and possibly talk about them.

Practical tip

Depending on the severity of the dementia, the objects can be used for creative activities afterwards, such as crafting or painting.

For a very severe dementia, the goal of the activity is mainly the well-being of the person affected. People with dementia who suffer from a lack of stimulation, as they can hardly perceive or process stimuli, should receive a treatment that uses stimuli in a targeted way.

Use of stimuli

The targeted use of stimuli, such as in **aromatherapy,** makes it possible to reduce **substitute actions**. People who suffer from a lack of stimuli try to provide themselves with stimuli through repetitive actions. These actions are usually disturbing and stressful for the environment.

substitute actions

- Spreading of surfaces, such as the table
- Tapping, such as on the table, also with objects

- Continuous calling of words or parts of sentences
- Wandering around
- Chewing movements
- Talking to oneself
- Hallucinations (▶ Chap. 2)
- Whining
- Screaming

If the person with dementia is offered other stimuli, the substitute actions are no longer necessary.

Stimuli from all areas of sensory perception can be used.

Optical stimuli

The viewing of photo albums, pictures or memory albums is a positive stimulus that reduces the occurrence of substitute actions.

The use of optical stimuli is limited in time and can therefore be combined with other stimuli.

Well suited for an offer of optical stimuli are also colorfully designed rooms or so-called sensory corners.

Acoustic stimuli

Among the acoustic stimuli that counteract the lack of stimulation are any kind of music and singing. Also reading aloud and conversations are acoustic stimuli that can have a temporary calming effect on people with dementia, but not necessarily.

It is always important to observe how the affected person reacts to the offered stimulus. The musical taste also plays a big role.

The use of musical instruments in the care of people with dementia and mental changes is carried out in music therapy. There, the affected people can make music themselves on various instruments under guidance.

Tactile stimuli

Tactile stimuli can easily be integrated into various care activities. Touching, tapping, stroking and massaging parts of the body that are far from the trunk often contributes to calming the affected person.

People with dementia can also touch objects on their own, and they should be offered various objects that can be easily held in the hand and that feel good.

► Example

Bean box: A box filled with dried beans and small objects, such as marbles, buttons and beads, invites to feel, touch and search. ◄

Olfactory stimuli

Cooking smells, for example, stimulate the appetite.

Smells often evoke associations with past experiences and contribute to well-being, if the smell is perceived as pleasant. Olfactory stimuli can be used from all areas of life.

Possible olfactory stimuli

- Herbs and spices
- Fruit, fragrant foods
- Scents from nature, such as flowers, leaves, wood
- Soap, perfume
- Essential oils
- Massage oils

Taste stimuli

Taste stimuli are not only taken in when eating and drinking, they can also be used specifically to reduce substitute actions.

Practical tip

It should be considered that people with dementia often prefer the sweet taste.

Possible taste stimuli

- Chocolate
- Candy
- Gummy bears
- Ice cream
- Ice cubes made of fruit juice
- Cheese cubes
- Chips

Sensory corners

The combination of different types of stimuli can take place in so-called sensory corners. Here, optical stimuli, such as monochrome images, objects and light chains, are combined with acoustic stimuli, preferably calm or stimulating music, as well as with various smells and possibly taste stimuli.

The design of a sensory corner must be carefully selected. For example, the red color has a stimulating and activating effect and should therefore be used with stimulating music

for passive people. The colors blue and green have a cool and calming effect. They are therefore combined with calm music. Yellow has a warm and balancing effect.

The color scheme of rooms has a great influence on the well-being of people with dementia.

Snoezelen

Snoezelen is used in a similar way.

Snoezelen

Snoezelen is a coined word from Dutch, which is composed of the terms "snuffelen" (sniff) and "doezelen" (doze). It was developed in the 70s in the Netherlands in facilities for severely disabled people.

Behind Snoezelen is a multifunctional concept: In an appealingly designed room, sensory impressions are triggered by light, sound and tone elements, aromas and music. These have a relaxing, but also activating effect on the various perception areas as needed.

Many stationary facilities had set up Snoezelen rooms, which is relatively expensive due to the technical equipment with a water bed and a projector. However, it was then found that the rooms cannot be used by all affected people.

Practical tip

To ensure that also **immobile** residents benefit from the offers, there are now Snoezelen mobiles that can be driven from room to room. Also, people with dementia who are afraid to enter a Snoezelen room can be reached by the Snoezelen mobile.

Use of technical aids

Special computers have been developed for people with dementia, which have a large monitor with a touchpad and are very easy to use. The topics of the PC are also oriented to the needs of older people.

In Japan, a plush toy robot in the shape of a seal was developed especially for people with dementia. The toy is interactive and responds to speech and touch. For Europe, other animal species are more suitable, such as dogs or cats (Fig. 6.12). In this area, new products are continuously developed.

Fig. 6.12 Sleeping dog. (With kind permission of Inovento AG, Perfect-Petzzz.ch, Switzerland

Practical tip

Films that were specially shot for people with dementia are produced by "Ilses weite Welt" (Fig. 6.11). These films are adapted to the needs of cognitive impairments in terms of theme and camera work. In addition, accompanying material is offered for each film. Popular with dementia are also animal films or films from the past.

6.2.4.2 Individual Care

Most of the measures and activities listed can also be carried out for people who are mainly confined to bed for various reasons. These people are not able to participate in group offers due to their **immobility** and are therefore threatened by social isolation.

Individual care is also advantageous for people with dementia or mental changes who do not feel comfortable in the group or who are not acceptable in a group due to their behavior.

Practical tip

Especially suitable for individual care are walks for mobile people, movement exercises for immobile people, reading aloud, household activities, 10-minute activation,

biographical offers, use of stimuli, use of animals, aroma or music therapy, day structuring, **milieu design** and memory work.

6.2.5 Securing Social Areas of Life

Social isolation worsens behavioral problems and accelerates the loss of cognitive abilities.

Older people, people with dementia, mentally ill and mentally disabled people are in principle at risk of social exclusion. Regardless of whether they live at home or in a facility, they are socially isolated and at risk of loneliness due to physical limitations, behavioral problems or fear of other people.

It is therefore important for the dementia companion to establish contacts with other people and to integrate the affected people into a social environment. Important interlocutors are the relatives, as well as volunteers, groups and associations from the community or the district. The family, friends, acquaintances, neighbors and former colleagues can be specifically involved in activities.

Practical tip

To establish social contacts, activities can be pursued in the accompaniment that are either offered for the affected people and their relatives together or prepared in cooperation with groups and associations.

Joint offers for affected people and relatives

- Coffee afternoon
- Barbecue, campfire
- Parties, e.g. summer party, birthday party, advent afternoon
- Bazaar
- Excursions, e.g. park, forest, zoo, museum, carnival event, sports event
- Joint dancing or gymnastics
- Joint cooking or baking
- Craft afternoons
- Joint singing circles

Contacts to groups and associations

- Kindergarten, schools
- Choir
- Animal welfare association
- Sports club

- Theater groups
- Musicians
- Church community
- Youth groups
- Carol singers

6.2.6 Resting and Sleeping

Phases of excitement and exertion, as well as phases of rest and relaxation should always alternate.

Just as important as the activity and occupation is the AEDL "resting and sleeping". Here too, the dementia companion can offer the affected person possibilities that serve to rest after phases of activity and exertion.

If the group participants are exhausted after movement exercises or concentration games, they must have the opportunity to rest briefly.

Possibilities in the area of resting

- Relaxation exercises
- Imaginary journeys, where the participants sit relaxed in a circle, the group leader takes them on journeys in their imagination
- Sitting in an armchair and reliving the events of life
- Retreat possibilities, room of silence, also together with relatives

Ideally, there is a rest room or a niche with chairs or couches for the care of inpatient patients. Another offer in connection with sleeping is the so-called Night café or also the Twilight drink. Here, the affected persons are cared for in a smaller group in the late evening, if they do not want to go to bed yet. It is therefore a preparation for sleep.

► Example

Night café: With this form of accompaniment, there are a variety of possibilities how the evening time before going to sleep can be designed in a varied way. For example, a regulars' table can take place in a cozy, slightly darkened room, where one simply talks and drinks a tea, possibly also a glass of wine or beer together.

Quiet music, reading poems, short stories or fairy tales can have a calming effect on people who suffer from insomnia.

For people who are bored in the evening, offers such as playing together or a movie night are suitable. In the night café, a small late meal is also always offered. In the night café, individual sleep rituals can also be carried out, if they are known. ◄

6.2.7 Feeling as a Man or Woman

The AEDL "Feeling as a man or woman" also plays an important role in the accompaniment of people with dementia or mental changes. The aspect of sexuality is usually not addressed at all in this area and is also embarrassing for many affected people.

Nevertheless, gender-specific characteristics and the learned gender role have an influence on the everyday interaction with the affected people. For example, there is a possibility that affected people feel violated in their intimate sphere during care measures and only want to be cared for by a certain gender.

It is irrelevant whether it is a same-sex or opposite-sex caregiver, the wish to be cared for only by a female or male person should always be respected.

Deviations from this "normal" role behavior must always be noticed.

The gender role can also play a role in offers. For example, male affected people usually find little pleasure in baking cakes or folding laundry, whereas female affected people are not so interested in tools and the like.

Since a large part of the offers refers to the female gender and male affected people are usually underrepresented, one should pay attention to gender-specific differences when planning the care.

Employment opportunities in the area of "Feeling as a man or womanfeel"

- Beauty salon
- Occupation with jewelry, makeup, hairstyles, clothing
- Fashion show, sewing studio
- Wood workshop
- Politics round
- Skat evening
- Chess club
- Build railway or car racing track

6.2.8 Care for Oneself

The necessary measures of personal hygiene are completely taken over by the nursing staff, both in the outpatient and in the inpatient sector, the dementia companion has hardly any contact with nursing measures. Nevertheless, there are offers for activation and occupation that come from the area of AEDL "Care for oneself".

Here too, the preservation of privacy has the highest priority, so that these offers are mainly carried out by staff from the nursing sector, as they already have a more intimate contact with the people concerned. This applies especially to measures where the people concerned are completely undressed.

Measures in the area of "Care for oneself"

- Relaxation bath
- "Wellness" offers, such as massages, Kneipp cures, sauna

6.2.9 Existential Experiences

Taking into account the biography, life experiences that contain existential feelings and that require dealing with life, illness, limitation, disability, need for care, dependence, dying, farewell and death are repeatedly evident in the context of accompanying people with dementia, mental illness and intellectual disability.

The dementia companion must be able to react adequately to questions from the people concerned and deal with these existential topics himself.

This phase of the disease is therefore often marked by depression and despair.

In the different stagesof dementia, the people concerned process these existential experiences of their lives in different ways. At the beginning of the disease, they consciously deal with the impending helplessness, as they feel that certain signs of the disease are present, and as they know in most cases what consequences result from them.

In later phases of the disease, the people concerned no longer perceive their deficits consciously or cannot classify them in terms of their meaning. Nevertheless, the people concerned also go through difficult emotional times when they process stressful and traumatic experiences.

Sometimes people with dementia ask for support in dealing with existential experiences. Many ask for pastoral care or for a joint prayer. Such a wish must never be denied.

6.2.9.1 Pastoral Care

Even people who do not express religious needs may need support.

Pastoral care supports the affected people in the area of processing existential experiences of life.

The term pastoral care is usually equated with religious needs. However, pastoral care actually means "caring for the soul" and thus also includes people who do not belong to any religion or who were lifelong avowed atheists. They too find comfort in conversations or when someone can simply listen to them.

6.2.9.2 Religious Needs

The support and joint practice of religious needs or rituals has the same meaning for people with dementia as for other believers.

For many people with dementia, the Sunday visit to the church service has a fixed place in the weekly structure. Usually this also includes putting on a particularly festive Sunday outfit.

Possibilities for practicing religious needs

- Church service, possibly mosque or synagogue visit
- Special services for people with dementia
- Design of services or religious holidays
- Praying together
- Contact with pastoral carers
- Contact with the church community

6.2.9.3 Memory Work

One of the main tasks of aging is the processing of experiences and memories. People with dementia are overwhelmed by this task due to the impairment of their memory. They need support to reactivate memories.

Practical tip

Helpful for this is the joint work with the affected people and, if possible, with their relatives, to refresh memories.

Possibilities of memory work

- Conversations
- Photo albums
- Diaries
- Old letters
- Poetry album
- Family tree
- Memory albums

Memory album

The memory work is supported by creating a memory album. This album makes it easier for the person affected to recall memories that are not spontaneously available. By repeatedly browsing through the memory album, these buried memories become present again.

To create a memory album, you need a beautiful, empty photo album. On the first page, a photo of the person affected is glued. Next to it, write the first name, the name and the date of birth in large, legible letters, as well as possibly the place of birth.

On the following pages, the reference persons are glued in the order of their importance. Pictures where the persons are easy to recognize are advantageous. For example, on the next pages of the album you will find: "My parents… my siblings… my spouse… my children", also with name and date of birth, such as "My son Albert, born on 05.02.1948, now lives in Berlin" (◘ Figs. 6.13 und 6.14).

Old photos from the hometown or from other important places can also be added, such as the favorite vacation spot, which evokes particularly positive memories, or the house that was built with a lot of self-work. Close friends and colleagues also belong in the memory album.

By creating and viewing the memory album, it is easier for the people affected to answer questions about their past for themselves. This is reassuring for most people with dementia, as there is probably nothing worse than not being able to answer questions about one's own spouse or even one's own children.

◘ **Fig. 6.13** Wedding photo. (© M. Werner/PIXELIO)

Fig. 6.14 Family photo. (© pandi/PIXELIO)

6.3 Daily Structure

People with dementia, mental illness and intellectual disabilities cope better in everyday life if they can prepare for certain activities. Therefore, an individual, regular daily structure is useful to support the affected people through recurring rituals and to facilitate their daily routine.

Of course, the daily structuring for each individual affected person is based on his or her personal habits and preferences.

The following section lists possible orientation points in the course of the day that are important for the daily structuring.

Daily structure
- Morning ritual
- Early riser coffee bar, small breakfast
- Newspaper round
- Late sleeper breakfast buffet
- Occupational offer
- Snack
- Preparation and consumption of lunch
- Midday rest
- Afternoon coffee
- Occupational offer
- Dinner
- Night café
- Late meal
- Sleep ritual

From these fixed points of the daily course, an individual, reliable and predictable daily structure for the affected person should be developed together with him or her or with the relatives or reference persons.

In case of recurring deviations, an update of the daily structure may be necessary.

Deviations from the daily structure must be explained and justified to the affected person, unless his or her own physical condition or own wish is the trigger for the deviation.

In addition to the daily structure, a longer manageable period of time should also be structured, as not all everyday activities take place daily.

6.3.1 Week Structure

A week structure should also be created for individuals who are supported on an outpatient basis.

Continuity facilitates orientation in old age. Therefore, regular activities should be planned throughout the week. In addition, there are the spontaneous, flexible offers that are based on the individual needs of each person, such as biographical offers in small groups or individual care. These offers are not mentioned in the week structure.

Practical tip

The week structure should be hung up in a well-readable place that is easily visible.

In addition to the week structure, a monthly overview can also be useful.

Example of a week structure

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7.00	Coffee bar	Coffee bar	Coffee bar	Coffee bar	Coffee bar	Coffee bar	
8.00	Newspaper round	Newspaper round	Newspaper round	Newspaper round	Newspaper round	Newspaper round	Breakfast
8.30	Breakfast buffet	Breakfast buffet	Breakfast buffet	Breakfast buffet	Breakfast buffet	Breakfast buffet	Breakfast
10.00	Memory training	Singing circle	Cooking group	Sports group	Chair dance	Excursion	Worship service
12.00	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
	Lunch break	Lunch break	Lunch break	Lunch break	Lunch break	Lunch break	Lunch break
15.00	Coffee	Coffee	Coffee	Coffee	Coffee	Coffee	Coffee and dance tea
15.30	Walking	Game afternoon	Creative group	Puzzle round	Fairy tale hour	Storytelling circle	Local history museum
18.00	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Evening buffet
20.00	Movie night Club night	Dance night Midnight soup	Bingo Tea time	Skat Regulars' table	Bowling Twilight drink	Beauty salon Cocktails	Reading hour with classical music and wine

6.4 Environmental Design

To improve the well-being of people with dementia, the environment must adapt to the needs of the person affected, as they are no longer able to adapt to the environment.

Especially in new buildings, attention must be paid to the design of the environment. Even a concrete wall can gain

atmosphere by a floral wallpaper, old wall lamps and old pictures. However, the color scheme and the lighting conditions must be taken into account to avoid a risk of falling.

The desire to go home is an expression of longing for the original home and the family of origin.

People with dementia often express that they want to go home. This does not always mean the wish to actually go to their own apartment or house, but rather it is an expression of the feeling that they feel alien and are looking for security.

In some facilities, caregivers searched together with the people with dementia for the last place of residence, if they wanted to go home again and again. It was noticed that some of the people affected did not recognize the building as their former home and continued to look for it.

Therefore, the new environment should be adapted to the habits of the people affected, that is, the furniture, furnishings and design should remind of the time of childhood, adolescence and young adulthood (◘ Figs. 6.15, 6.16, 6.17, 6.18, 6.19 und 6.20). This includes outside the home environment also the garden, which can be designed from this point of view (◘ Fig. 6.21). The accompaniment in nature, such as in the garden, park or forest, has proven to have an activating effect.

The objects are not only there to look at, they can also be used practically by people with dementia. Some facilities have set up a "local history museum" with old objects that invites to use.

Often the affected people suspect that they have been stolen from, when they cannot find something. The design of the environment helps to find missing objects.

Activity material in the context of Environment design

- Dish towels, aprons, pot holders
- Knitting, baskets with wool, embroidery frames
- Old books, picture books
- Board games
- Handbags, wallets
- Key board
- Spice rack
- Hats, jewelry, scarves
- Eating and drinking islands, fruit bowl
- Lace doilies
- Display case or cabinet with small things to look at
- Chest of drawers with many drawers, in which things for occupation are stored
- Kitchen cabinet with old dishes, coffee grinder
- Desk with phone, paper, pens, paper clips etc.
- Dressing table with mirror
- Dining table, set with old dishes
- Sewing box or sewing machine

Fig. 6.15 Environmental design by the facility

- Old suitcases with maps, straw hat, passport
- Hat boxes
- Memory chest or cabinet, filled with objects from the past

People with dementia enjoy carrying and collecting objects or calm down when they find things they desperately look for in their environment, such as the handbag, the wallet or the key ring.

Practical tip

Milieu design also means designing the social relationships by using an approach that is oriented towards the needs of the affected people (▶ Chap. 3).

Fig. 6.16 Environmental design by old household appliances

6.4.1 Orientation Aids

In addition to spatial orientation, the affected people need support with temporal orientation. Especially during the course of the day, it happens again and again that they misjudge the time of day, especially if they have slept briefly.

Therefore, it is important to provide clues in the rooms where the person often stays, which facilitate orientation in time.

Possible orientation aids

This not only creates a reference to the season, but also to events of the year, such as Easter or Christmas.

- Seasonal design
- Clearly visible calendar, large clock
- Large boards with date and other information (menu, offers)
- Posters with day and month and corresponding seasonal elements
- Door signs for spatial orientation

When designing for the seasons, care must be taken not to use childish motifs, such as Window Color or similar. Suitable are things from nature that reflect the season in a typical way, e.g. snowdrops, daffodils and tulips, shells, leaves and chestnuts, Christmas tree.

When designing door signs, care should also be taken not to use childish symbols and to involve the affected people in the selection and creation of the sign.

Fig. 6.17 Environmental design by pictures

Suitable are photos, personal items and symbols that the person associates with themselves, such as a dog picture for a dog lover, their own wedding picture, a picture from their home or a large sign with their own name. However, some people with dementia have problems with writing, as they used to write in the so-called **"Sütterlin script"** (Fig. 6.22).

6.4.2 Animals

Animals have a calming effect, they mean affection and verbal communication is not required.

Animal contact is a positive experience for some people with dementia and is also well accepted by those who used to be afraid of animals.

Therefore, many animal welfare associations offer so-called "visiting services", in which not only dogs but also

Fig. 6.18 Environment design with old everyday objects. (© Dieter Schütz/PIXELIO)

Fig. 6.19 Environment design with old music devices. (© Dieter Schütz/PIXELIO)

cats, rabbits, guinea pigs, goats or pot-bellied pigs are used. If animals are kept in the facility or in the household itself, a positive experience is created by the fact of having a task, having to or being allowed to take care of something, and by the contact through touch and stroking.

Fig. 6.20 Environment design with old washing utensils. (© Dieter Schütz/PIXELIO)

Fig. 6.21 Garden design

If animal keeping is planned, it must be clarified in advance who will bear the costs, who is responsible for hygiene and for taking over necessary veterinary visits and vaccinations.

However, dealing with animals can also lead to great fears or delusions in mentally ill people, and the confrontation with the animal should then be ended immediately.

Fig. 6.22 German script or Sütterlin. School notebook from 1929

6.5 Person-Centered Interventions

Person-centered interventions

Person-centered interventions are therapeutic measures that target the person themselves and their behaviors.

In this section, the validation according to Naomi Feil and the method of Dementia Care Mapping DCM are briefly presented.

A targeted use of person-centered interventions requires intensive training and experience with the respective method.

6.5.1 Validation

Validation

The term validation comes from English and was coined by the American social worker Naomi Feil. In translation, it means "appreciation" or "declaring something valid".

Validation is a method of communicating with disoriented people. Validation is based on an empathic, i.e. empathetic approach and a holistic understanding of the individual. By "stepping into the shoes" of another person and "seeing with

their eyes", one can penetrate their world and unravel the reasons for sometimes strange behavior.

Naomi Feil grew up in a nursing home in Cleveland (Ohio), as her parents both worked there after fleeing Germany as Jews in 1936. She became, like her mother, a social worker and developed the method of validation between 1963 and 1980.

The basis of the method is the idea that behavioral problems arise because the person with dementia has to work on unresolved issues of their life. The validation user (VA) helps them by using special conversation techniques to reduce stress and thus enables them to regain dignity and happiness.

► Example

Frau Weber – I have to go home urgently.

VA (Validation User) – You have to go home?

Frau Weber – Of course, my husband and my children are waiting for me. I really don't have any more time.

VA – Your husband and your children are waiting, then.

Frau Weber – Exactly, that's why I have to hurry up now, I have to make something to eat.

VA – You are a very good cook, aren't you?

Frau Weber – Yes, I suppose you could say that. Everyone always liked what I cooked, and that was not always easy, especially in the bad times, to put something good on the table. You can believe me.

VA – I believe you, you have certainly gone through difficult times.

Frau Weber – I have indeed, my husband died in the war, my brother Josef too and I had to raise the children all by myself.

VA – That was a difficult task and you did it well.

Frau Weber – That was not an easy task, but everyone managed to do something and I am glad that my boys were spared from having to go to war. They were still so young, the older one had just turned 14 and the younger one was only 12 years old.

VA – You must have had great worries.

Frau Weber – Oh yes, I was very afraid for my children. Also that they could get sick in the war.

VA – I can imagine that very well.

Frau Weber – But I always took good care and saved the food from my mouth. And besides, I always sewed, so that I could buy the children a little sausage or a few eggs.

VA – Your husband would surely be very proud of you, that you were so diligent and brave.

Frau Weber – You could say so.

VA – He has good reason to be. ◀

The principle of appreciation is also the basis of the Integrative Validation according to Nicole Richard, in which existing resources are to be used in a targeted way. The emotional content of statements and behavior of a person with dementia are picked up and validated in this method, in order to gain access to his or her experiential world. A prerequisite for this is the presence of language ability.

6.5.2 DCM

DMC

The method of Dementia Care Mapping (DCM) was developed by Tom Kitwood in the late 1980s in Great Britain, introduced in Germany in 1997 and means roughly translated "dementia - care - records".

A "mapper" or observer observes over a period of twice six hours in five-minute intervals a person with dementia or a group of people with dementia in the interaction with each other and with the caregivers. His behavioral observations, such as facial expressions, gestures, language or alertness, are documented in 24 different categories and according to fixed rules. The well-being is also evaluated on a scale from -5 to +5.

The DCM procedure has the aim of increasing the relative well-being of people with dementia. The results of the measurements are evaluated and then serve as a guide for dealing with the person concerned.

Tom Kitwood has established precise rules for dealing with people with dementia. He distinguishes a malignant, i.e. malicious, and a benign, benign social psychology.

The malignant and benign social psychology listed here is derived from the translation from English, the original terms are in brackets.

6.5.2.1 Malignant Social Psychology According to Kitwood

1. Treachery—Use of forms of deception to distract, manipulate or coerce someone.
2. Disempowerment—Not allowing someone to use existing abilities; denying support for completing started actions.
3. Infantilisation—Treating someone very paternalistically or maternally authoritarian, as an insensitive parent would do with their small child.
4. Intimidation—Provoking fear in someone by threat or physical violence.
5. Labelling—Using a category such as dementia or "organic mental disorder" as the main basis for interacting with the person and explaining their behavior.
6. Stigmatization—Treat someone as if they were a contaminated object, a stranger or an outcast.
7. Outpacing—Provide information, offer alternatives, etc., but too fast for the person concerned to understand; the person affected is under pressure to do things faster than they can bear.
8. Invalidation—Not acknowledge the subjective reality of experiencing and especially the feelings of a person.
9. Banishement—Send someone away or physically or emotionally exclude them.
10. Objectification—Treat someone as if they were a lump of dead matter, which can be pushed, lifted, filled, inflated or deflated, without really referring to the fact that it is a sentient being.
11. Ignoring—Simply continue in a conversation or action in someone's presence, as if the person concerned were not present.
12. Imposition—Force someone to do something and push aside the wishes of the person concerned or deny them choices
13. Withholding—Deny someone a requested information or the satisfaction of a recognizable need.
14. Accusation—Blame someone for actions or omissions that result from a lack of ability or a misinterpretation of the situation.

15. Disruption—To break in suddenly or in a disturbing way into the action or thought of someone; a rude breaking of the frame of reference of a person.
16. Mockery—To make fun of the "strange" actions or remarks of a person; to tease, humiliate, joke at the expense of another person.
17. Disparagement—To tell someone that he or she is incompetent, useless, worthless etc.; to convey messages that damage the self-esteem of a person.

6.5.2.2 Benign Social Psychology According to Kitwood

1. Recognition—A man or a woman with dementia is recognized as a person, e.g. by greeting with name but also by attentive listening for a longer time. Recognition is never purely verbal and can also be completely wordless. The basic requirement for recognition is direct eye contact.
2. Negotiation—The characteristic feature of this type of interaction is that people with dementia are asked about their preferences, wishes and needs, instead of being adapted to the assumptions of others. Skillful negotiation takes into account the fears and insecurities of people with dementia, as well as the slower pace at which they deal with information. Negotiation gives the other person a certain degree of control back.
3. Collaboration—Characteristic of this is that care is not something that is "done" to a person. It is a process that involves one's own initiative and abilities.
4. Play—Has no goal outside of the activity, is an exercise in spontaneity and self-expression. Many adults have poorly developed skills in this area. A good care environment is one that allows these skills to grow.
5. Timalation—This term refers to forms of interaction in which the primary mode of access is sensory or sensory-related, without concepts and intellectual understanding playing a role, e.g. in aromatherapy, massage or snoezelen. The significance of this type of interaction lies in the fact that it can provide contact, security and pleasure, while requiring little.
6. Celebration—Form of interaction in which the separation between carer and cared-for begins to dissolve. The mood is open and sociable, everyone is seized by a similar mood, not only on special occasions but also on everyday joys.

7. Relaxation—This form of interaction with the lowest intensity and low pace. For people with dementia, it is often difficult to relax alone. People with dementia with their pronounced social need often only manage to relax when others are nearby or when direct physical contact is established.

From these access modes described above, it becomes clear that there are always two components involved, communication and reminiscence care. Kitwood describes three more access modes that are mainly psychotherapeutic in orientation:

1. Validation—It is about appreciating the experiences of another person, accepting their "subjective reality". The core of the matter lies in acknowledging the emotions and feelings of a person and responding on the emotional level. It requires a high degree of empathy.
2. Holding—In the psychological sense, holding here means providing a "container". In this way, possibly hidden traumas or conflicts can be brought out and areas of vulnerability can be shown. The psychological holding can also include physical holding.
3. Facilitation—The simplest meaning of this term is to enable a person to do something that they otherwise could not do. The task of facilitation is to initiate, enhance and gradually help the person to fill the interaction with meaning.

6.6 Expert Standard for Relationship Building in the Care of People with Dementia

All the interventions and special features described in this book for the care and support of people with dementia are also based on the contents of the **expert standard** "Relationship building in the care of people with dementia", which was created by the German Network for Quality Development in Nursing DNQP in 2018. Since March 2019, these must be taken into account by all care facilities.

In addition to the requirements for communication, perception promotion, relationship building and person-centredness, the formation of an **understanding hypothesis** is also described.

6.6.1 Understanding Hypothesis

In the understanding hypothesis, the behaviour of the person with dementia is observed and discussed and analysed in the (multi-professional) team. The aim is to identify the possible causes of the behaviour. Behaviour whose causes are known can be better understood and accepted.

Based on the understanding hypothesis, relationship-enhancing measures (together with the person concerned or his or her reference persons) can be planned. However, it is very important to bear in mind that this is only a hypothesis, i.e. a conjecture. If it turns out that the assumption was wrong or the derived measure was not effective, an evaluation with the aim of a new understanding hypothesis should be carried out.

Ideally, the understanding hypothesis is created and documented in the team, for example in the form of a **case discussion**.

6.7 Organization

The implementation of activities with people with dementia, mentally altered and mentally handicapped people always requires good planning and organization.

6.7.1 Preparation

When preparing, it is especially important to consider that the dementia companion cannot leave for a short time to get forgotten materials, as people with dementia should not be left unattended.

A material list is therefore essential in the preparation.

The following points are important in the planning:

Planning
- Time frame
- Room or outdoor activity
- Participants
- Number of caregivers
- Material
- Transport of participants
- Supervision

- Risk of wandering
- Other hazards
- Supply of food and drinks

Practical tip

The orientation to a structured action plan facilitates the preparation. A form for the action planning can be found in the appendix (Appendix 5).

6.7.2 Implementation

The most important factor in the implementation is the motivation of the participants. For this reason, one should choose activities that one also personally likes.

Who is not motivated, cannot motivate.

Equally significant is the observation of the participants. The quality of the accompaniment can possibly be assessed and continuously improved by the behavioral observation.

Criteria of observation

- Which behaviors occur?
- Are the participants relaxed, interested and approachable?
- Do they enjoy the activity?
- Does the activity match their abilities?
- Can resources be promoted or maintained by it?
- Do the measures correspond to the individual needs?

6.7.3 Follow-up

Besides the disposal of the material, the hygienic cleaning and possibly the disinfection of the rooms and surfaces, the transport of the participants is a measure that has to be clarified in consultation with other persons involved in the care (▶ Chap. 10).

The task of the dementia companion is also the timely, handwritten documentation of the services in the designated form of the care documentation or the entry of special features in the report sheet (▶ Chap. 5 and Appendix 3).

Nutrition

Contents

S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_7

» Eat to live, not live to eat. (Mahatma Gandhi)

The need for food is one of the most existential basic needs that accompany us throughout our lives. Balanced eating and drinking contributes to well-being and also has direct effects on health. Although the connections between well-being, health and nutrition are generally known, nutrition that is appropriate to the respective life situation of the person hardly takes place. The consequences for people in need of care and older people, and especially for people with dementia, are considerable. Therefore, it is necessary to deal with the topic of nutrition in dementia in a special way.

7.1 Components of Nutrition

With nutrition, we supply our body with the energy necessary for life. We need this continuously to maintain all our vital functions, such as breathing, circulation, **metabolism** and the regulation of body temperature. Furthermore, we supply the body with substances that are required for the formation and maintenance of body cells (◘ Fig. 7.1).

7.1.1 Macronutrients (Carbohydrates, Fat and Protein)

Carbohydrates, proteins and fats are the most important nutrients and energy sources in terms of quantity.

7.1.1.1 Carbohydrates

Carbohydrates (also known as saccharides or sugars) are still the basis of a healthy diet. They serve, like fats, as energy suppliers for our body. In the course of life, the energy requirement of the human being decreases—due to reduced physical activity and lower metabolic activity. However, the protein, vitamin and mineral requirement remains unchanged. In case of diseases (especially in dementia) and infections, the energy requirement increases again. Carbohydrates are found in bread, rice, pasta, but also in fruits and vegetables.

7.1.1.2 Fats (Oils)

Energy from the fat deposits is only consumed after half an hour of physical work without a break.

Fats are among the basic foods from which our body obtains energy, but they are not necessarily required for this, as we mainly cover our energy needs from carbohydrates. Excess energy is stored as storage and reserve substance under the skin in the depot fat and waits for consumption.

Fig. 7.1 Food—means of life

Fats are indispensable in food!

But fats provide raw materials for the construction of various body substances and the vitamins A, D, E and K. They also serve as a protective cushion for internal organs and the nervous system. Chemically speaking, fats consist of **triglycerides, cholesterol** and fatty acids.

Fatty acids are divided into essential and non-essential fatty acids. Essential fatty acids must be taken in with food. Humans cannot produce them themselves, but they are vital (essential) for them. In case of a lack of essential fatty acids, the active metabolism comes to a standstill.

Deficiency symptoms

- Skin changes (e.g. excessive keratinization) and hair loss
- Susceptibility to infection

Fatty acids are additionally divided into saturated and monounsaturated or polyunsaturated fatty acids (Fig. 7.2). The unsaturated fatty acids are considered to be the healthier ones (e.g. omega-3 fatty acids, gamma-linolenic acid). Saturated fatty acids, on the other hand, are not ideal for the body, as they can increase the cholesterol level in the blood.

7.1.1.3 Proteins

The word protein comes from the Greek word "proteuo" (I take the first place) and is meant to emphasize the importance of proteins for life.

Proteins (Proteins) are the basic building blocks of all life. The (essential) **amino acids** contained in them are needed for the formation of tissue. In addition, proteins are involved in various metabolic processes.

Our muscles, connective tissue, tendons, cartilage and ligaments, skin, hair and nails, as well as the internal organs

Fig. 7.2 Vegetable oils—healthy fats

require a continuous protein supply throughout life. If the protein intake decreases, it affects many functions of the body.

Functions that are affected by insufficient protein intake

- Weakening of the immune system and thus susceptibility to diseases
- Poor wound healing and thus delayed recovery

A low-protein diet over a long period of time results in the breakdown of muscle mass and thus a general physical weakness. With the loss of muscle strength, movement patterns can be disturbed and the risk of falls and fractures increases.

Proteins serve to build and maintain body cells.

Proteins can be obtained from animal and plant sources. Animal sources include milk and eggs, meat and seafood (they contain nine essential amino acids). Plant sources include soy, legumes, grains and nuts.

7.1.1.4 Fiber

The term "fiber" comes from a time when these food components were considered as "unnecessary ballast", as it was assumed that they were not usable for the human body. Today we know, fiber fills the stomach, delays emptying and causes the blood sugar to rise slowly. This way they satiate persistently. Insoluble fiber mainly acts in the intestine, where it stimulates intestinal activity. Fiber is contained in plant foods, such as grains (e.g. whole wheat bread), potatoes, fruits, vegetables and legumes.

7.1.2 Micronutrients (Vitamins, Minerals, Trace Elements, Secondary Plant Substances)

Micronutrients are indispensable helpers for health and well-being.

7.1.2.1 Vitamins

Without vitamins, there is no joy, no activity, no dynamism, no concentration and no enthusiasm.

Vitamins regulate the metabolism, because they are involved in all essential synthesis, breakdown and transformation processes. Therefore, they are vital, but cannot be produced by the body in sufficient quantities. It is all the more important that they are supplied in the form of food. Fresh fruits and vegetables as well as fish make an important contribution to the prevention of many diseases (Fig. 7.3).

Fig. 7.3 Five portions of vegetables and fruits daily

7.1.2.2 Minerals

Minerals (Sodium,Potassium,Calcium,Magnesium and Phosphorus) are vital, non-energy-providing substances that usually cannot be produced by the body and therefore have to be supplied from outside (Table 7.1). They are needed in small amounts for building processes and metabolic reactions and cause various disorders when deficient.

7.1.2.3 Trace Elements

Trace elements (Iron,Zinc,Copper,Manganese,Iodine,Chromium,Selenium,Boron and Chloride) are non-energy-providing substances that are needed in trace amounts (traces) and are essential for the normal course of life processes. A lack of essential trace elements in humans causes severe physiological damage. Known deficiency symptoms are anemia due to iron deficiency or metabolic disorders (e.g. of the thyroid gland) due to iodine deficiency. A balanced diet, which includes fresh vegetables, whole grain products and sea fish, can cover the need for trace elements.

7.1.2.4 Secondary Plant Substances

The term "secondary plant substances" covers more than 30,000 different substances that are only formed by plants. Secondary plant substances have a proven positive effect on health and are now considered an important protective factor against the occurrence of many diseases.

Table 7.1 Overview of important minerals

Mineral	Significance	Food
Sodium	Fluid balance, heart rhythm, protein metabolism	Table salt, cheese, mineral water
Potassium	Fluid balance, heart rhythm, protein metabolism	Whole grain products, meat
Calcium	Formation of bones and teeth, nerve impulses	Legumes, leafy vegetables
Magnesium	Immune system, blood clotting, nerve impulses	Soybeans, nuts, fish
Phosphorus	Building of bones and teeth, energy production	Eggs, meat, whole grain products

Protective functions of secondary plant substances

- They strengthen the immune system.
- They protect the body from free radicals.
- They kill pathogens.

A diet that is rich in plant foods and thus contains a variety of secondary plant substances contributes to the protection against cancer and cardiovascular diseases.

7.2 Healthy, Balanced Diet

Everyone has to create their own individual menu, because not everyone tolerates e.g. whole grain products or legumes. However, the balance of the food composition (Fig. 7.4) is always important.

- About 55% of the food energy should be provided by carbohydrates. They are found in cereals, rice, pasta, potatoes, muesli, vegetables and fruit. The most favourable choice is carbohydrates with a lot of fibre, e.g. wholegrain products, vegetables and salad, which also contain many vitamins and minerals (high nutrient density).
- Fats cover about 30% of the energy requirement. "Good" fats, namely those with polyunsaturated fatty acids, are found in nuts, many vegetable oils and in fatty fish. To meet the fat requirement, one should prefer olive and rapeseed oil (2–3 teaspoons/day) and avoid hardened fats as much as possible.
- The remaining 15% of the food should consist of protein. The intake can be of animal (dairy products, meat, fish, eggs) and plant (cereals, legumes) origin (Table 7.2).

Fig. 7.4 DGE nutrition circle. (With kind permission: Deutsche Gesellschaft für Ernährung e. V., Bonn)

Table 7.2 Optimal daily amount of macronutrients

Nutrient	Daily amount	Comparison
Protein	1 g/kg body weight	100 g turkey breast contains 24.1 g protein
Fat	65 – max. 80 g/day	100 g soft cheese, 70% fat in dry matter contains 40 g fat
Carbohydrates	ca. 250 g day	100 g potatoes contain 14.2 g carbohydrates

Practical tip

As a general rule for the food selection applies:
- Plenty of plant-based foods
- Moderate animal foods
- Sparingly fatty foods
- Rarely sweets and white flour products

In case of stress and illness, the protein requirement can increase up to 1.5 g/kg body weight/day.

7.2.1 Body Weight

Objective measures, such as body weight and the calculated **Body Mass Index** (BMI), help to assess the nutritional status. The BMI is determined with the following formula:

Body weight in kilograms divided by height in meters squared (Fig. 7.5).

The "desirable" BMI depends on the age. In Table 7.3 BMI values for different age groups and in Table 7.4 the corresponding evaluation are shown.

For seniors (>64 years) the following applies:

- BMI < 24.0 kg/m^2 = increased risk of malnutrition, observation absolutely necessary!
- BMI < 20.0 kg/m^2 = undernutrition, intervention often required!

$$\text{BMI} = \frac{\text{Body weight in kg}}{(\text{Body height in m})2}$$

Fig. 7.5 BMI formula

Table 7.3 BMI values

Age	BMI
19–24 years	19–24
25–34 years	20–25
35–44 years	21–26
45–54 years	22–27
55–64 years	23–28
>64 years	24–29

Table 7.4 BMI evaluation

Classification	BMI
Underweight	<20
Normal weight	20–25
Overweight	25–30
Obesity	30–40
Massive obesity	>40

7.2.2 Energy Requirement

The energy requirement of seniors decreases with increasing age, but the nutrient requirement does not. The daily energy requirement can be calculated with the following formula:

Energy requirement = Basal metabolic rate + Activity metabolic rate.

The basal metabolic rate is the energy that a person needs at rest (approx. 1500 kcal). The activity metabolic rate depends on the physical activity. It can vary depending on the type of activity, e.g. for heavy workers, it can be a multiple of the basal metabolic rate.

The dementia disease often leads to high mobility and restlessness, so that the energy requirement can increase significantly in individual cases.

With calories (actually kilocalorie (kcal = 1000 calories) one measures the amount of energy that is in food (Table 7.5). The term "kilocalories" is an outdated unit today, but still common in the population. Today one uses the unit joule or kilojoule (kJ). 1 kcal corresponds to 4.184 kJ.

Table 7.5 Energy contentof theMain nutrients

Nutrient	Energy content
Protein	1 g = 4 kcal (17 kJ)
Carbohydrates	1 g = 4 kcal (17 kJ)
Fat	1 g = 9 kcal (30 kJ)
Alcohol	1 g = 7 kcal (30 kJ)

7.2.3 Calculation of the Energy Requirement

Calculation of the basal metabolic rate (BMR) for over 65-year-olds:

1kcal/kg body weight and hour

► Example

65 kg = 65 kcal/h x 24 h = 1560 kcal/day (BMR) ◄

The total energy requirement is however a multiple of the basal metabolic rate:

Fully immobile seniors	GU × 1.2	Performance expenditure	= Total energy requirement
Light activity	GU × 1.5	Performance expenditure	= Total energy requirement
Moderate activity	GU × 1.75	Performance expenditure	= Total energy requirement
Heavy activity approx.	GU × 2.0	Performance expenditure	= Total energy requirement

► Example

65 kg = 65 kcal (h) x 24 = 1560 kcal (day) (GU) x 1.2 = 1872 kcal total energy requirement
65 kg = 65 kcal (h) x 24 = 1560 kcal (day) (GU) x 1.5 = 2340 kcal total energy requirement ◄

7.3 Over-, Mal- and undernutrition

If the energy intake is adjusted to the energy requirement, one usually has a normal weight. If the energy intake is above the energy requirement, the body weight increases, if it is below the requirement, this results in weight loss. The body burns its own fat reserves in this case to produce energy.

The dementia disease can cause the affected person to eat either too much or too little.

7.3.1 Physical Changes in Old Age—Loss of Muscle Mass

In old age, the body and the nutrient utilization change. The muscle mass does not simply decrease due to age. The causes

The cause of most accidents of seniors is the decline of strength.

for the loss of muscle mass are rather in a poor nutrition, physical inactivity and possibly hormonal changes. Loss of skeletal muscle leads to lower body strength and reduced mobility and can lead to the loss of physical independence. A vicious circle that can lead to overweight in one and weight loss in another. A sufficient (protein-rich) nutrition combined with physical training preserves the muscle mass typical for the younger body even for care-dependent and older people.

7.3.2 Overweight (Obesity)

New studies show that with increasing age, it is possible to live longer and healthier with a few pounds above the normal weight. Obesity, however,—a pathological overweight—is the most common form of malnutrition in this country. The disease is triggered by a variety of factors.

Causes of overweight in relation to food intake

- Overnutrition, i.e. the intake of too many calories
- Malnutrition, i.e. a too high percentage of fat and sugar
- Disturbed energy balance, which leads to more calories being taken in than consumed (see total energy requirement)

As can be seen in Table 7.5, 1 g of fat provides more than twice as much energy as 1 g of carbohydrates. Therefore, the best way to save calories is to reduce the daily fat consumption. Alcohol and "empty calories", such as sweets or white bread, also have a high energy content with very low nutrient content at the same time.

Even an overweight person can be malnourished (=lack of important nutrients)!

7.3.2.1 Overweight Reduce

- Save fats (consumption of max. 60 g/day) and use "healthy" fats (with mono- and polyunsaturated fatty acids), e.g. olive oil for frying
- The right carbohydrates: wholemeal pasta, brown rice, boiled potatoes, especially many carbohydrates from fruits and vegetables
- Enough protein: lean meat such as turkey, chicken, veal, beef, lean fish, milk and yogurt with 1.5% fat, low-fat curd, lean sausage and lean cheese
- Only 3 meals per day

Diet without exercise goes at the expense of muscle mass. Therefore, with any diet, a—within the possibilities—physically stronger movement is necessary.

7.3.3 Underweight -Malnutrition (Malnutrition)

According to an estimate by the Medical Service of the Associations of Health Insurance Funds (MDS), almost one in 12 of those over 60 years of age (that is 1.6 million people) in Germany suffer from chronic malnutrition. This means that their body is no longer sufficiently supplied with energy, protein and essential nutrients. 1.3 million of them live at home. In the nursing home, 2/3 of the residents are at risk of malnutrition (ErnSTES study). The degree of need for care and dementia are the main risk factors for malnutrition.

Consequences of malnutrition

- Increasing physical weakness (muscle loss) associated with decreasing joy of life and risk of falling
- Increased loss of mental abilities
- Depression, lack of motivation and participation

If the nutrient deficiency persists (e.g. lack of vitamins and trace elements associated with low-protein diet), severe physical impairments and disturbances of important organ functions are the consequence.

Possible consequences of creeping deficiency symptoms

- Increased susceptibility to infection
- Increased risk of pressure ulcers (decubitus risk)
- Weaker breaths due to the decrease of the respiratory muscles (pneumonia risk)
- Reduction of the heart muscle mass with cardiac arrhythmias

7.3.3.1 Causes of Malnutrition

A clear sign of malnutrition is often weight loss, which sometimes is only noticed when the clothes are loose.

General reasons for malnutrition in old age

- Problems with food intake (chewing and swallowing difficulties)
- Changed hunger and satiety feeling
- Loss of appetite
- Changed taste perception (sweet pudding instead of crisp salad)

- Increased food requirement (e.g. due to diseases and infections)
- Side effect of medications (e.g. impairment of appetite, digestive problems)
- Social problems (loneliness, lack of money, etc.)

Aggravating factors in dementia patients

- Forgetfulness (confusion and dementia make food intake forgotten)
- Lack of insight (the necessity of eating is not understood)
- Changed perception (food and drinks are not recognized as such)
- False interpretation (food and drinks are seen as poisonous)

7.3.3.2 Nutritional Measures for Malnutrition

In the life of the person in need of care, meals are often the only change of the day. For people with dementia, eating is one of the few remaining joys. If there is malnutrition, it takes a lot of care to balance this nutrient deficit. In the nursing homes, nutritional concepts are increasingly being developed.

Goals of special nutritional concepts

- Offer residents an adapted, healthy and varied diet
- Respond to the individual needs of the residents (especially those with dementia)
- Recognize, avoid, correct or alleviate forms of mal-/undernutrition of the residents

Guidelines for home care by outpatient nursing services

- Basic statement of the MDS "Eating and Drinking in Old Age"—Nutrition and Fluid Supply for Older People
- Expert standard "Nutritional management to ensure and promote oral nutrition in nursing care" (DNQP).

These include tools for assessing the nutritional status (e.g. the Mini Nutritional Assessment MNA). The results are incorporated into the nursing plan and result in a nutritional plan with targeted measures (▶ Chap. 5).

7.4 Diet or Hospital Diet

A special diet for people in need of care is the diet, the light diet, the supplementary food or drink food and also the artificial nutrition.

7.4.1 Diet

A diet becomes necessary when certain organ and metabolic functions are disturbed. It always represents a drastic change in the usual eating habits for the person concerned. Usually, the doctor prescribes it. Some diets last a lifetime, (e.g. low-salt diet for heart, circulatory and kidney diseases), others are only temporary (e.g. after operations) necessary (▶ Chap. 4).

7.4.1.1 Diabetes Diet

The basic pillar of any diabetes treatment is adhering to a diet. The diet essentially corresponds to a healthy whole food diet. However, for diabetics, the exact knowledge of the nutrient content of foods is very important, because foods that contain carbohydrates cause an increase in blood sugar. Especially for **insulin**dependent diabetics, it is important to be able to estimate the carbohydrate content of a meal.

Carbohydrates are absorbed differently depending on their composition and the effect can be fast (e.g. after a drink) or less fast (e.g. after a whole grain bread). The right carbohydrates (vegetables, salad, legumes, whole grain products, pasta, rice, potatoes, fresh fruit) are well suited for diabetics. In practice, a diabetic diet should look like this, that the carbohydrates are distributed as evenly as possible throughout the day. Specially made products for diabetics are not necessary.

7.4.2 Light Diet

A light diet becomes necessary when foods cause discomfort such as pressure and fullness, bloating, heartburn, constipation, etc. Often these are hard to digest dishes, which should then be avoided as much as possible from the menu.

Examples of hard to digest dishes

- Fatty meats (mutton and pork)
- Smoked fish
- Deep-fried, breaded or fried dishes
- Legumes, cabbage and mushrooms

7.4.3 Liquid Nutrition

Malnourished seniors often only consume small amounts of food. Therefore, it is particularly difficult for them to ensure adequate energy and nutrient intake. Energy and nutrient-rich liquid nutrition (**Supplements** in the form of protein-rich,

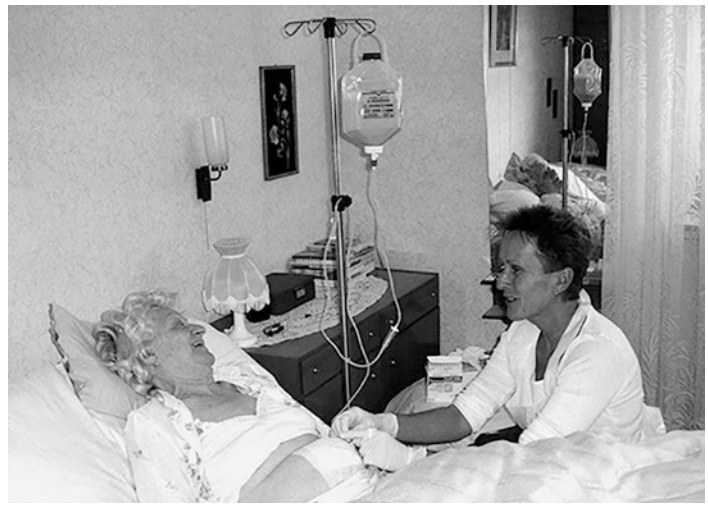


Fig. 7.6 Supply with a lying gastric tube (PEG)

high-calorie liquid nutrition) can help to balance deficits and deficiencies (e.g. as a supplement or to enrich the prepared food).

7.4.4 Artificial Nutrition (Tube Feeding)

However, a complete nutrition with liquid food is not always possible. Therefore, tube feeding is paid for by the statutory health insurance companies if the doctor considers it medically necessary and the ability to adequately normal nutrition is lacking in the person in need of care (see DiätV § 14a).

Reasons for tube feeding

- Severe swallowing disorders
- Strong weakness
- Need for care

Tube feedings are specially made liquid foods that are inserted through a feeding tube directly into the stomach or the small intestine (Fig. 7.6).

7.5 Balanced Fluid Balance

Water is our most important food!

Water – a vital element – is the main component of our body with about 60% (Fig. 7.7). It is essential for the formation and maintenance of the body as well as a solvent and transport medium for humans. Water is present in all body

Fig. 7.7 Water is vital. (© Andreas F./► fotoliia.com)

fluids and cells. However, the body loses considerable amounts of water every day.

Types of water loss

- Urination (micturition)
- Bowel movement (defecation)
- Sweat (transpiration)
- Breathing (respiration)

Although water is a basic component of the human body, humans have no water reservoirs that they can draw on in

emergencies, and therefore have to constantly replace it. The average daily requirement is 25–40 ml/kg BW in 24 h or as a rough guide: 1.5–2.0 l/day.

Demand figures are guidelines and may differ from the actual individual demand!

► **Example**

65 kg × 25 ml = 1625 ml/day ◄

Reasons for a higher fluid intake

- Physical activity (sports, strenuous work)
- Illness (diarrhea, vomiting)
- Temperature (heat with heavy sweating, fever)

► **Example**

65 kg × 40 ml = 2600 ml/day ◄

We also supply fluid through our food. The fluid content in usual nutrition is about 0.33 ml of fluid per kilocalorie supplied (about 1/3).

► **Example**

65 kg = 1872 (kcal) total energy requirement × 0.33 ml = 618 ml (rounded) ◄

The thirst sensation decreases, but not the water demand of the body.

The total fluid requirement is thus covered by the fluid in the food and the drinking fluid.

7.5.1 Lack of Thirst in Old Age

Older people often drink only when they are reminded. Even when prompted, their fluid intake is usually too low.

In addition to malnutrition or undernutrition (see above), there is then the risk of dehydration **(dehydration).** Water-rich organs such as the brain (it consists of 75% water) or the muscles react particularly sensitively to fluid loss.

Effects on the body

- Impairment of performance
  - Reduced concentration and reaction
  - Premature signs of fatigue
  - Confusion
  - Lack of motivation
- Health damage

– Constipation (obstipation)
– Stomach complaints and loss of appetite
– General immune deficiency

7.5.2 Dehydration (Dehydration)

If the fluid withdrawn from the body is not replaced, there is a deficit in the water and electrolyte balance. Especially seniors are at risk, because in advanced age the normal thirst sensation usually decreases.

Symptoms

- Dry lips
- Dry mouth with mouth and tongue burning
- Flabby, dry skin (parchment skin ◘ Fig. 7.8, skin can be lifted in folds)
- Headaches, fatigue, dizziness and confusion
- Fever
- Sudden onset of gait instability
- Decreased urine output

7.5.2.1 Measures for Dehydration

In the nursing home and also in professional outpatient care, the fluid requirement is calculated individually (nutrition and fluid plan) and a drinking plan is created for control (▶ Chap. 5).

◘ **Fig. 7.8** Dry parchment skin. (© Michael Bührke/PIXELIO)

Tips from the Alzheimer Society Switzerland to promote the drinking amount

- Offer drinks with all meals
- Remind to drink again and again
- Provide favorite drinks
- Vary the drink offer
- Sweet drinks
- Offer open drinks instead of bottles
- Enable self-service
- Colored drinking vessels are easier to recognize than glasses for people with visual impairment
- Provide thickened drinks for swallowing disorders
- Use straws, cups with nose cutout, special cups, suction bottles, etc. to facilitate drinking
- Offer drinks in company
- Maintain drinking rituals (e.g. give a glass of juice first thing in the morning after getting up)

Housekeeping

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S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_8

» One is not at home where one has one's residence, but where one is understood. (Christian Morgenstern)

Especially in old age, people spend more and more time in their own apartment. The own four walls become increasingly a terrain for retreat and recovery from the stress of the outside world. Over time, they have furnished themselves according to their personal taste and needs and have run their household independently. When illness or age-related complaints make the daily tasks in the household more difficult, this can greatly endanger the remaining in one's own home.

8.1 People with Dementia at Home

Still live most dementia patients in private households and are mostly cared for and supplied by their relatives (such as spouses, children). However, more and more affected people live alone today, either because they have no relatives or relatives who can only take care of them to a limited extent for various reasons. The demographic and sociocultural changes in our society lead to the fact that in the future more and more dementia patients will live alone at home.

The dementia disease means for the affected person a gradual loss of independence also in the continuation of his household. The use of a household help or cleaning lady can be a valuable support at the beginning of the disease. However, the increasing need for help, even with simple activities of daily living, can lead to extensive support for the continuation of the household by relatives or outpatient care services or the own household must finally be given up.

8.2 People with Dementia in Residential Groups

Outpatient supervised dementia residential groups are a possibility of living for people with dementia. The life in the residential group is very oriented to the classic everyday life at home. The focus is on running the common household. The main aspects of household management are the common preparation of meals but also all other usual tasks, such as shopping, washing, ironing, cleaning, etc. The members of the residential group participate in the completion of everyday tasks, also here according to the individual abilities and skills of each individual.

8.3 Household Care within the Framework of the Long-term Care Insurance

As soon as a person is in need of care within the meaning of the long-term care insurance law, he or she receives benefits for basic care and household care. Activities of household care are only taken into account as a need for help if they relate to the care of the person in need of care himself or herself.

Household care

Household care means a professional care in one's own domestic environment in all matters of household (household organization and execution of the daily household tasks).

The law provides for the following areas

- Shopping/Errands
- Preparing meals/Cooking
- Washing dishes
- Cleaning the apartment
- Changing and washing clothes
- Heating

The inclusion of people with dementia in all activities depends on their remaining abilities. Over- and under-demanding should be avoided. Precautions help to preserve the greatest possible independence.

8.3.1 Shopping/Errands

Shopping involves first planning the shopping together with the person in need of care. This also includes obtaining information and keeping track of which foods need to be purchased where. It also includes obtaining the necessary foods for a diet.

Shopping includes

- Food
- Hygiene and personal care products
- Cleaning products
- Other items of need
- Errands of all kinds (e.g. prescriptions at the pharmacy)

Important factors when buying food

- Season
- Required quantity
- Knowledge of the value (cost-conscious shopping)
- Edibility and shelf life of food
- Proper storage (putting away the purchases in the cupboard and refrigerator)

Household chemicals, tobacco products and medicines and possibly also personal care products can cause poisoning and should be stored under lock and key (► Chap. 9).

8.3.1.1 Special Features When Shopping for Food

When shopping, dealing with smaller amounts of money is sometimes still possible.

As described in ► Chap. 7, people with dementia have a high risk of malnutrition.

Preferred foods

- Familiar and regional foods
- Foods that are suitable as finger food (e.g. vegetable pieces, cheese pieces, wholemeal biscuits)
- Sweet and colourful drinks
- Appetising dishes (e.g. peppers, celery) and drinks (e.g. fruit and vegetable juices)
- Foods with a high fat content (milk 3.8%, yoghurt 10%, cheese without fat reduction, fatty fish)

Practical tip

People with dementia hide objects that are important to them, such as food, out of a need for security. Therefore, before shopping, look for hoarded food. Spoiled food must be removed.

Food is not only hoarded, but also thrown away. If this is noticed, this observation must be reported immediately to the nursing service and/or the relatives.

8.3.1.2 Helping with Shopping for Food

Going for a window-shopping stroll together, buying food and other things you need, offers a nice change in everyday life. Depending on the remaining abilities of the person with dementia, the shopping list can be written beforehand or the shopping bag and wallet can be prepared. A daily shopping trip can structure the day and counteract possible isolation.

On the way, you have to keep an eye on the person with dementia. Due to a stimulus (e.g. visual) or misinterpreting a situation, it can happen that the person with dementia runs somewhere or away.

8.3.2 Preparing Meals/Cooking

Cooking involves first setting up a menu plan for proper nutrition together with the person in need of care (Fig. 8.1).

To be considered are

- Living conditions, wishes and preferences of the person in need of care
- Prescriptions of a diet (e.g. diabetes diet, low-salt diet Chap. 4)

Practical tip

An eating biography can provide clues for favorite dishes, eating habits, rituals, likes and dislikes (Fig. 8.2).

Important for the preparation of food

- Estimation of quantity ratios
- Observance of cooking times

Book tip The cookbook "Cooking for People with Dementia" by C. Menebröcker, J. Rebbe and A. Gross contains numerous recipes and tips

Fig. 8.1 Cooking together

Fig. 8.2 Meal. Food from past days

- Preparation of the components of the meals
- Cooking of dishes
- Follow-up work such as tidying up
- Observance of hygiene rules
- When cooking with affected persons, individual preferences and disease-related changes such as swallowing disorders, restlessness or loss of appetite should be taken into account

8.3.2.1 Assistance in the Preparation of Meals

Helping with cooking is especially for people with dementia a possibility to participate actively in the daily routine and to satisfy their desire for activity.

Help options depending on the remaining abilities

- Setting the table
- Preparing, such as peeling potatoes, stirring dough, chopping salad
- Cooking itself
- After and tidying up work

A person with dementia may be careless with heat and scald or burn themselves while cooking.

Therefore, pay attention to hot liquids and hot stove plates when helping. Banish pointed and sharp knives from the kitchen, operate or remove hand mixers and bread slicers yourself. Kitchen stoves should be secured by timers or shut-off valves.

8.3.3 Dishes

Dishwashing includes washing by hand and/or in the dishwasher.

8.3.3.1 Helping with Dishwashing

Dishwashing is a familiar activity that can not only be a suitable occupation, but also be perceived as meaningful by the person with dementia.

A person with dementia can scald themselves if the water temperature is set too high. Do not let them wash fragile and sharp objects (glasses, fine porcelain, knives).

8.3.4 Cleaning the Apartment

Cleaning involves first setting up a cleaning schedule (times for routine cleaning) together with the person in need of care.

Cleaning involves

- Regular cleaning of floors, furniture, windows and household appliances in the usual living area of the person in need of care, as well as knowledge of cleaning products and equipment
- Making beds
- Separation and disposal of waste

8.3.4.1 Helping with Cleaning

Cleaning surfaces (tables, shelves), dusting or sweeping the floor can be a good way of involving the person with dementia in using their practical skills. All tasks that the person can still perform independently should not be taken away from them. This can increase their life satisfaction and self-esteem.

When cleaning, it is important to put all objects back in their place, so that the person with dementia can find them again.

Cleaning products, vacuum cleaner cords and wet floors pose accident hazards.

8.3.5 Laundry Care

Laundry care includes dividing and sorting the textiles, changing the laundry, washing, hanging, ironing, mending and sorting the clothes into the closet, as well as making the beds.

An iron is not only a danger for burns, the cable can, like other electrical appliances (e.g. vacuum cleaner), be a tripping hazard.

8.3.5.1 Helping with Laundry Care

A good way of occupation is folding clothes, towels and dishcloths or polishing shoes. Everyday skills and personal abilities are thus recalled and available in this way.

Practical tip

Changing the laundry can sometimes prove to be difficult if the person with dementia wants to wear dirty clothes again and again. Discussions should be avoided and dirty laundry should rather be removed inconspicuously.

8.3.6 Heating

Heating also includes the procurement and disposal of heating material. This requires the use of wood, coal and oil.

First Aid

Contents

S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_9

» Some prefer to drown rather than call for help. (Wilhelm Busch)

First aid saves human lives. In Germany, everyone is legally obliged to provide first aid. First aid means the assistance measures that are to be carried out in an emergency until professional help arrives, such as by a doctor and emergency service. This includes the correct assessment of emergency situations and the implementation of the necessary assistance measures to prevent or mitigate possible dangers or health problems. One of the tasks of the care worker is to activate the dementia patients, e.g. by light gardening, handicraft work, walks, visits to events. Therefore, in an emergency, he or she may initially be on his or her own and must act quickly and correctly.

9.1 The Emergency

Emergencies are all situations in which there is danger to the life and limb of the person concerned. They can be caused by burns, poisoning, injuries and life-threatening diseases. The focus of first aid is on ensuring the vital functions of consciousness, breathing and circulation.

9.1.1 The Rescue Chain

The optimal care is provided by the rescue chain.

5 links of the rescue chain

1. Secure and self-protection, e.g. rescue from the danger zone, for example if there is a fire
2. Life-saving immediate measures, e.g. perform stable side position, stop threatening bleeding, fight shock
3. Call for emergency
4. Provide further first aid, e.g. resuscitation, relieve pain by proper positioning or other assistance, care for and comfort the injured
5. The emergency service continues the measures of the first aider and ensures the admission to the hospital

9.1.2 The Emergency Call

In any case, do not forget the emergency number 112.

When making an emergency report, you will be guided through the following questions by the rescue control center:

Questions of an emergency report

- **W**here is the emergency? (Place, street, house number)
- **W**hat happened? (Briefly describe the emergency situation)
- **H**ow many injured/affected people need to be cared for?
- **W**hat injuries or signs of illness do the affected people have? (Important: Is there a life-threatening situation?)
- **W**ait for questions from the rescue control center! The conversation is always ended by the control center!

9.2 Life-saving Immediate Measures

Life-saving immediate measures include, in addition to the emergency call, the recovery position, shock treatment, resuscitation and bleeding control.

It is advisable to attend a first aid course or a course on "life-saving immediate measures".

9.2.1 Recovery Position

The recovery position (Fig. 9.1) ensures that the airways are kept clear. Accidental inhalation of liquid, such as saliva or blood, as well as solids, such as vomit, is prevented. The affected person is thus protected from suffocation, because the mouth of the affected person is turned to the lowest point of the body. The recovery position is the standard position for all unconscious people who breathe independently.

Fig. 9.1 Recovery position

Recovery position

- The affected person is in a supine position, the helper kneels next to him.
- The near arm of the affected person is bent upwards. Make sure that the palm of the hand faces upwards.
- Place the far arm across the chest. Place the back of the hand of the affected person against his (the helper's near) cheek and hold it firmly with one hand.
- With the other hand, grasp the far leg of the affected person shortly above the knee and pull it up. Make sure that the foot of the affected person stays on the ground. Place the upper leg at a right angle to the hip.
- Extend the neck to clear the airways.
- Open the mouth and make sure that secretions can flow out

9.2.2 Shock Treatment

Shock can be life-threatening due to circulatory collapse, severe bleeding, burns or other disturbances of vital functions. The immediate measures depend on the type of injury, e.g. haemostasis, covering the affected person or positioning.

Signs of shock, depending on the cause

- Rapid pulse
- Cold sweat
- Shallow breathing
- Impaired consciousness or unconsciousness
- Possibly visible external bleeding
- Paleness

Call the emergency service immediately if shock is suspected

9.3 First Aid for Cardiac Arrest

An existing living will must be respected (▶ Chap. 10).

Cardiac arrest means a cessation of the heart function, which leads to the stoppage of the blood circulation and thus to pulselessness. The affected person is no longer responsive, i.e. shows no reaction to speech and shaking of the shoulders and does not breathe normally. A cardiac arrest requires immediate resuscitation (reanimation). The aim of resuscitation is to create a minimal circulation by external chest compression and to perform adequate ventilation. When seconds count, quick and correct action is essential:

Resuscitation

- If the person is unconscious and not breathing normally, call the emergency service immediately (emergency number 112, in the nursing home another person who then makes the report) and start cardiopulmonary resuscitation.
- Immediately after the report, start with 30 chest compressions. Press on the center of the sternum (frequency about 100 per minute).
- Then ventilate twice. Each emergency ventilation lasts 1 s, so a total of 2 s.
- Then perform 30 chest compressions again, etc.
- This rhythm (chest compressions and breaths alternately) is maintained until the arrival of the emergency doctor or until the person starts breathing normally again.

9.3.1 Chest Compression

For chest compression, the hands are placed directly on the lower half of the sternum and the sternum is pressed with straight arms about five centimeters in the direction of the spine (Fig. 9.2).

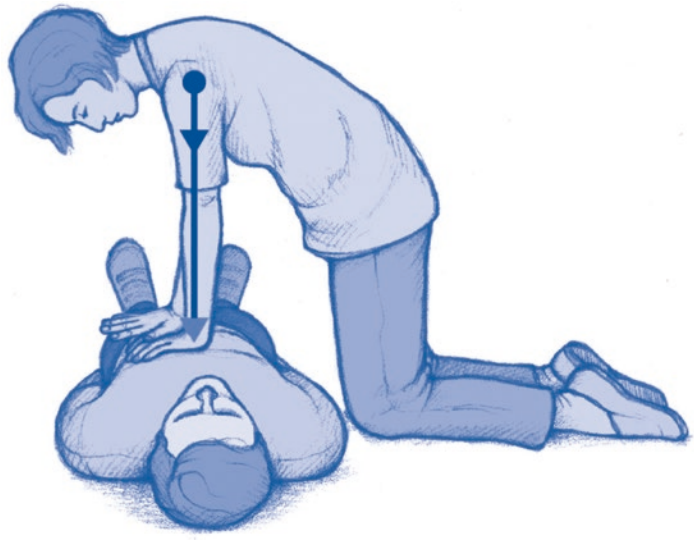

Fig. 9.2 Position for chest compression

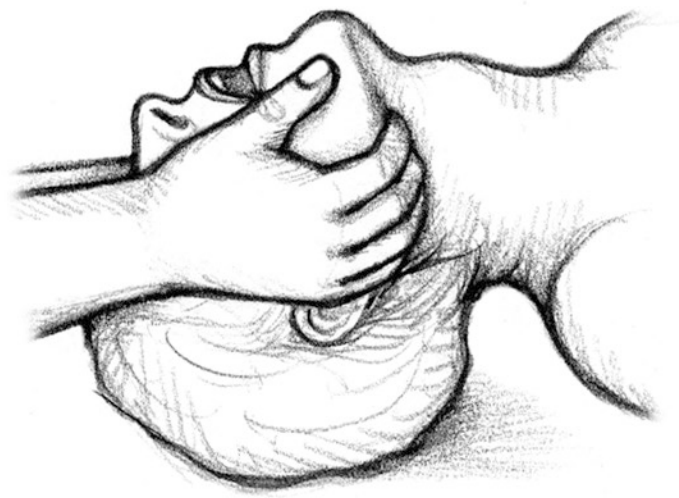

Fig. 9.3 Extend the head

9.3.2 Breathing Donation

The breathing donation can be performed by mouth-to-mouth resuscitation or mouth-to-nose resuscitation.

Breathing donation

- Clear the airways
- Tilt the head back, while lifting the chin (Fig. 9.3)
- Close the soft part of the nose with one hand, open the mouth of the affected person
- Breathe normally
- Place the lips tightly around the mouth of the affected person (Mouth-to-mouth resuscitation)
- Blow air evenly into the mouth of the affected person over a period of one second, so that the chest visibly rises
- Maintain the head position of the affected person, turn your own head to the side, breathe in again and watch whether the chest of the affected person lowers again
- Resuscitate the affected person a second time
- If the breathing resumes, the affected person should be brought into the recovery position

9.4 First Aid for Injuries

Every second person with dementia injures themselves at least once a year. Very often the injuries are severe, falls often lead to fractures. Not always is an injury immediately visible,

such as by bleeding, bruises, lack of resilience when standing. A healthy person judges by the pain whether they have injured themselves badly. People with advanced dementia who can no longer express themselves with words are not able to name pain. Here, only a careful observation of the person concerned can provide clues to the presence of pain.

Observation

- How does the injured person breathe? Normally or loudly strained?
- What sounds does the injured person make? None or does he groan loudly, shout or cry?
- What is his facial expression? Meaningless or distorted into a grimace?
- What is his body posture? Relaxed or rigid, clenched fist, drawn-up knee?
- Does he respond to comfort? Does he let himself be distracted and calmed by comfort?
- If signs of severe pain are evident, the emergency service must be called.

It is advisable, especially on walks or excursions, to always carry a mobile phone with a programmed emergency number with you.

9.4.1 Injury from Falls

In residential care facilities, the acute fall event is one of the common emergency situations. When elderly people fall, this is disproportionately often associated with serious consequences.

Causes are usually the increasing gait insecurity of the person concerned, but also misjudgments of distances, balance disorders, general muscle weakness or a slowed reaction due to slowed fall and defense reflexes.

In the domestic area, additional risks arise from a home that is not adapted to the disease, which increases the risk of falling.

The risk of falling can increase on unfamiliar terrain, e.g. uneven ground, shopping center, venue etc.

Additional risk factors

- Stairs without slip-resistant covers and markings on the thresholds
- Loose carpets or cables
- Poor lighting
- Few or no handrails, e.g. in the bathroom
- Knee-high objects, e.g. small tables

In the nursing home, falls can also occur, although the facilities usually do not have any sources of danger, as described above for the home area.

Causes

- Existing visual impairment
- Poorly fitting shoes
- Certain medications

9.4.1.1 Minor Fall

If the fall is not so serious (no pain, no visible injuries), one can apply the getting-up technique over the "four-legged position". Often support is needed, especially if the person has been lying for a long time or cannot follow or understand the instructions.

Getting up

- Ask the person to turn from the back position to the stomach, or turn him there. This works well if he bends his head backwards.
- Now the person should pull his elbows in, to raise himself a little at the upper body.
- Then the legs can be pulled in one after the other.
- Now he can support himself on his hands and raise himself further in the upper body.
- The person is now in the four-legged position.
- He can now support himself with his hands on a chair or something similar and get from his knee to his feet.
- Now he can sit or stand up.

9.4.1.2 Severe Fall

If the fall is serious, e.g. in case of unconsciousness, shock, heavy bleeding, the measures according to the rescue chain must be carried out (▶ Sect. 9.1.1).

9.4.2 First Aid for Bleeding

First aid for minor bleeding

The bleeding from small wounds stops and clots after a few minutes by itself. The wound is cleaned and covered with a plaster (Fig. 9.4).

First aid for severe bleeding

Bleeding from deep, more severe and heavily bleeding wounds must be stopped by a pressure bandage.

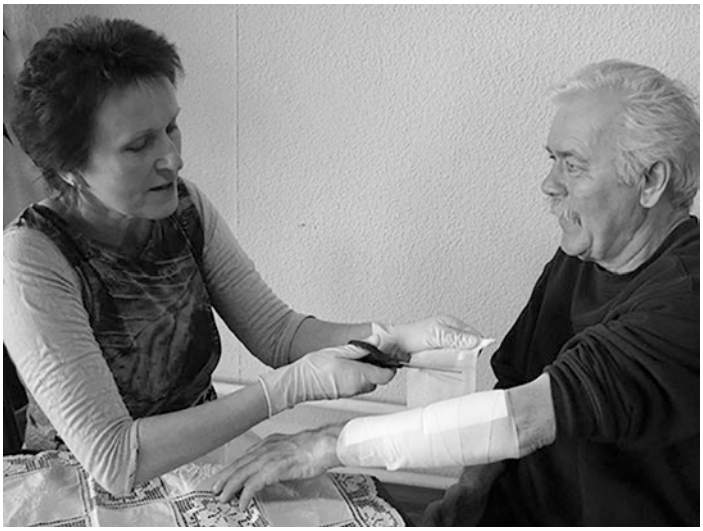

Fig. 9.4 Dressing for small injury

Pressure bandage

A pressure bandage is a bandage that applies enough pressure to a heavily bleeding wound to reduce or stop the bleeding. A pressure bandage can only be applied to the extremities. For bleeding on the trunk of the body, the bleeding can be reduced or stopped by pressure from the helping person.

Material

- Sterile compresses, alternatively fresh washcloth
- Two gauze bandages, alternatively compression bandage or T-shirt strips
- Several gauze dressing packs, if necessary from the car first aid kit or alternatively rolled up washcloth, wallet, cigarette box
- Scissors

Measures

- Do not tie off affected body part!
- Place sterile compress on wound, if no sterile compress is available, start wrapping the gauze immediately or place fresh washcloth on the wound

In case of severe bleeding, sterile work is secondary in an emergency.

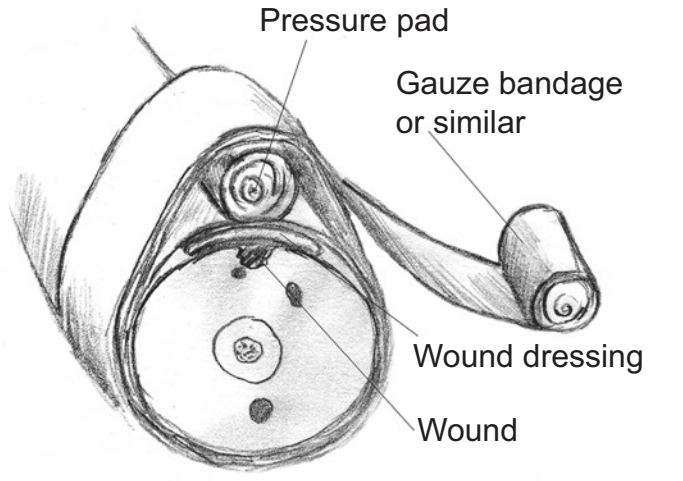

Fig. 9.5 Applying a pressure bandage

- Fix the compress with the gauze bandage in about 2–3 windings
- Place the second, unpacked gauze bandage package whole on the wound or alternatively rolled-up washcloth, wallet, cigarette box
- Fix with the rest of the first gauze bandage package under slight pressure
- If the bandage bleeds through, do not remove it, but place another gauze bandage package on top and fix with another gauze bandage Fig. 9.5

When the pressure bandage is finished, check the pulse on the affected extremity (wrist, behind inner ankle), pulse must be palpable.

9.4.2.1 First Aid for Injury of an Artery

If the accident occurs in the nursing home, call a nursing professional immediately.

Bleedingfor Injury of a large artery can lead to death in a short time (a few minutes). The bleeding is strong, pulsating and spurting, the color of the blood is bright red. When an artery is injured, you must react quickly and correctly:

Arterial bleeding

- Call for emergency (emergency number 112, in the nursing home call another person who then makes the report)
- Stop the bleeding with firm pressure, using a sterile or clean cloth, if necessary with the bare hand

- If possible, apply a pressure bandage; if the bandage bleeds through, press firmly on the wound again, possibly put a second bandage over it (leave the first bandage!) ◘ Fig. 9.5
- If possible, raise the bleeding area
- If possible, put the affected person in shock position—elevate the legs

9.4.3 First Aid for Burns/Scalds

BurnsorScalds are caused often by carelessness, but also by lack of sensory performance in old age. Especially with the increasing loss of everyday competence in dementia patients, there is a high risk of accidents. In addition to falls, burns and scalds are common. They can be caused by burning candles, fan heaters, bath water, hot stove plates or hot drinks. People with dementia may have difficulties in judging the right temperature. Signs of burns or scalds are severe pain and redness of the skin up to blistering.

9.4.3.1 First Aid for Minor Burns/Scalds

Minor accident

- In case of scalding: remove clothes immediately
- In case of burning: only remove clothes if they do not stick; leave sticking material
- Always cool light burns and scalds before further care; hold affected body part, but not on the trunk, under running, approx. 20 °C cool water, or immerse in cool water
- For further care, consult the nursing staff and inform the family d'octor

9.4.3.2 First Aid for Major Burns/Scalds

Major accident

- Remove clothing—if possible—immediately, if necessary, cut off loose clothing pieces in case of adhering clothing
- Cover affected area sterile, do not cool, as there is a risk of hypothermia
- Wrap unaffected body parts warmly

For burns that are larger than 10% of the body surface, call emergency immediately. Do not use home remedies (ointments, powder, oil)!

9.4.4 First Aid for Poisoning

The most common cases of poisoning occur in childhood, but in old age the risk of poisoning increases again. People with dementia often lack the ability to distinguish between edible and inedible, even when they have a preserved sense of smell and taste. Poisoning can be caused by the ingestion of medications, cleaning agents, pesticides, household products, chemicals, essential oils, perfumes, shampoos or similar. Medical help is necessary for any form of poisoning.

If you suspect poisoning, you should contact the poison emergency center. Phone numbers of the poison emergency centers are in appendix 6. If there is a threat to life, call the emergency doctor immediately (Tel. 112).

Legal Knowledge

Contents

S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_10

» The foundation of law is humanity. (Albert Schweitzer)

In care facilities, a variety of laws, guidelines and regulations govern the treatment of people in need of care and strengthen the rights of the patient or resident. In the accompaniment and support of people with dementia, the dementia companion comes into contact or even into conflict with these legal requirements. To achieve a sensitivity for legal requirements and to exclude possible legal disputes, this chapter describes the basics of legal knowledge that are relevant for the dementia companion in his daily work.

10.1 Charter of Rights of People in Need of Help and Care

The basis of all measures that are carried out in the care, therapy and accompaniment of people in need of help and care is the Charter of Rights of the Human Being, who depends on help, support and care (overview).

In contact with people with dementia, mentally ill and intellectually disabled people, these rights must be respected especially, as the affected people may not be able to stand up for their rights themselves.

The "Charter of Rights of People in Need of Help and Care" can be seen as a basic law for the protection of these people.

The "Charter of Rights of People in Need of Help and Care" describes what rights these people and their relatives have in Germany, and informs how the help and care process can be concretely designed.

The Charter goes back to the work of the "Round Table Care", an expert working group that dealt with care quality, initiated by the Federal Ministry for Family, Seniors, Women and Youth and the Federal Ministry of Health in autumn 2003.

Charter of rights for people in need of care and assistance

Article 1: Self-determination and help for self-help
Every person in need of care and assistance has the right to help for self-help and to support, in order to lead a life as self-determined and independent as possible.

Article 2: Physical and mental integrity, freedom and security
Every person in need of care and assistance has the right to be protected from dangers to body and soul.

Article 3: Privacy
Every person in need of care and assistance has the right to respect and protection of his or her private and intimate sphere.

Article 4: Care, support and treatment
Every person in need of care and assistance has the right to a health-promoting and qualified care, support and treatment that is oriented to his or her personal needs.

Article 5: Information, advice and education
Every person in need of care and assistance has the right to comprehensive information about possibilities and offers of advice, help, care and treatment.

Article 6: Communication, appreciation and participation in society
Every person in need of care and assistance has the right to appreciation, exchange with other people and participation in social life.

Article 7: Religion, culture and worldview
Every person in need of care and assistance has the right to live according to his or her culture and worldview and to practice his or her religion.

Article 8: Palliative care, dying and death
Every person in need of care and assistance has the right to die with dignity.

10.1.1 Significance of the Charter

In the care of people with dementia and mentally or intellectually altered people, the right to self-determination, to privacy, to communication and appreciation, as well as the right to participate in society, should be especially considered, as the affected people are considerably endangered in these areas due to their basic illness.

Violations of these rights are often not perceived in everyday life, as the affected people are frequently not able to communicate such incidents due to the altered thought processes.

The task of the companion and all persons involved in the care is therefore an increased sensitivity and attention, in order to recognize and avoid corresponding violations of these rights.

10.2 Confidentiality

Maintaining confidentiality is especially important towards people with mental changes and their relatives.

The disclosure of information, even accidentally, about the person concerned, his or her illness or behavioural abnormalities can lead to social **stigmatisation** and are embarrassing, unpleasant and to be avoided for both the person concerned and his or her family.

10.2.1 What is Covered by Confidentiality?

As a rule, there is an obligation of confidentiality with regard to what was entrusted to the person obliged or otherwise became known to him or her in his or her professional capacity. This applies, for example, in the medical field to all personal data and facts.

Protected data

- The fact that there is a treatment relationship with a specific person at all
- The type of injury or illness
- The course of the accident or illness
- The results of the examination, diagnosis and (suspected) diagnosis
- The measures taken
- All other information that became known to the helper during the treatment relationship, e.g. living and life situation, addiction, sexual preferences, financial situation, physical hygiene

This applies, as far as the details allow conclusions to be drawn about a specific and thereby identifiable person, and also beyond the death of the patient.

10.2.2 To Whom does Confidentiality Apply?

Confidentiality applies to everyone. These are, for example, also relatives of a person concerned, professional colleagues and superiors of the person obliged, as far as they are not themselves involved in the processing of the specific case of the person concerned, beyond that the own friends and family members of the obliged person, the mass media and depending on legal regulations also towards police, public prosecutor and courts.

10.3 Important Legal Regulations

10.3.1 Long-term Care Insurance

With regard to the financing of care services, basic knowledge of social legislation is necessary for the dementia companion.

The provisions of the Social Code SGB XI form the basis of the activity of the dementia companion.

The long-term care insurance regulates in principle different entitlements to benefits.

§ 28 types of benefits, principles

The long-term care insurance grants the following benefits:

1. In-kind care benefit (§ 36)
2. Care allowance for self-procured care helpers (§ 37)
3. Combination of cash benefit and in-kind benefit (§ 38)
4. Home care in case of prevention of the care person (§ 39)
5. Care aids and measures to improve the living environment (§ 40)
6. Day care and night care (§ 41)
7. Short-term care (§ 42)
8. Full-time care (§ 43)
9. Care in full-time facilities for assistance to disabled people (§ 43a)

9a. Additional care and activation in stationary care facilities (§ 43b)

10. Benefits for social security of caregivers (§ 44)
11. additional benefits for care leave and short-term work interruption (§ 44a)
12. Care courses for relatives and voluntary caregivers (§ 45)

12a. Conversion of the outpatient benefit in kind (§ 45a)

13. Relief amount (§ 45b)
14. Benefits of the personal budget according to § 29 of the Ninth Book
15. additional benefits for care recipients in ambulatory assisted living groups (§ 38a).

The benefits should be known to the dementia companion, because besides the now generally known care allowance,

care recipients receive further benefits (see above) from which tasks for dementia companions can arise:

- All care recipients with the care levels 1 to 5, who are cared for in the home environment, have a claim to the relief amount (125, - €). The relief amount is intended to relieve the caring relatives (temporal and emotional relief) and at the same time—by carrying out activities such as reading, walking etc.—to increase the well-being of the care recipient.
- In addition, persons from care level 2 in the outpatient area can use 40% of unused benefits in kind for relief services. This means that more money is available to each person affected for support in everyday life (e.g. taking over care).
- Furthermore, benefits for day or night care, which correspond to the care in kind (Table 10.1), can be fully exhausted in addition to care allowance or outpatient care in kind. This makes the visit of a day care center affordable for many people and can also create areas of responsibility for dementia companions.
- In addition, residents of ambulatory shared apartments receive an amount of up to 214 EUR per month under certain conditions, in order to finance a person who supports them in organizing their cohabitation and thereby facilitates their independence and autonomy. This task could be performed by dementia companions.

Table 10.1 Care allowance and care in kind

Care level	Care allowance (EUR)	Care in kind (EUR)	Degree of independence
1	0	0	Minor impairments of independence or abilities
2	316	689	Significant impairments of independence or abilities
3	545	1298	Severe impairments of independence or abilities
4	728	1612	Most severe impairments of independence or abilities
5	901	1995	Severe impairments of independence or abilities with special requirements for nursing care

Care allowance and in-kind benefit according to PSG 2

10.3.2 Care Strengthening Acts 1 and 2

Since the beginning of 2017, the second Care Strengthening Act (PSG) has been in force with improved benefits for people in need of care. Also, since the PSG II came into force, the existing independence of an applicant for care benefits is decisive for whether he or she receives benefits from the long-term care insurance or not.

Specifically, an expert opinion determines how independently a person can cope with their everyday life, what abilities they still have and how much they depend on nursing help from others. Physical, mental and psychological limitations are equally recorded. On the basis of the determined remaining independence, the person concerned receives one of the care levels 1, 2, 3, 4 or 5.

The **degree of independence** (► Chap. 5) is measured in six different modules and – with different weighting – combined into an overall assessment. This results in the classification into a **care level**. The six areas are:

1. Mobility
2. Cognitive and communicative abilities
3. Behavior and psychological problems
4. Self-care
5. Coping with and independent handling of disease- or therapy-related requirements and burdens
6. Design of everyday life and social contacts

► Example

The module 1 Mobility, for example, provides information on how independently someone can move over short distances and maintain a stable sitting position.

Mrs. Maier has Parkinson's and dementia. The Parkinson's disease and also the dementia are progressing. Her daughter takes care of her at home. For some time now, she has to support and accompany her mother on every short distance (e.g. to the kitchen/bathroom), because she has a shuffling gait and threatens to fall. Mrs. Maier is therefore "predominantly dependent" when walking. If she has to be pushed by her daughter in a wheelchair at some point, she would be "dependent" in the criterion "walking". However, once she arrives in the kitchen/bathroom, she can sit well and stable on the kitchen chair/toilet, without threatening to tilt to the side. In this posture, she is therefore "independent". ◄

Dementia companions may spend a lot of time with a person in need of care in different activities. They know where

the person has so far needed no or little support. A good observation skill is necessary to perceive changes in the abilities.

> The companion should always inform the responsible facility management about perceived changes.

The higher a level of care is, the more dependent the person concerned is assessed by experts and the more benefits he receives from his nursing care fund (Table 10.1).

10.4 Crimes Against Life

When accompanying and caring for someone, there is a risk of unintentionally committing a crime against life. Therefore, examples from the nursing field are listed here, which fall under § 223 "Bodily injury" of the Criminal Code (StGB) or § 323 "Failure to render assistance" StGB and can result in punishment.

Examples of crimes against life

- The delegation of treatment-related nursing measures, such as injections or bandage changes, to nursing assistants constitutes an incitement to bodily harm.
- The administration of medication without a doctor's order can mean intentional or negligent bodily harm, especially when giving psychotropic drugs or other drugs with significant side effects. Also, an accidental medication mix-up, the refusal of medication administration by the nurse, or the incorrect dosage corresponds in principle to bodily harm.
- An improper wound care is also a form of bodily harm.
- An employee of a nursing facility is attacked by the patient when entering the room, as he does not recognize her. He screams loudly and starts to strangle her. The caregiver kicks the patient to free herself. A witness notices the screaming and gets help. Both parties suffer minor injuries. Bodily harm by the patient is not present in this case, as he is not culpable or diminished culpable due to mental disorder. Also, the caregiver cannot be prosecuted for bodily harm, because she acted in self-defense in this situation.
- The disregard of hygiene regulations can fulfill the offense of bodily harm, if it causes health damage. The staff of a nursing home wash their work clothes in the domestic washing machine. The family of an employee is infected

with a norovirus, which leads to a transmission to several patients.

- Malnutrition and dehydration as a result of inadequate care correspond to a crime against physical integrity. Due to lack of time, a patient who can no longer independently take food was not sufficiently supplied with food and liquid for a longer period of time. A clear documentation in the nutrition and fluid protocol was not available. In this case, the offense was not bodily harm, but mistreatment of wards, as the patient was given food and liquid against her will by pinching her nose. In addition, in this case, the offense of failure to render assistance is also given.
- A missing or incomplete documentation can also lead to the accusation of bodily harm. A deficient entry in the positioning protocol with simultaneous occurrence of a decubitus ulcer leads to the fact that the correct and professional execution of the **decubitus prophylaxis** cannot be proven. Since in this case a reversal of the burden of proof occurs, measures that are not documented are considered not performed.

The Civil Code also contains statements that influence the activity of the dementia companion. The legal basis of legal guardianship was created in Germany by the Guardianship Act, which came into force on January 1, 1992.

10.5 Legal Guardianship

The legal guardianship is essentially regulated in the §§ 1896 ff. of the Civil Code (BGB).

If an adult is unable to manage his or her affairs due to a mental illness or a disability, a guardian is appointed by the guardianship court upon request. The person concerned must be heard by the judge beforehand. A guardian may only be appointed for the areas in which the guardianship is necessary. It is not necessary if the matters can be regulated by an authorized representative.

Areas of responsibility of the guardian

- Health care, personal care
  - Medical care
  - Initiation and consent to therapeutic measures
  - Consent to operations
  - Information of the guardian about the effects and side effects of medications by the doctor

The institution should establish a procedural rule for this case to clearly define competence and responsibility.

- Asset management
  - Assertion of income claims
  - Application for pension
  - Application for benefits from the health or nursing insurance
  - Tax return
  - Debt settlement
  - Cash management
- Determination of residence
  - Housing matters
  - Determination of the center of life
  - Consent to placement

For the dementia companion, it is important to know exactly who is responsible for which area in case of decisions that fall within the authority of the guardian, so that they can be contacted immediately in an emergency, such as a necessary hospital admission.

At this point, conflict situations in dealing with the legal guardianship are exemplarily presented, in order to achieve an increased sensitivity for this area as well.

► Example

Mr. Volk is 82 years old and lives in his own small apartment in the neighborhood of his youngest daughter. She takes care of Mr. Volk several times a day and is also his legal guardian for financial matters. The patient has two more children, a daughter who lives several hundred kilometers away, and a son who lives nearby and who has taken over the guardianship for health care and residence determination.

Two weeks ago, Mr. Volk fell in his apartment and suffered a fracture of the femoral neck. The daughter, who wanted to check on him shortly afterwards, immediately arranged for a hospital admission. However, complications occurred during the surgery, so that Mr. Volk currently has to be treated for respiratory insufficiency in the intensive care unit. Due to multiple pre-existing conditions, the ward doctor has a conversation with Mr. Volk's daughter and son to inform them about a possible resuscitation. However, the daughter and son have different views, with the daughter advocating resuscitation and the son, who exercises the guardianship for health care, rejecting resuscitation. Even after consulting the daughter who lives far away, no agreement can be reached. ◄

Similarly, the existence of a power of attorney or a living will influences the decision-making process in dealing with people with dementia, mentally ill and intellectually disabled.

10.5.1 Power of Attorney

With the power of attorney, a representation authority is transferred directly to the attorney-in-fact. The principal determines in healthy days that the attorney-in-fact is authorized to act on his behalf. The exact legal provisions for the power of attorney are regulated in the BGB (German Civil Code).

For a better understanding, a conflictual example situation is also described here.

► Example

Mrs. Meyer lives in an assisted living facility, as she could no longer cope at home. She has given a general power of attorney to her two children, as she trusts them fully. The daughter goes to the bank once a week and withdraws an agreed amount of money from Mrs. Meyer's account. Mrs. Meyer has disposal over this money, similar to pocket money. For several weeks, however, the daughter has noticed that Mrs. Meyer has additionally withdrawn larger amounts from her account, although she has not made any major purchases.

Mrs. Meyer's children are very surprised by this, but in a conversation with their mother, they find out that Mrs. Meyer has given away large sums of several 1000 EUR to other residents and to the nursing staff of the assisted living facility. Both children are therefore very worried about their mother's financial future. However, she assures them that she has given away the money of her own free will and wants to keep it that way. The authorized representatives are not entitled to act against the mother's will in this case. They apply to the guardianship court for a legal guardianship for financial matters. ◄

Even more difficult is the decision-making process when a living will is available. The legal situation was changed again on September 1, 2009.

10.5.2 Advance Directive

An example on the topic of decision-making at the end of life is described here, as the significance and validity of advance directives have repeatedly led to problems.

Advance directive

An advance directive is a precautionary expression of will. It contains not only values and wishes, but also provisions for treatment measures.

The advance directive becomes effective when the person concerned is no longer able to directly express his or her necessary consent or refusal to a treatment measure. An advance directive must be written.

The existence of an advance directive can lead to disagreements and doubts among the persons involved in the care.

► Example

Mrs. Bayer is 94 years old and lives with her son, his wife and two adult grandchildren in a house. For eight years, she has also been cared for by an outpatient nursing service, which now comes by three times a day. The basic care in the morning is mostly performed by nurse Silvia. She has been coming regularly to Mrs. Bayer for several years and has a warm, familial relationship with her and her relatives.

In the last few months, the patient's physical condition has deteriorated massively, and there was suspicion of a tumor disease. Mrs. Bayer and her family declined further diagnostics because of her old age and the already limited general condition. Instead, Mrs. Bayer wrote an advance directive of her own free will and in a state of mental health, in which she expressly rejects hospitalization, resuscitation, artificial nutrition, and infusion and antibiotic therapy. The family supports her decision and shares it with the treating physician and the outpatient nursing service. Sister Silvia and her colleagues can understand Mrs. Bayer's motives.

Mrs. Bayer's condition worsens dramatically and she becomes increasingly somnolent, so that adequate fluid supply is no longer guaranteed. In addition, a beginning pneumonia with elevated temperatures occurs. Meanwhile, Silvia doubts Mrs. Bayer's decision. She wonders whether an antibiotic administration and an infusion therapy might be indicated, and discusses this with her colleagues in the team meeting. However, they unanimously agree that this procedure corresponds to Mrs. Bayer's wishes and is therefore justified. After almost six weeks, Mrs. Bayer dies in the circle of her relatives. ◄

The problem of deprivation of liberty is also significant for the dementia companion, when affected persons participate in the care situation with restraint belts and other measures or want to leave during the measure.

10.6 Deprivation of Liberty

The legal basis of deprivation of liberty is presented here. The freedom of every human being is guaranteed by the Basic Law (GG):

- (1) Everyone has the right to the free development of his personality, as long as he does not violate the rights of others and does not act against the constitutional order or the moral law.
- (2) Everyone has the right to life and physical integrity. The freedom of the person is inviolable. These rights may only be interfered with on the basis of a law (GG Art. 2).

This freedom guaranteed by the Basic Law can only be restricted in accordance with the provisions of the guardianship law of the BGB § 1906 or if there is a justified state of emergency, which means a situation of self-defense, to avert harm from others or the person concerned (§ 34 StGB).

The § 1906 BGB deals with the **confinement** of the person under guardianship in a facility that is associated with deprivation of liberty. This can only be arranged by the guardian if certain conditions are met.

Conditions for a confinement

- Due to a mental illness or intellectual or emotional disability of the person under guardianship, if there is a danger that he will kill himself or cause significant health damage to himself.
- If an examination of the health condition, a medical treatment or a surgical intervention is necessary, which cannot be carried out without the confinement of the person under guardianship, and the person under guardianship cannot recognize the necessity of the confinement or act according to this insight due to a mental illness or intellectual or emotional disability.

10.6.1 Restriction of Freedom by Mechanical Devices

There is a variety of aids on the care market that serve to restrict freedom by mechanical devices. These are devices that are attached to the bed, chair or wheelchair of the patient.

Mechanical devices

- Bedside part/bedrail
- Protective blankets, bed sheets
- Abdominal belts
- Hand, foot or shoulder straps
- Therapy tables for chair or wheelchair

10.6.2 Closed Accommodation

Locking up in the apartment, in a closed living area or in a room counts as one of the measures that deprive freedom, which may only be carried out with a legitimation.

Other methods that are intended to prevent the patient from leaving a room, such as taking away shoes, clothing, glasses, wheelchair, walker or other aids, also fall into this area.

If the person concerned is not capable of consenting, as is very often the case with people with dementia, a judicial authorization must be obtained in any case. This is usually limited in time and must therefore be extended as necessary. The application must be made by the legal guardian.

Practical tip

Alternatively, electronic aids can be used that reliably indicate the leaving of the apartment or the facility. These are offered in the form of arm or foot bands or chips to sew into the clothing and work by radio waves or satellite technology.

The advantage of the GPS system is the easier finding of the person concerned, as the system determines the location if necessary and sends it, for example, as an SMS. This is also a freedom deprivation that requires authorization.

10.7 Protection Against Infection Act

The Protection against Infection Act (IfSG) replaced, among others, the Federal Epidemic Act and the Act on the Control of Sexually Transmitted Diseases as of 01.01.2001.

- § 1 Purpose of the Act
  (1) The purpose of the Act is to prevent communicable diseases in humans, to detect infections at an early stage and to prevent their further spread.

The section "Hygiene in outpatient and inpatient care for the sick and elderly, rehabilitation" of the German Society for Hospital Hygiene (DGKH) also demands, due to the increasingly problematic conditions in care facilities, the establishment of hygiene officers with qualified further training in all care facilities.

The task of the hygiene officer is to develop the internal hygiene plan of the facility and to regularly monitor the compliance with the hygienic regulations. The hygiene officer also has an advisory function for all staff members, if problems or uncertainties arise regarding hygiene.

For the occurrence of various infectious diseases or **parasites**, action plans should be available, which are immediately accessible in case of an acute situation and enable each staff member to react timely and adequately to the infection. These action plans should either be handed out directly to each staff member or be kept in the ward rooms, as some diseases require an immediate reaction.

Action plans

- Diarrheal diseases, especially norovirus
- Influenza or new flu
- Lice infestation
- Scabies (itch)
- Multiresistant pathogens MRE, e.g. MRSA, ESBL

Cooperation

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S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_11

» There are people who want to be carried on the shoulders of their fellow human beings. But these people overlook that we can only move forward if we support and help each other. (Henry Ford II)

In the Nursing Care Development Act was the activity of the dementia companion or the additional care staff in a guideline in August 2008 newly created and defined more precisely. The guideline makes clear statements about the tasks and qualifications of these employees, in order to improve the care situation of people with dementia-related impairments, mental illnesses or intellectual disabilities in the sense of § 45a para. 1 SGB XI. The cooperation of the dementia companion within the facility is not specified in more detail in this guideline. The facility itself determines which organizational structure it chooses for this purpose. To ensure the most comprehensive care possible for people with limited everyday competence, the cooperation in the team and with relatives must be clearly regulated. Responsibilities, accountability, contact persons and areas of responsibility should be visible in a job description for each employee.

11.1 Cooperation in the Facility

In order to enable good cooperation between the different professional groups within a nursing facility, each employee must know exactly which tasks he or she takes on, which responsibility he or she has and which position within the organization he or she is subordinate or superior to.

The exact knowledge of the organizational peculiarities of a nursing facility is therefore important for the dementia companion. This structure exists in a clear form through the organigram of the nursing facility, which can usually be found in the quality management manual.

11.1.1 Organizational Structure

The **organizational chart** contains statements about the structural organization of a company and should be known to every employee. At this point, only the individual organizational units are listed, since the structural organization differs considerably from institution to institution.

Organizational units

- Management, e.g. managing director, home manager
- Nursing area with nursing service management (PDL), residential area management (WBL) and shift management (SL)

- Housekeeping with housekeeping management (HWL)
- Technology with technical manager
- Department of occupational therapy
- External cooperation partners, e.g. laundry, pharmacies, medical supply stores, catering
- Volunteer staff
- Home council

The more precisely the organizational structure is defined, the easier the daily cooperation of the different professional groups works. The quality management manual therefore also contains clear guidelines on the topics of communication, information transfer and documentation (▶ Chap. 5) as well as on the concept of care.

However, the result also depends on the self-understanding of the individual professional groups. Since the profession of dementia companion is still relatively new, there is no uniform picture yet. However, the initial skepticism has meanwhile turned into a positive attitude towards the additional care.

11.1.2 Responsibility

Within this framework, the dementia companion takes on tasks that are precisely defined in the care staff directive.

Tasks of thedementia companion

- Painting and crafting
- Handicrafts and light gardening
- Feeding and caring for pets
- Cooking and baking
- Making memory albums or folders
- Listening to music, playing music, singing
- Board and card games
- Walks and excursions
- Movement exercises and dancing in a group
- Visiting cultural events, sports events, church services and cemeteries
- Reading and reading aloud
- Looking at photo albums
- Being available for conversations

Care and activation offers should be based on the expectations, wishes, abilities and feelings of the residents, taking into account their respective biography, possibly including their **migration background**, gender and the respective situational **context**.

In order to fulfill these tasks, the dementia companion needs important information about the affected persons (▶ Chap. 5) and about the conditions within the facility.

The following questions must be clarified in advance

- What tasks does the dementia companion perform?
- What materials are available?
- What rooms can be used?
- How does the material procurement work?
- Is there a financial budget for the materials?
- How does the cooperation with other departments, e.g. occupational therapy, nursing, housekeeping, work?
- Who picks up and brings the participants?
- Which authority is superior?
- Who are the responsible contact persons and how can they be reached?
- How is information passed on?
- What meetings take place and who participates in them?
- Who is responsible for documenting the measures (Appendix 3, 4 and 5)?

To answer these questions comprehensively and document the result, there is a form in the appendix as a guide for preparing and reflecting on the internship and the activity of the dementia companion (Appendix 7).

11.1.3 Job Description

The tasks of the dementia companion are defined in the care staff directive, but it is still useful to record these tasks in a **job description**. For the preparation of the internship, the job description can be a significant relief.

Of course, the dementia companion must know the contents of the job description at the beginning of his or her activity.

11.1.4 Concept

Every care facility should create a concept for the different areas of service delivery. This includes more detailed information on the objectives, the personnel resources, the implementation of the services and the review of the outcome quality. It is always advantageous if the people who provide the service are directly involved in the development of the concept.

At this point, possible contents of the concept "Additional Care" are listed. Further concepts that may be important for the dementia companion are the areas of "Care", "Milieu Design" and "Family Work".

Care and Activation Concept

- Mission statement of the facility and, if applicable, of the care
- Goals of the care
- Eligible persons
- Tasks of the care
- Services
- Induction
- Documentation
- Training
- Special features, for example immobile residents, protected living areas

11.2 Cooperation with Relatives

Apart from the **cooperation** within the facility, the collaboration and contact with relatives are important factors to enable a successful accompaniment. However, as an employee of a care facility, one often has the feeling that relatives behave critically, observantly and reproachfully.

> One must always bear in mind that it means a tremendous psychological burden for relatives to give the affected person into "strange hands", with the feeling of neglecting one's own responsibility and losing control over the condition of the affected person.

A **constructive** cooperation with relatives is therefore only possible if the dementia companion understands the emotional situation of the relative and tries to involve relatives and reference persons in activities and decisions.

> Regular activities, conversations, events and surveys with staff, affected persons, relatives and reference persons are a prerequisite for an open exchange of opinions, creative ideas and the possibility to express constructive criticism and work out improvement suggestions together.

Possible activities that promote cooperation with relatives are described in ▶ Chap. 6 "Care" (▶ Chap. 6).

Another important factor is the support of the work with relatives, which is usually planned by the facility management. Dementia companions can also actively participate in

this, as the understanding of relatives and reference persons for measures increases when they are well informed. The attitude towards the disease picture can also be improved by a targeted work with relatives, whereby the exchange of reference persons among each other can also be promoted.

► Example

At a relatives' evening on the topic of "activation", the various materials are arranged on tables according to topics, the relatives can touch and try out, the companion answers questions and guides. At a relatives' evening on the topic of "aids", relatives can try out a wheelchair course and get to know other aids. A "wheelchair driver's license" can also convey security.

At a relatives' evening on the topic of "dementia", relatives are allowed to change perspective and put themselves in the shoes of a person with dementia: Imagine you want to fly on vacation and accidentally land in China. At the airport, you approach the friendly lady at the information desk, as you don't know where you are and where you can go. She smiles at you kindly and explains the way to you in a completely incomprehensible language. ◄

You as a caregiver and relatives as well as reference persons can develop more empathy and understanding for the person with dementia and for each other through direct experiences.

A way of dealing that is characterized by understanding and openness facilitates the cooperation with all persons involved in the care.

Outlook

S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2_12

As mentioned at the beginning, the use of trained dementia companions has become a success story. In the last 4 years, many additional care workers have been trained and have found employment in nursing homes. The expert report of the IGES Institute commissioned by the GKV-Spitzenverband (National Association of Statutory Health Insurance Funds) in December 2011 comes to the conclusion that the additional care has improved the overall care of the people in need of care. However, not only the cared for, but also the care workers benefit from their use. The cooperation between care and nursing staff is perceived as enriching by both sides according to the IGES study.

Many outpatient care services today offer the care of people with dementia not only to promote their well-being and to activate the affected people, but also to relieve the relatives. The demand for this service is high and many trained care workers have today found a secure job in outpatient care.

With the Care Strengthening Act, which came into force in January 2015, people with dementia receive higher benefits from the long-term care insurance. This could be an opportunity for trained care workers to offer care also in self-employment.

Further information is provided by the Federal Association of European Care and Nursing Workers BEBP, which among other things, advocates for the interests of care workers.

Practical tip

Important for the way into self-employment is also a targeted marketing, for example via local newspapers, flyers, contacts to care support points, general practitioners, hospitals and other service providers in the health care sector as well as the cooperation with the city administration.

According to current estimates, around 1.7 million people with dementia live in Germany today. Because the population is generally aging, this proportion could more than double by 2050. Many of the affected people will live in nursing homes, as dementia has become the most important reason for entering a home. However, the majority of people with dementia will still live in their own apartment in Germany, sometimes alone or cared for by family members. Also, new forms of living, such as shared apartments, house communities, neighborhood-based care, day or night care up to so-called

dementia villages will further develop. Dementia companions with a qualified training are and will be in demand. We are very pleased if this book can support you in the training and as a reference work.

Service Part

S. Schmidt and M. Döbele, *Dementia Companion*,
https://doi.org/10.1007/978-3-662-67042-2

Appendix

A1. Cohen-Mansfield Scale

Cohen-Mansfield Agitation Inventory (CMAI)

Instructions: For each of the behaviors below, check the rating that indicates the average frequency of occurrence over the last 2 weeks.

Behavior	Never 1	Less Than Once a Week 2	Once or Twice a Week 3	Several Times a Week 4	Once or Twice a Day 5	Several Times a Day 6	Several Times an Hour 7
1. Hitting (including self)	❑	❑	❑	❑	❑	❑	❑
2. Kicking	❑	❑	❑	❑	❑	❑	❑
3. Grabbing onto people	❑	❑	❑	❑	❑	❑	❑
4. Pushing	❑	❑	❑	❑	❑	❑	❑
5. Throwing things	❑	❑	❑	❑	❑	❑	❑
6. Biting	❑	❑	❑	❑	❑	❑	❑
7. Scratching	❑	❑	❑	❑	❑	❑	❑
8. Spitting	❑	❑	❑	❑	❑	❑	❑
9. Hurt self or others	❑	❑	❑	❑	❑	❑	❑
10. Tearing things or destroying property	❑	❑	❑	❑	❑	❑	❑
11. Making physical sexual advances	❑	❑	❑	❑	❑	❑	❑
12. Paces, aimless wandering	❑	❑	❑	❑	❑	❑	❑
13. Inappropriate dress or disrobing	❑	❑	❑	❑	❑	❑	❑
14. Trying to get to a different place.	❑	❑	❑	❑	❑	❑	❑
15. Intentional falling	❑	❑	❑	❑	❑	❑	❑
16. Eating/drinking inappropriate substances	❑	❑	❑	❑	❑	❑	❑
17. Handling things inappropriately	❑	❑	❑	❑	❑	❑	❑
18. Hiding things	❑	❑	❑	❑	❑	❑	❑
19. Hoarding things	❑	❑	❑	❑	❑	❑	❑
20. Performing repetitious mannerisms	❑	❑	❑	❑	❑	❑	❑
21. General restlessness	❑	❑	❑	❑	❑	❑	❑
22. Screaming	❑	❑	❑	❑	❑	❑	❑
23. Making verbal sexual advances	❑	❑	❑	❑	❑	❑	❑
24. Cursing or verbal aggression	❑	❑	❑	❑	❑	❑	❑
25. Repetitive sentences or questions	❑	❑	❑	❑	❑	❑	❑
26. Strange noises (weird laughter or crying)	❑	❑	❑	❑	❑	❑	❑
27. Complaining	❑	❑	❑	❑	❑	❑	❑
28. Negativism	❑	❑	❑	❑	❑	❑	❑
29. Constant unwarranted request for attention or help	❑	❑	❑	❑	❑	❑	❑

Name of Rater:

Name of Primary Caregiver/Informant:

Note: This is the nursing-home, long version of the Cohen-Mansfield Agitation Inventory. For definitions of the behaviors, administration, scoring information, and other versions, please consult the manual.

A2. Mini-Mental Status-Test (MMST)

Mini-Mental Status Test (MMST)

The MMST allows an estimation of the cognitive abilities of an elderly person by means of a simple questionnaire. It covers e.g. orientation, memory, attention and arithmetic, language and constructive practice.

1. Test duration	**approx. 10 minutes**
2. Evaluation	**Simple addition of the given points**
3. Interpretation	**30-27 points** **no dementia** **26-18 points** **mild dementia** **17-10 points** **moderate dementia** **≤ 9 points** **Severe dementia**

Mini-Mental Status Test (MMST)

....

Name and first name of the patient *Date*

1. Orientation

What year are we living in?

What season is now ?

What is the date today?

What month is it ?

Which state are we in here?

In which country?

In which locality?

Where are we (in which practice / nursing home)?

On which floor?

2. Retention

Ask the patient if you may test his memory. Then name three different things clearly and slowly (approx. 1 per sec) "lemon, key, ball". After you have said all three words, have the patient repeat them. The first repetition determines the score (award one point for each repeated word), but repeat the attempt until the patient can repeat all three words. There is a maximum of 5 attempts. If a patient does not learn all three words, recall cannot be meaningfully tested.

Points 0-3 ☐

3. Attention and calculation

Ask the patient to count backwards in increments of 7 starting at 100. Stop after 5 subtractions (93, 86, 79, 72, 65) and count the answers given in the correct order. Then ask to spell the word "prize" backwards. The score corresponds to the number of letters in the correct sequence (e.g., SIERP=5, SIREP=3). The higher of the two scores is counted.

Points 0-5 ☐

4. Remember

Ask the patient if he remembers the words he was supposed to memorize earlier. Give one point for each correct word.

Points 0-3 ☐

5. Repeat

Show the patient a wristwatch and ask him what it is. Repeat the task with a pencil. Give one point for each part of the task completed.

Points 0-3 ☐

6. Three part command

Ask the patient to repeat the expression "No ifs, no buts". Only one attempt is allowed.

Points 0-1 ☐

7. Three part command

Have the patient perform the following command. " Take a sheet in your hand, fold it in half, and place it on the floor." Give one correct point for each correctly performed command.

Points 0-3 ☐

8. React

Write on a white sheet in large letters: "Close your eyes". Have the patient read and perform the text. Give a point when the patient closes his eyes.

Points 0-1 ☐

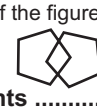
9. Writing

Give the patient a white sheet on which to write a sentence for you. Do not dictate the sentence, it should be written spontaneously. The sentence must contain a subject and a verb and make sense. Concrete grammar and punctuation are not required.

Points 0-1 ☐

10. Sign off

On a white sheet, draw two intersecting pentagons and ask the patient to draw the figure accurately. All 10 corners must be present and 2 must intersect to count as one point. Trembling and twisting of the figure are not essential.



Points 0-1

Sum of points ..... ☐

A3. Care Documentation

Care documentation

Name _____ born _____ Month _____ 20 _____

Issues and Resources:

Goals: Near-term goal/long-term goal/goals of the resident:

Measures:

Outcome and Evaluation:

Care documentation

Name _____ born _____ Month _____ 20 _____

Activity	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Walk																															
Excursion																															
10 minutes activation																															
Individual support																															
Cooking group																															
Baking group																															
Creative group																															
Memory training																															
Concentration training																															
Sit dance/sit gymnastics.																															
Dance																															
Sports group																															
Movie night																															
Night Café																															
Memory work																															

Care documentation

Name _____ born _____ Month _____ 20 _____.

Date	Report	Hz

A4. Recording Sheet for Care and Performance Verification of Additional Care Offers

Data entry form for care and proof of performance for additional care services

Data entry sheet care

Name _____ First Name: _____

Main Objective: _____

Date	Employment areas preferred	Employment areas not preferred	HZ

Date	What is needed (material, food, etc.)	HZ

Date	Other remarks / evaluation	HZ

Care documentation

Please sign off with hour (e.g., 1 or 1.5) (above) and hand sign abbreviation (below) for service rendered.

Support services	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Biography and memory work																															
Employment offer																															
Promotion of the movement																															
Targeted memory training																															
Promotion of existing skills																															
• manual / household																															
• social																															
• professional																															
• musical / artistic																															
Promotion of mental stimulation																															
Meeting with other people																															
Visit of cultural offers																															
Basal stimulation																															

Qualification	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Nursing Specialist																															
Supplementary assistant																															

Date / Signature of nursing management

Date / Signature of relatives

A5. Action Plan

Action Plan

Preparation of activities

What activities should be prepared?

Activity _____

Activity _____

Activity _____

Replacementactivities _____

Replacement activities _____

What to consider in the preparation?

☐ **Time frame**

_____

☐ **Number of participants**

_____

For outdoor activities:

☐ **Transportation**

_____

☐ **Additional accompanying persons**

_____

☐ **Wheelchair cab**

_____

☐ **Weather(forecast)**

_____

For indoor activities:

☐ **Space suitable and free**

_____

For outdoor and indoor activities:

☐ **Incontinent material**

☐ **Food order: provisions/lunch packs**

☐ **Drinks**

☐ **Participants with diet**

☐ **Participants with assistance with food intake**

☐ **Cooking or baking ingredients order**

☐ **Purchase money**

Follow-up

☐ **Documentation**

1. Care sheet
2. Care Report

Notes

Rating

Measure was suitable?

Participants were motivated?

Improvements/changes if the measure is repeated :

A6. Quick Help in an Emergency

Report
WHO– Injured persons, age, gender
WHEN– Day, time
WHAT– Course of events
WHERE– exact location
WHICH SYMPTOMS

Tab. A.1 Emergency call

Emergency service/Ambulance	Places	☎
Medical on-call service		116 117
Police		110
Fire brigade		112

Report
WHO– Injured persons, age, gender
WHEN– Day, time
WHERE– exact location
WITH WHAT– Name or type of substance or preparation (on the packaging, label)
HOW– Course of poisoning (oral, inhaled)
HOW MUCH– Amounts in ml, g, spoon, number of tablets or berries

Tab. A.2 Poison control centers

Emergency service 24 h	Places	☎
	Berlin	030–19240
	Bonn	0228–19240
	Erfurt	0361–730730
	Freiburg	0761–19240
	Göttingen	0551–19240 0551–3831 80 (for doctors)
	Homburg/Saar	06841–19240
	Mainz	06131–19240
	Munich	089–19240

A7. Preparation for the Practical Course

Preparation for the internship

Application and interview

- ☐ Resume
- ☐ Testimonials
- ☐ Possibly documents from the employment agency
- ☐ Health certificate, company doctor, vaccinations
- ☐ Declaration of confidentiality

Internship start

- ☐ Resume
- ☐ Testimonials
- ☐ Possibly documents from the employment agency
- ☐ Health certificate, company doctor, vaccinations

1. What are the tasks of the dementia companion

2. What materials are available?

3. Which premises can be used?

4. How does material procurement work?

5. 1st financial budget available for the materials?

6. How does the cooperation with other departments work, e.g. occupational therapy, nursing, housekeeping?

7. Who picks up and brings the participants?

8. Which office is over bergeordnet?

9. How is information forwarded?

10. What meetings are held and who attends them?

11. Who is responsible for documenting the measures?

12. Who are the responsible contacts and how can they be reached?

Who is responsible for documenting the measures?

Facility Management
contact person _____ ☎ _____

Personnel management
contact person _____ ☎ _____

Company doctor
contact person _____ ☎ _____

Occupational Therapy
contact person _____ ☎ _____

Home economics
contact person _____ ☎ _____

Nursing service
contact person _____ ☎ _____

Volunteer
contact person _____ ☎ _____

Home Advisory Board
contact person _____ ☎ _____

Reflection of the internship

- ☐ How strenuous and stressful was the work for me?
- ☐ Which aspects were positive and enjoyable?
- ☐ What did I particularly enjoy doing?
- ☐ How was the cooperation with other professional groups?
- ☐ How was the cooperation with relatives?
- ☐ How did you deal with the people affected?
- ☐ Where were there problems?
- ☐ Were there any situations I couldn't handle?
- ☐ Was there any positive feedback?
- ☐ Could I see myself doing this job for a longer period of time?

Glossary

abnormal different from what is generally considered normal, going beyond the normal.

abstract detached from the concrete, from the tangible.

ability to abstract ability to emphasize the general aspects of things and thus bring order and overview into the diversity of being, thinking process of omitting details and transferring to something more general or simpler.

affect emotional arousal, expression of feelings of a person to the outside.

aggressive prone to attack, quarrelsome, hostile behavior.

agitation pathologically increased, unproductive motor activity (restlessness) of a patient.

everyday competence ability of an adult to perform the daily tasks within his or her culture independently and autonomously in a self-responsible way.

amino acids simplest building block of protein bodies.

analysis holistic, systematic examination, in which the examined object or subject is dissected and broken down into its components and these are then arranged, examined and evaluated.

analyze examine in detail by breaking down into its components.

aphasia language disorder or speech inability due to injuries in areas of the cerebral cortex.

aromatherapy controlled application of essential oils to maintain one's own and others' health and to influence body, mind and soul in a positive way.

arteriosclerosis (colloquially often also called arteriosclerosis or hardening of the arteries) systemic disease of the arteries (arteries), which leads to deposits of blood fats, thrombi (blood clot), connective tissue and in smaller amounts also calcium in the vessel walls.

Aspiration (colloquially "swallowing") inhalation of body's own secretions (such as mucus) as well as foreign, solid or liquid substances into the airways.

Association conscious or unconscious linking of thoughts

associate establish, link, connect sequences of thoughts.

Movement coordination ability to control movement precisely; this requires the interaction of the central nervous system and the skeletal muscles.

Impairment of consciousness disturbance of consciousness, such as drowsiness; the clarity of consciousness is preserved, but affected persons react more slowly to their environment, thinking and acting are slowed down and also the information intake and processing may be impaired; with progressive disturbance of consciousness, it can lead to coma (see there).

Biography (Greek: life description) recording of the external life course and the inner development of a person, including their works and achievements.

Bobath concept holistic therapeutic nursing care over 24 h for patients with brain or spinal cord damage; named after its developers Berta Bobath and her husband Dr. Karl Bobath.

Body-Mass-Index (BMI) formula for assessing body weight and determining obesity; calculated by dividing a person's weight in kilograms by the square of their height in meters.

Cholesterol belongs to the group of animal fats; it enables the transport and absorption of fatty acids; can crystallize in the gallbladder to form gallstones.

Computed tomography computer-aided X-ray examination, which can make changes in the body visible: tomography means representation in layers or slices, in this case layers of the body or a body section.

Creutzfeldt-Jakob disease (CJD) progressive disease of the brain, in which the brain tissue is damaged by cell loss and protein deposits.

deficit lack or condition of lack.

dehydration, dehydrate drying out; excessive water loss from the body tissue, e.g. by sweating, with disturbance of the electrolyte balance; symptoms: reddened dry skin, "standing" skin folds, dry mucous membrane, possibly with confusion.

decubitus "bedsore", pressure ulcer; a decubitus is a locally limited damage of the skin and/or the underlying tissue, usually over bony prominences, as a result of pressure or of pressure in combination with shear forces. The decubitus is divided into 4 degrees of severity.

decubitus risk risk of getting a pressure ulcer, for example by lying too long on one spot.

decubitus prophylaxis preventive measures against pressure ulcers, especially by pressure relief, mobilization, skin care.

delirium acute mental disorder, which has an organic cause; characteristic is a clouding of consciousness (see there).

demented relating to a mental disorder, in which the cognitive (see there) abilities, e.g. learning, remembering, attention, creativity, are impaired.

depression 1) feelings of sadness, despair and hopelessness, which are in direct relation to a personal loss or a tragedy; 2) abnormal emotional state with inappropriate feelings of sadness, lack of motivation, emptiness and hopelessness.

disorientation state of mental confusion with perceptual disturbances of space, time, identity.

Diabetes mellitus "Sugar disease", (Greek: "honey-sweet flow") is a metabolic disorder, in which either no own insulin is produced anymore (type-I-diabetes), or the sufficiently available insulin cannot be released adequately (type-II-diabetes).

Dysphagia Swallowing disorder; patients usually cannot swallow solid food due to different causes.

Emotion; emotional Mood movement; emotional.

Substitute action Action that replaces the originally intended action, if this cannot be executed due to repression or inhibition.

Evaluation Review, assessment.

existential vital, essential, indispensable.

Expert standard Instrument of quality development at the national level; explains how care standards should/can be structured in the individual institutions of the health care system.

Finger food small snacks that can be eaten without a plate and cutlery and preferably with one bite.

Flexibility here: the adaptability to changing circumstances.

Gangrene Necrosis or tissue death, usually due to insufficient blood supply or after bacterial infection.

Gerontopsychiatry, gerontopsychiatric Examination and treatment of the psychiatric diseases in connection with the aging process and the mental disorders of older people.

Gestures communicative movements especially of the arms and hands.

Hallucination Perception of a sensory area (e.g. hearing), without a stimulus basis being present; i.e. for example, hearing voices without anyone speaking; hallucinations can affect all sensory areas.

HIV infection Disease caused by the**h**uman**i**mmunodeficiency**v**irus (HIV); the HIV virus damages or destroys certain cells of the immune system, making the body unable to effectively fight bacteria, viruses or fungi; this makes one more susceptible to infections that the body would normally cope with easily, as well as certain cancers.

ENT doctor Specialist for ear, nose and throat medicine.

Hygiene Science of preventing diseases and maintaining and strengthening health.

hygienic very clean and without (disease-)germs.

I-messages Statements that communicate one's own opinion and feelings.

Immobile not movable.

Immobility Immobility.

Insulin 1) natural hormone that is produced in the pancreas to regulate blood sugar levels; 2) manufactured as a medication to treat diabetes.

Interaction here: mutually related action of two or more persons.

Interpretation here: the understanding or the explanation, interpretation of the underlying statement.

Interventions Interference (lat. intervenire: to intervene, to interfere).

Intuition; intuitive Ability to gain insights into facts, perspectives, laws or the subjective coherence of decisions without using reason (also gut feeling, knowledge from the unconscious); to act, decide, etc. based on a hunch.

Magnetic resonance imaging Device with a strong magnetic field and radio waves, which can produce cross-sectional images of almost any body region in a short time.

Kinaesthetics Science of movement sensation; describes and analyses the aspects of movement and function; the aim is to support care-dependent people in health promotion, the development of skills for mobilisation.

cognitive Functions of humans that are related to perception, learning, remembering and thinking, i.e. human cognition and information processing.

Carbon dioxide here: used oxygen in the form of carbon dioxide: chemical compound of carbon and oxygen.

Coma State of deep unconsciousness, absent eye reflexes, absent response to pain stimulus; a comatose patient cannot be awakened.

constructive here: adopting a conducive, positive attitude.

Context Connection.

Continence here: Ability to retain bodily excretions.

Concentration here: Attention to a specific activity.

Cooperation Cooperation, interaction.

Creativity creative talent, lat. creare: to create, to produce.

Libido loss Loss of sexual drive, of sexual desire.

Mania (Greek Manía: the frenzy) Disorder, which usually runs in phases and in which the drive and the mood are far above the normal level.

malignant evil.

Medication intoxication Poisoning by medication.

Migration background statistical size for a population group, which consists of persons who immigrated since 1950 and their descendants.

Milieu design holistic view of the living conditions of people with dementia; here not only structural, but also organizational and social requirements are taken into account.

Facial expression; facial Part of the non-verbal communication possibility by visible movements of the facial surface; concerning the facial expression.

mmHg Millimeters of mercury; measure for blood pressure measurement.

motor concerning the movement process.

MRSA Hospital infections, which are caused by**M**ethicillin-**r**esistant**S**taphylococcus**a**ureus strains caused by; Staphylococci are common bacteria that colonize the skin and mucous membranes in particular. The peculiarity of MRSA strains is that they are resistant to the antibiotic methicillin.

Neurotransmitters biochemical substances that transmit information from one nerve cell to another.

Norepinephrine Hormone and neurotransmitter (see there).

Upper body elevation The head of the bed is raised by 30°; the patient is in a sitting or semi-sitting position; for mobile patients for food intake, swallowing training, oral care, better orientation and mobility, easier breathing; disadvantage: strong pressure on the buttocks, shear forces, risk of falling.

Constipation "Constipation"; difficulty in defecation, too little or irregular and hard stool.

olfactory belonging to the sense of smell.

Organigram (organizational chart, organizational diagram) graphical representation of the organizational structure of a company.

Orientation here: cognitive ability to find one's way around in terms of time, place, situation and one's own person.

Estrogen most important female sex hormone.

Panic State of extreme fear of actual or assumed (life-) danger.

Parasites Blackheads or parasites, living beings (worms, insects, arachnids) that live wholly or partly in or on another living being, the host (e.g. the human being).

Parkinson's disease Parkinson's disease with progressive loss of certain cells (dopamine-producing cells) in the brain; as a result, the hormone dopamine can no longer be produced in sufficient quantity; without the right amount of this messenger substance, however, the human being cannot move properly, the consequence is lack of movement or slowness, muscle stiffness and trembling.

PEN "pen" = eng. "fountain pen". Injection aids such as insulin pens or simply pens, serve diabetics to inject their insulin.

Need for care Necessity of nursing care, usually caused by illness, disability or old age; the MDK (see there) determines the need for care at home or in stationary facilities

and assigns it to care levels, which decide on the amount of financial and material benefits.

Nursing documentation written recording of all nursing-specific measures and considerations of a nurse, which are related to a patient.

physiological corresponding to the normal life processes, concerning the physiology.

Pneumonia risk Risk of getting pneumonia. Bedridden people are especially affected.

presenile before old age, introducing old age.

Prevention (lat. praevenire: to anticipate, prevent) preventive measures to avoid an undesirable event or development.

preventive preventive.

Prophylaxis Prevention of secondary diseases, early detection measures.

rational guided by reason and not by feelings.

reflect think about something carefully and intensely, reconsider.

Stimulus here: signal (e.g. noise) from the environment of a living being or from its own organism, which is detected by means of a sensory organ (e.g. ear) or a receptor and triggers a reaction.

Resources Skills and resources that enable the patient to perform everyday activities. These include internal resources, such as motivation, or external resources, such as the social environment.

reversible reversible, can be undone.

Risk assessment Evaluation of hazards.

Rollator Walking aid.

sedating calming or inhibiting drive in relation to the effect of medications.

sensomotor relates to the sensory stimuli (sensory reaction) and the resulting muscle reaction (motor reaction).

Serotonin important messenger substance of the body.

Snoezelen The term is derived from the Dutch snuffelen (sniff = do what you want) and doezelen (doze = relax). It serves to improve sensory perception and relaxation and is usually carried out with the help of music, light effects, gentle vibrations and pleasant smells etc. in specially designed rooms.

Job description Workplace description, written description of a job in terms of its work objectives, tasks, authorities and relationships to other jobs.

Stigmatization characterization of a person or group leading to social discrimination by attributing socially or group-specific negatively evaluated characteristics.

Metabolism Intake, transport and chemical transformation of substances in an organism as well as the release of metabolic end products to the environment.

Fecal incontinence Involuntary discharge of stool.

Fall prevention Nursing measures to prevent falls

Sütterlin script Handwriting developed by Ludwig Sütterlin in 1911.

Supplements Additions, here: dietary supplements.

Symptom In medicine, a sign that indicates a disease.

Symptomatology The totality of the symptoms resulting from a disease process, forms the clinical picture.

Syndrome The simultaneous presence of different symptoms (see there).

Testosterone Sex hormone of both sexes.

Therapeutic Relating to the measures of treatment.

Trauma In medicine, trauma means an injury, damage or wound caused by external force. Here: From a psychological point of view, trauma describes a mental injury resulting from a stressful event.

Triglycerides Dietary fats.

Tumor Growth, swelling.

Ultrasound measurement here: medical examination by sound; the generation of an ultrasound image in medicine is based on the fact that ultrasound irradiated into the body is reflected differently by different tissues; ultrasound allows to quickly obtain information about the tissue structure.

Accommodation in the context of guardianship law, a measure involving deprivation of liberty.

Urinary incontinence involuntary loss of urine.

vascular relating to, or belonging to the blood vessels.

verbal with words, with the help of language.

visual belonging to seeing.

Whole food diet Nutritional concept, in which fresh and untreated foods as well as whole grain products are preferred. A diet is considered whole food if it contains all the necessary nutrients in sufficient quantity, in the right proportion and in the right form. The satiety value of the foods is also taken into account.

Central nervous system (CNS) The CNS comprises the spinal cord and the brain; here, all information from the body and from the environment converge, are processed and reactions in the form of movements, behavior or organ activity are generated.

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