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Canadian Nursing Home
Published quarterly since 1990 by
HMI - Health Media Inc.
Publisher
Agnes Forster
Surrey, British Columbia
(604) 535-7933
Editor
Frank D. Fagan, Guelph, Ontario
E-mail: <ffagan@hotmail.com>
(519) 824-8942
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Surrey, B.C. V4A 9N3
Telephone: (604) 535-7933
E-mail: info@nursinghomemagazine.ca
Website: www.nursinghomemagazine.ca

Canadian Nursing Home . . .

Is directed to the owners, administrators, directors of care, clinical coordinators, nurses and related health care personnel involved in the care of residents in long-term care homes/residential care facilities and hospitals.

Canadian Nursing Home . . .

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One of the early researchers of dementia facility designs, Uriel Cohen, a professor of architecture and director of the Institute on Aging and Environment at the University of Wisconsin, in a review of environments for people with dementia, lamented that the use of outdoor parks, gardens, patios, and courtyards was found to be relatively neglected in environments for people with dementia. “Few facilities,” he said, “considered the outdoors an extension of the indoors or a major activity area integral to the facility program” (Cohen and Day, 1994).

A broad national review of 320 U.S. facilities in 1999 found that 62% of them reported that the outdoor area was not used as much as it could be. Reasons given were inclement weather, accessibility problems, design considerations, supervision, and lack of familiarity (Cohen-Mansfield, 1999).

Neglected resource
Cutler and Kane (2005) analysed outdoor use in 40 nursing homes with a view to improving usage of this neglected resource. They found that in their sample of 1,988 residents, almost 50% were never included in outdoor programming, and of those interviewed, close to 40% felt that they did not get outside as much as they wanted. A third do less than once a month. A post-occupancy evaluation of a B.C. facility, The Lodge at Broadmead, found that many respondents believed the gardens were not used enough. Comments suggested that this was because not enough staff or volunteers were available to take residents into the gardens (Heath and Gifford, 2004).

Fleming and colleagues (2008) in their literature review of the design of physical environments for people with dementia concluded that “... the lack of access to outside areas when they (residents with dementia) are present is usually associated with staff practices.”

Connell, et al. (2007) had already come to the same conclusion in their structured activity study. They point out that planned outdoor spaces for residents with dementia were initially expected to be staffing-neutral. However, in their research they found that few residents frequented outdoor space. They further noted that self-initiated use of outdoor space by residents with dementia is quite limited.

Benefits of outdoor activities
Dementia residents have problems in planning and carrying out activities; that is, they need to decide to go outdoors, get the appropriate clothes on for weather conditions, find their way to the outdoor space without getting lost or distracted, and then if they wish to engage in an activity, find the appropriate tools or props and then stay engaged in the activity.

In their 2007 study, Connell and associates showed that beneficial sleep and behaviour results with the use of a structured activity approach. They concluded that outdoor activity is far more likely to occur if structured activities programming is provided and staff are available to assist residents to get outdoors and to stay engaged (Connell, et al., 2007).

Types of resident outdoor use
Charlotte Grant, who was part of Connell’s early studies, based her Ph.D. thesis on finding a way to increase use of available outdoor space by dementia residents. She studied five sites in order to understand the relationship between organizational programming policies and physical attributes of outdoor spaces.

An especially insightful part of Grant’s research is her finding that structured activities are needed to increase outdoor space use. Connell and associates’ study is far from the only research supporting the need for structured activity programming to initiate use of outdoor space by people with dementia. Grant found the appropriate tools or props and then stay engaged in the activity.

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Maximizing the use of outdoor gardens in dementia care facilities

This aluminum patio table (left) fell over, thanks to its umbrella and a nasty breeze. The glass top was smashed. The designer wanted to block residents from wandering into the garden, so placed the table - with a planter inside - in this nook. It is seen as the handsomest of the planters and is tall enough to have residents take in the scent of the plants. Remember, “when life (‘or the wind’) gives you lemons - make lemonade.”
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analysis is the division of residents’ outdoor use into four types: 1. self-initiated or independent 2. enabled 3. staff-initiated, and 4. programmed.

‘Self-initiated’ involves residents being self-motivated with no influence by others. ‘Enabled’ category is when residents initiate the move to enter the outdoor space and are aided by another, for example, helping with a heavy door. ‘Staff-initiated’ includes residents who are physically or verbally influenced by staff to go outdoors. ‘Programmed’ denotes outdoor use as planned, or scheduled group activities.

Grant concluded that the policies of management, the attitudes of staff, and training affect the use of outdoor space as much as garden design. However, a management operating philosophy supportive of garden use, by itself, will not guarantee high utilization. Realizing this, Grant developed a particularly helpful new model called “Outdoor Design Element Model for Increasing the Use of Outdoor Space.”

In this model, each of five factors must be realized:
1. organizational policy negotiated for the use of the garden
2. barrier-free design
3. visual access
4. physical access, and
5. garden design layout and amenities

(Grant, 2003; Grant and Wineman, 2007)

Mary Jane Lovering, a Canadian landscape architect and physiotherapist, has developed eight dementia garden design principles to optimize use: 1. motivating elements 2. comfort features 3. barrier-free design 4. safety qualities 5. ease of supervision 6. calm environment 7. private and social opportunities, and 8. maintenance (Lovering, 2002)

These design principles, and a number of other ‘outdoor environment studies,’ provide guidance and understanding for determining the most desirable design features for such gardens and the supports needed to maximize their benefit.

The attached checklist (page 11) can serve as a review and reminder of these elements, both in planning new outdoor spaces and in reviewing existing ones.

The Checklist has two sections: (1) Support Elements, and (2) Design Elements

**SUPPORT ELEMENTS**

Management support (policies)

Organizational policy is determined by the facility mission statement, available literature and brochures, the director’s own attitude, the education and training of staff, and programming philosophy. All these elements should serve to encourage the use of outdoor space at a facility by:

- promoting residents’ independence
- maintaining residents’ optimal abilities
- encompassing a positive belief in the value of the outdoors for residents, and
- reflecting, through programming, an active effort to promote outdoor use.

Grant found that, although all five of the facilities she studied incorporated supportive policy for the use of the garden, not all followed through with actual encouragement of independent use or through active programmed use (Grant, 2003).

Troxel (2005) recommends that program leaders give staff clear directions to encourage residents to be outdoors and lead by example, for example, by holding staff meetings on a patio.

Attitude, training, involvement

Staff attitudes involve the overall staff mindset regarding the benefits of outdoor space for residents. They (attitudes) are an important element in encouraging and assisting residents to go outside and allowing them a degree of independence and taking (Grant, Grant, 2007). Detweiler and associates (2009) studied resident behaviour over a 12 month period after a garden was added to a facility. They found that the majority of staff spent less than 15 minutes a day with residents outdoors. During the study there was a reduction in recreational staff so that for the most part staff went into the garden to bring a resident in from the rain, to pick up a resident who had fallen, or to get a wheel chair-bound resident back onto the garden path. Detweiler reasoned that this interference with their nursing work schedule interfered with line nurses and a strong incentive to restrict garden use.

Wood and colleagues (2005) studied residents in a Special Care Unit which included an outdoor patio and gardens with a well-demarcated wandering path. It was found that, despite a rich home-like, accessible and attractive environment, residents remained unengaged unless staff intervened and managed activities that continued to support their involvement.

Lovering’s findings (2002) highlighted the crucial role of staff in the success of the garden she studied. She added that other staff support staff by giving them a list of essential elements, and strongly recommends staff training and provision of a manual that documents appropriate garden space for the facility.

Chapman and colleagues (2007) developed a training program for staff to increase their knowledge of possible activities re-lated to horticulture and how residents can be involved in outdoor gardens. They taught their program on 20 facilities and enjoyed notable success in effecting activity programming in the participating facilities.

Troxel (2005) suggests staff brainstorm “on things to do outdoors, program soil setting, and uneven surfaces on the paths, all due to poor maintenance.

Meaningful engagement/activities

‘Motivation’ is Mary Jane Lovering’s first design principle for dementia gardens. In her three year follow-up study of a garden that she had designed, she found that residents were more likely to use the garden where activities were featured (Guizita, et al., 2011). The researchers also found that the number of residents in Alzheimers using the gardens increases when other people are present (Guizita, et al., 2011).

Maintenance (plants and structures)

‘Maintenance’ is one of Mary Jane Lovering’s eight design principles for dementia gardens. In her three year follow-up study of a garden that she had designed, she found that residents were more likely to use the garden where activities were featured (Guizita, et al., 2011). The researchers also found that the number of residents in Alzheimers using the gardens increases when other people are present (Guizita, et al., 2011).

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Visible and accessible

To encourage use, outdoor areas need to be visible and easily accessible from each care unit (Beauher, 1994).

There is general agreement among researchers that outdoor gardens should be located immediately adjacent to each household unit’s common areas (dining, lounge, activity). This facilitates “self-initiation” for independent use, gives both residents and staff a sense of security (Bengtsson and Carlsson, 2006).
The railings, made of sturdy aluminum, connect the wooden planters and benches so that residents no longer fall or step into the gardens. The railings have prevented residents from doing a balancing act along the cement curbing and falling into the gardens - although they can be a challenge to the gardeners. The railings are about 42 inches high. Note convenient height of raised planters.

Author notes:
“The courtyard setting is ideal for the residents - especially those living in the restricted wing of Ayre Manor. Gardens give a sense of freedom while still keeping our residents safely within its boundaries. Many residents at risk of “eloping” find that the courtyard focus takes away from their feeling of restrictions on their movement and encourages them to focus on the growing garden.”

Volume 25, Number 1, March/April, 2014
Shade
Heath found that the most frequently requested addition was for more shade, followed by a roof over the garden for rain. Rodiek calculates that walkways that have shade will nearly double garden use (Heath and Gifford, 2001; Rodiek, 2009).

One facility, as described by Cutler and Kane (2005) hung sun hats for every resident by the entry to the garden. Consider, as well, a screening option for areas with a significant bug problem.

Outdoor furniture/fixtures
Outdoor furniture should accommodate wheelchairs; tables should have a minimum height under the top of 685mm (27 in.) to allow wheelchairs to partially slide under; and a maneuvering space of 915 mm (36 in.) surrounding the usable portion of the table.

If drinking fountains are provided, there should be a minimum clear knee space below of 700 mm (27 in.) and the spout should be a maximum 915 mm (36 inches) and easily operable with one hand.

Garden beds
Raised garden beds or containers at a height of 400 - 600 mm (18 in. - 24 in.) are suitable for wheelchair users; they should be able to put their knees underneath.

For standing use, raised garden beds should be approximately 1 metre high and about 50cm wide with 230mm (9 in.) high toe allowance (City of Toronto, 2004; Grove, 2012).

Layout
Clare Cooper-Marcus provides an excellent case study of a Michigan garden in which she reiterates five elements we use to organize finding our way:

1. paths
2. places
3. landmarks
4. nodes, and
5. edges

The main orienting element is the path which connects the other elements. She holds that residents are more likely to use outdoor spaces if they can see where they are going at a glance. This requires a simple layout such as a looped walkway with destinations and landmarks visible going and returning (Cooper-Marcus, 2007).

Round-trip walkways appear to increase use nine-fold (Rodiek, 2009). If space is limited, an outdoor/indoor loop could be used using a two-door layout. For this to work, doorways need to be easily recognized landmarks from inside and out. Frequent rest stops are essential (Lovering, 1990).

Amenities/convenience features
Consider/convenience features such as easy access to a washroom, a drinking fountain and a coffee and snack cart. A garden Shed is handy for tools and supplies. Lovering found that the lack of convenient proximity to washrooms was a major deterrent to use of the garden (Lovering, 2002).

Seating
Seniors need a variety of seating options to enjoy both sun and shade, to provide opportunities for privacy and social interaction, and for rest stops along the walkway (Lovering, 2002).

Rodiek discovered that stable secure seating, seating with good views, and choices of places to sit, each nearly doubled the minutes spent outdoors (Rodiek, 2009).

Benches or seats should be located to one side of walkways, mounted on a firm and level base, with suitable back supports and arms to allow for easy transfers, with a seat height between 405 - 460 mm (16 in. - 19 in.) (City of Toronto, 2004).

Poorly balanced or poorly constructed furniture is unsafe and oversized seating is uncomfortable and difficult to get up and out of safely. Many finishes are too rough for fragile skin (Brawley, 2007).

Plants and natural features
Rodiek found natural features were the magnets that increased the interest of residents in going outdoors, particularly greenery, fresh air, flowers, and birds. In her

Author Notes: 
“Many garden objects - wind chimes, water features, gazebos, even old clotheslines - evoke memories of happy times.”

Ayre Manor Garden
Glare and intensity of the sun offering a place to sit sheltered from the contained fountains are safer. A water feature can provide interesting done while sitting on the porch at home can view daily life - as they might have desirable, especially one where residents involving activity is probably the most stimulations, or other surroundings that may be of interest to the residents. A lack of views from a seated position increasing use than plants. “They can be a symphony of a Wander Garden, with Dementia, American Journal of Alzheimer’s Disease and Associated Disorders; 13(2); 1999. Conner, B.R., Ethical Effects of features in a therapeutic garden, American Journal of Alzheimer’s and Dementia; 24(4); p.333-340; 2009. See: <http://www.annalsofonline.com/content/american-journal-of-alzheimers-disease-and-associated-disorders/journal/doi/10.1177/1521371109358270>.

Conclusions
Simply building gardens does not guaran-
tee they will be used, or that facility administrators and staff know how to take full advantage of what the outdoor environment can offer residents. However, a strong relationship between management operating philosophy, staff attitudes and dementia care, or art therapy, programming, gardening design and visual and physical access will maximize garden use.

References
• B.C. Building Code - Building Access Hand-
• Beckwith, Margarette, and Gilster, Susan, The Paradise Garden: A Model Garden Design
Cohen-Mansfield, J. Outdoor Wandering Parks for Persons with Dementia, Alzheimer’s Disease and Associated Disorders; 13(2); 1999.

About the author
Bill Benbow is a Health Planner and Consultant on seniors health care and housing projects. He assists in coordinating with health authorities to ensure quality, value, efficiency, and compliance with regulations and guidelines. Recently he was the Development Consultant for a combined complex care and assisted living facility on Vancouver Island.

Bill has extensive experience as a Project Manager of Capital Projects and as a Capital Treasury Board Grant with the B.C. Government; he also chaired the Multilevel Care Design Guidelines Review Committee in B.C. Mr. Bebow is particularly interested in the development and implementation of functional design guidelines in the fields of seniors’ housing and long-term care facilities.
Horticultural therapy is a process through which plants, gardening activities, and the atmosphere we feel in gardens are used as variables in programs of therapy and rehabilitation. Horticulture as a therapeutic tool is relatively new (Davis, 1998); however, as we shall see, the practice of horticulture as a salubrious undertaking has been around for centuries.

Significant declines

Horticulture has been recognized as the number one leisure pursuit of the elderly—and a therapeutic activity which enhances physical and mental health (Simons and Haller, 1977). Studies in the late 1970s found that older people living in long-term care facilities who did not participate in an activity therapy program experienced a significant decline in satisfaction levels over a two-month period (Wilkins and Mattson, 1979). An earlier and related study reported that studies in nursing home indicated that active therapy programs for older adults, maintain life satisfaction indexes, whereas seniors who were inactive had a significant decrease in self-esteem (Mattson and Hillert, 1976).

Horticultural therapy

While horticulture is the art and science of growing plants, horticultural therapy (HT) is the engagement of a patient in horticultural activities facilitated by a trained therapist to achieve a specific goal. HT is an active process that takes place in the context of a treatment plan where the process itself is considered the therapeutic activity rather than the end result. Programs involving HT are found in a wide variety of healthcare settings, including hospitals, rehabilitative centres, as well as residential care/nursing home settings.

Therapeutic horticulture

Therapeutic horticulture, to make the distinction from HT, is a process or program that uses plants, landscape features and plant-related activities to provide the opportunity to improve their quality of life through active or passive involvement in their surroundings. In this type of program, therapeutic objectives are not clinically defined or even discussed. A therapist or caregiver involved who may have training in the use of horticulture as a medium for health well-being.

Growing plants, horticulture therapy (HT) is the type of activity which enhances physical and mental health. Horticulture has been recognized as the number one leisure pursuit of the elderly and a therapeutic activity which enhances physical and mental health (Simons and Haller, 1977). An earlier and related study reported that studies in nursing home indicated that active therapy programs for older adults, maintain life satisfaction indexes, whereas seniors who were inactive had a significant decrease in self-esteem (Mattson and Hillert, 1976).

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The Live Oak Project

Motivated by the experience of his grandmother’s life in a 1960s nursing home, Barry Barkan created the Live Oak Project in 1977 in an old nursing home in Oakland, California. He and his wife worked hands-on with nursing home residents to evolve the Regenerative Community Culture, a system of care that demonstrates the healing potential when social isolation is eliminated from the lives of the elderly.

Barkan’s project challenged negative stereotypes of aging, even among the most frail and isolated people, and focused on expanding their physical, cognitive, emotional, spiritual and social potential. It was Barkan’s Live Oak Project that articulated a new vision of quality of life for long-term care residents in the U.S., ultimately influencing an historic U.S. Federal Nursing Home Re-organization legislation in 1998 (OBRA), a law that has had a significant impact on changes in how long-term care was to be delivered in Canada’s provinces.

An incomplete reality

My conflict with the medical model driven performance collided with my making a mind-body connection. I was also coming to understand that the top down institutional model of care, standing in every nursing home, was not capable of understanding, respecting and not supporting the new vision. We needed to get decisions closer to the elders supporting them, that is, their families and the caregivers, rather than the top down model with the administrator and nurse deciding the decisions and controlling people’s lives. This was a realization of how complex elders and humans are, and the only way to deal with that complexity was to become part of it.

The conflict, the discord, the fear I felt was simply overwhelming. I could no longer operate a nursing home the way I was trained. It was an incomplete reality.

‘Born to be an administrator’

Let me back up and share that I was born and raised to be an administrator.

My mother, Betty Zwicker, a Yale Graduate student, was born in Milwaukee, Wisconsin, was a Wisconsin State Nursing Home Surveyor most of her life. She was the reason I became an administrator. Our countless hours of conversation about nursing home care and was influential in my choosing Administration as a career.

My father and I, on the other hand, had a broken relationship. I grew up afraid of my father. He represented the status quo and I was always looking to move on from the trauma he left behind.

With my heart and mind fully engaged, I experienced a personal transformation and began spending a great deal of time implementing culture change. I focused on companionship, love, value, healing potential, elimination of the rough water ahead. Changing the culture of an organization is an immense task. I did think, however, that it is easier to implement culture change in a ‘brokered’ nursing home that is looking to turn a profit, than in a hospital.

I was committed to the transformation; it was the right thing to do. My passion was by my parents living at Lakewood, making it personal, making it hurt.

Right from the start the traditional model did not support mom and dad. They could not age in place and when they came to Lakewood, they had to be split up because my dad needed more care than my mom. I didn’t want to be in the same program pay. I finally changed my dad’s Medicare benefit enabling both to live together in one room.

I struggled painfully, avoiding seeing my mother on the Alzheimer’s Floor. We were meeting all her medical needs, but there simply were not enough hours in the day, or staff on the payroll, to meet all the needs of the elders - let alone the needs of the pets.

It also created laughter and spontaneity in an otherwise sterile environment. In following the guidelines found in “A Life Worth Living,” we added many animals. In the mornings, the chaos the animals created made it feel like morning in our own homes. Staff were extremely adamantly opposed to the addition of the animals because they ‘brought in’ they were aligned to the decision. They said they couldn’t do it.

The animals were wonderful, and with few exceptions, welcomed. You could not walk by a room without seeing large kitties curled up on the sofa, and on the floor, with the elders. There were no restrictions or cages and the cat litter boxes.

In the ‘big picture’

Although the presence of animals might appear as the most important aspect of transforming the nursing home, in the big picture of what is being articulated, it is only a small part.

Our standard model of care was a return to a ‘shared’ way of living. We created a leadership team, inducted elders into management meetings, and utilized them in our hiring practices. We reorganized, from program-based, to communities, where staff and residents participated in component decisions.

Also, in many cases, direct care workers did not report directly to a nurse. So, we changed the organizational chart to get decision-making closer to the elders and their caregivers.

We also used the power of local schools - from funeral homes, elders and family members, clergy and others in order to change with dignity and proper solemnity a dehumanized our community was feeling.

We enrolled doctors, and helped with the training of new residents supporting their innovation and visioning. We also partnered with a University to train social workers and other caregivers.

We created our school programming in order to bring more children into the nursing home. The children walked the dogs, helped clean the bird cages and the cut litter boxes.

Every child that participated through the school program paired with an elder in order to develop a one-on-one relationship.

We blocked off the street and did “Woodstock" picnics (as the address was Woodstock Place), inviting neighbors to join as for food and music, to understand the turbulence and significance of life. Many made new friends in the neighborhood.

Experiencing the nursing home through caring for our parents was an invaluable experience. As I once feared my father, I was now given the opportunity to embrace his frailty, his human and, to understand his vulnerability.

The greatest joy I experienced in caring for my parents was that I had a total reconciliation with my father before he died. I was able to visit and live with him in his final days. His accomplishments; he could always understand the truth in a way he had never been able to do before. He could understand business. I could also take care of him when he was home by myself.

We were very happy to have him when he was home by myself.

Passion, love and skill

Perhaps one of the most touching moments occurred when one of the student volunteers (part of the partnership we had with local schools) would push my dad’s GiGi chair to his bed. He became aware that my dad was passing. It took his mom many days to die. The young man was so courageous. When it was explained that he was dying, he asked them to do it, and to bring him, to talk and be with him. He was not afraid to be part of the end-of-life experience.

My mother on the other hand was difficult. I had a wonderful and close relationship with her. I am not certain I can ever reconcile the symptoms of Alzheimer’s and the way it robbed her of life. However, it gave me joy to observe other elders like my wife, and how the nurses and caregivers found ways to connect with them. I could see my mother gently on the face and experience her incredible smile, but beyond that, the pain was difficult to endure.

My mom and dad both took their last breaths together with us, our caregivers, Lakewood staff. I always had total and complete trust in the passion, love and skill of the caregivers of Lakewood Health and Rehabilitation Center.

Having my parents cared for in my own nursing home allowed me to be with them every moment, and to experience their accomplishments; he could always understand the truth in a way he had never been able to do before. He could understand business. I could also take care of him when he was home by myself.

About the authors

Thomas Zwicker, NHA (Nursing Home Ad- ministration), and Debbie Van Straten were the co-founders from 1993 to 2003 of the Lakewood Health and Rehabilitation Center in Milwaukee when the 246-bed facility underwent a dramatic culture change. Both are students of the Eden Alternative and both ascribe to the tenants of the Regenerative Community Culture of the Live Oak Project which advocates for a system of care that demonstrates the healing potential when social isolation is eliminated from the lives of the elderly - long-term care homes.

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Canadian Nursing Home

Volume 25, Number 1, March/April, 2014
of the more than 100 cognitive disorders, after Alzheimer’s disease, Lewy Body Dementia (LBD) is the most prevalent progressive dementia. LBD is identified by the presence of Lewy bodies, abnormal accumulations of a protein called alpha-synuclein. These deposits are found in regions of the brain that regulate behaviour, memory, movement, and personality. Many of the symptoms of Alzheimer’s, Parkinson’s and LBD overlap, with the latter the most difficult to diagnose. This difficulty in diagnosing and recognizing LBD symptoms is the main reason why this type of dementia is still relatively misunderstood.

Lewy Body Dementia

Dementia with Lewy bodies (DLB) and Parkinson’s disease dementia (PDD) are neuro-degenerative disorders characterized by accumulation of Lewy bodies in brain cells. Collectively, DLB and PDD are known as Lewy Body Dementia (LBD). After Alzheimer’s disease, LBD is recognized as the second most prevalent progressive dementia. LBD is identified by the abnormal accumulations of a protein called alpha-synuclein. These deposits (commonly called Lewy bodies) are found in regions of the brain that regulate behaviour, memory, movement, and personality. Many of the symptoms of Alzheimer’s, Parkinson’s and LBD overlap, with the latter the most difficult to diagnose. This difficulty in diagnosing and recognizing LBD symptoms is the main reason why this type of dementia is still relatively misunderstood.

Compiled by Editorial Staff

Adjusting our care efforts for one of the most misunderstood neurodegenerative disorders

O

of the more than 100 cognitive disorders, after Alzheimer’s disease, Lewy Body Dementia (LBD) is the most prevalent progressive dementia. LBD is identified by the presence of Lewy bodies, abnormal accumulations of a protein called alpha-synuclein. These deposits are found in regions of the brain that regulate behaviour, memory, movement, and personality. Many of the symptoms of Alzheimer’s, Parkinson’s, and LBD overlap, with the latter the most difficult to diagnose. This difficulty in diagnosing and recognizing LBD symptoms is the main reason why this type of dementia is still relatively misunderstood.

LBD actually encompasses two disorders: dementia with Lewy bodies (DLB) and Parkinson’s disease dementia (PDD). Both of these disorders account for a spectrum of symptoms involving cognition, movement, behaviour, and sleep, with the difference in diagnosis pretty well dependent on the order of symptoms presented. If the movement disorder begins more than one year before any cognitive symptoms, it is usually referred to as PDD, while any other pattern of symptoms is usually referred to as DLB. Both are called LBD.

Symptoms blurred

In order to understand how LBD differs from Alzheimer’s, it is necessary to clearly define what is meant by the term ‘dementia,’ a generic term that describes a progressive decline in cognitive function representing the following: (a) a change from previous abilities; (b) interference with daily functioning; (c) a condition not caused by other illness.

While all individuals with a dementia experience decline in memory, thinking, language, problem solving, judgment, behaviour changes, and the ability to carry out activities of daily living, i.e., function independently, there is wide clinical overlap between the different types of dementia. As these diseases progress, the distinctions blur even further – and what probably makes the distinctions even more difficult and confusing is that many cases of dementia are due to multiple causes.

LBD or AD symptoms?

Nearly 80% of individuals with LBD will also have brain changes consistent with Alzheimer’s disease, while almost 40% of those diagnosed as having Alzheimer’s are found to have features of LBD (Galvin, Pollock, Morris, 2006; Barker, et al., 2012).

This overlap probably contributes to the difficulty in making a clinical diagnosis of LBD, and helps to explain why so many patients find the diagnostic experience so frustrating (Galvin, Duda, et al., 2010).

This under-diagnosis of LBD can have grave implications. In addition to delaying appropriate treatments that may alleviate symptoms, the under-diagnosis can expose patients to potentially dangerous adverse reactions to certain medications (e.g., anti-psychotic medications).

Early diagnosis helps family members and formal caregivers prepare for their role in caring for, especially behavioural management issues since the trajectory of symptoms will have their own unique challenges and burdens (Leggett, et al., 2011).

Lewy body dementia and Alzheimer’s share clinical as well as pathological features, making the distinction challenging for most clinicians and caregivers. The presence of mixed forms of the two disorders complicates the picture even more. A review of the features of LBD will help to clarify the distinctions.

Detecting LBD symptoms

The LBD diagnosis is made when a patient presents with cognitive decline with at least two of the following features:

1. slowness in movement, stiffness, tremor, and balance problems (Parkinson’s-like movements);
2. visual hallucinations, frequent colour changes or other experiences, visual hallucinations usually occur at night, particularly during the REM sleep cycle;
3. spontaneous alterations in cognition, attention and arousal (cognitive fluctuations);
4. sleep disorders causing patients to “act out” (i.e., REM sleep behaviour disorder [see box next page] (McKeith, et al., 2005).

These four features are specific to LBD, and are not evident in most cases of Alzheimer’s or other conditions. The challenge is to detect and properly interpret the symptoms, in particular, cognitive fluctuations - those alterations in cognition, attention and arousal that can occur spontaneously in LBD patients.

Presenting symptoms of LBD

A study focusing on caregiver reports (Auning, et al., 2011) revealed that the most common presenting symptoms of LBD are:

(a) memory impairment (57%);
(b) depression (44%);
(c) difficulties with problem solving (33%);
(d) difficulty with gait (28%); and,
(e) tremor/stiffness (25%).

(a) Memory impairment - As a presenting symptom, 57% of LBD patients reported memory impairment to their caregivers; in contrast, almost 100% of individuals with AD reported memory impairment as a presenting symptom (Auning, et al., 2011). While difficulty with memory is a common presenting complaint in both AD and LBD, the nature of the impairment differs, particularly at the onset. Alzheimer’s, for example, affects the ability to encode new experiences into one’s long-term memory, whereas memory impairment in LBD can be one that affects retrieval of memory (Johnson, Morris and Galvin, 2005). LBD patients may perform worse on visual-spatial tests than AD patients, whereas AD patients perform worse on language function tests (Karantoniou and Galvin, 2013).

(b) Visual hallucinations - As a psychiatric symptom, visual hallucinations are more likely to occur in the early stages of LBD. The patient not only sees nonexistent people, animals, body parts, and even vehicles, but may describe them in detail; the patient may even respond to talking by describing these hallucinations to those present. Paranoid caregivers and unshakable false beliefs, such as family members and care staff being replaced by impostors, are more common among individuals with LBD than among Alzheimer’s patients. This symptom, known as Capgras syndrome (Thaipisuttikul, et al., 2013), commonly occurs in those with paranoid schizophrenia as well as in older individuals with a neurodegenerative disease such as LBD (Josephs, 2007). Patients with Alzheimer’s disease frequently develop psychotic symptoms later in the course of their disease, such that the late stages of LBD and AD may be indistinguishable (Stavisky, Brickman, et al., 2006).

(c) Depression - LBD patients may have partial awareness of their diminishing cognitive abilities; this self-awareness may be

Why knowledge of Alzheimer’s is more advanced than for LBD

Compared to LBD, current knowledge of Alzheimer’s is far more advanced. There are several reasons for this gap:

• The abnormal protein in LBD, alpha-synuclein, (referred to as Lewy bodies) was discovered a decade after the proteins involved in Alzheimer’s disease.
• The amount of pathology associated with alpha-synuclein protein occurs at lower levels than amyloid and tau proteins in Alzheimer’s; this makes it more difficult to develop tests to measure alpha-synuclein.
• There are not as many genetic causes of LBD that can be used to create experimental models as there are for Alzheimer’s disease.
• In a similar vein, it is more difficult to develop animal models (laboratory animals, i.e., mice etc.) of LBD that reliably distinguish LBD from normal aging (Fermen, et al., 2004).

Lewy Body Dementia

Dementia with Lewy bodies (DLB) and Parkinson’s disease dementia (PDD) are neuro-degenerative disorders characterized by accumulation of Lewy bodies in brain cells. Collectively, DLB and PDD are known as Lewy Body Dementia (LBD). After Alzheimer’s disease, LBD is recognized as the second most prevalent progressive dementia. LBD is identified by the abnormal accumulations of a protein called alpha-synuclein. These deposits (commonly called Lewy bodies) are found in regions of the brain that regulate behaviour, memory, movement, and personality. Many of the symptoms of Alzheimer’s, Parkinson’s, and LBD overlap, with the latter the most difficult to diagnose. This difficulty in diagnosing and recognizing LBD symptoms is the main reason why this type of dementia is still relatively misunderstood.

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Rapid eye movement sleep behaviour disorder linked to development of Lewy body dementia

Patients are five times more likely to have Lewy body dementia if they experience a condition known as rapid eye movement sleep behaviour disorder more than once if they have one of the risk factors now used to make an LBD diagnosis, i.e., fluctuating cognition, hallucinations, etc. This finding was presented by Dr. Murray at the annual meeting of the American Academy of Neurology in San Diego last March.

REM sleep behavior disorder is caused by the loss of the normal muscle paralysis that occurs during REM sleep. It can appear three decades or more before a diagnosis of dementia with Lewy bodies is made in males, the researchers say. They note that the link between dementia with Lewy bodies and the REM sleep disorder is not clear.

"While it is true that not everyone who has this sleep disorder develops dementia with Lewy bodies, up to 80% of men with dementia with Lewy bodies in our database did experience REM sleep behaviour disorder; so it is a very powerful market for the disease," says lead investigator Melissa Murray, Ph.D., a neuroscientist at the Mayo Clinic in Florida. The study’s findings could improve diagnosis of this dementia, which can lead to beneficial treatment, she says.

"Screening for the sleep disorder in a patient with dementia could help clinicians diagnose either dementia with Lewy bodies or Alzheimer’s disease," Murray points out. "It can sometimes be difficult to tell the difference between these two dementias, especially in the early stages; but we have found that only 2% to 3% of patients with AD have a history of this sleep disorder."

Once the diagnosis of dementia with Lewy bodies is made, patients may be able to use drugs that can treat cognitive issues, Dr. Murray says.

The Mayo researchers checked patients’ histories to see if the REM sleep disorder had been diagnosed while under their care. Using this data and the brain scans, they matched a definitive diagnosis of dementia to the sleep disorder. They did not, however, track symptoms of the REM sleep disorder over time;

"The patients did not have the sleep disorder had characteristics of Alzheimer’s disease.

"With greater certainty in the diagnosis, we can treat patients accordingly. Patients with Lewy body dementia, who lack AD-like symptoms, and do not have the atrophy (a certain drugs) than those who have some Alzheimer’s pathology," Dr. Murray says.

Source: “Acting out dreams linked to development of dementia.” ScienceDaily; March 21, 2013.

See: <www.sciencedaily.com/releases/2013/03/130321204814.htm>

Cholinergic system - A number of neuromodulators are involved in Lewy body dementia. One of these, the cholinergic system, is involved in both LBD and AD; however, with LBD, it occurs earlier and to a greater degree than in AD (Sabbagh, et al., 1999).

It is the dysfunction of the cholinergic system that is responsible for the earlier onset of hallucinations and cognitive fluctuations in LBD (Tawarneh and Galvin, 2007). Cholinesterase inhibitors (Cholinergic (t.) inhibitors, Racacynine (galantamine); Acricept (donepezil); Exelon (rivastigmine), etc.), are being used for their benefits in AD therapy; they have also been shown to reduce some of the neuropsychiatric symptoms of LBD, dementia impairments, particularly early onset stages. They also help to improve attention, focus and executive functioning. However, like antipsychotics, there are some LBD patients who do not respond well to cholinesterase inhibitors, or who will experience intolerable side effects.

Dopamine system - This neurotransmitter system is also affected in LBD, and is involved with the movement problems - a hallmark symptom. This is a major goal of research. It has also been shown by nuclear medi
Increasing amounts of sleep (7 to 9 hours), the genetic influence on symptoms of depression was 27%, versus 53% for those who slept only five hours a night - and 49% depression risk among those who slept 10 hours. "Both short and excessively long sleep duration appear to activate genes related to depressive symptoms," said lead investigator, Dr. Nathaniel Watson, an associate professor of neurology at the University of Washington Sleep Center in Seattle. "Ensuring that patients get optimum levels of sleep may be one way to boost the effectiveness of treatments for depression," he said.

The second study, involved more than 4000 young people aged 11 to 17. It found that sleeping six hours or less per night increased their risk for major depression, which in turn increased their risk for too little sleep.

A precursor to depression
"These results are important because they suggest that sleep deprivation may be a precursor for major depression, occurring before other symptoms of major depression and additional mood disorders," said principal investigator of this study, Dr. Robert Roberts, a professor of behavioural sciences at the School of Public Health, University of Texas Health Science Center, Houston. "Questions on sleep disturbance and hours of sleep," he explained, "should be part of the medical history in order to ascertain depression risk."

Prioritizing sleep
"Healthy sleep is a necessity for physical, mental and emotional well-being," commented a spokesperson for the American Academy of Sleep Medicine in the news release. "This new research emphasizes that we can make an investment in our health by prioritizing sleep."

How diligent monitoring improves hand-washing
If hand hygiene compliance at your facility isn’t what it should be - and chances are it isn’t - read on. With video monitoring, hand-washing rates have been shown to increase from less than 10% to around 90%, according to author, John Di Capua, M.D., writing in the Oct. 22 issue of Health & Social Care Reform.

It was realized that it’s one thing to have cameras installed in your care facility, but it’s a whole new hockey game when you have people actually monitor and report on what happens (and what doesn’t) in your facility. “It might sound exorbitant, but it’s paying off in improved hand hygiene...” says Di Capua.

Compliance problems
The breakthrough occurred when North Shore University Hospital in Manhasset, N.Y., was having trouble with hand hygiene compliance. When cameras had been installed in an intensive care unit to record when staff washed their hands, it was assumed that compliance would be around 60%. Surprisingly, during a four-month preliminary period in which staff were filmed but not given results, rates were actually less than 10%. Lesson learned, says Di Capua, “installing cameras doesn’t change behaviours.”

However, after initiating monitoring and data collection, and then streaming the scores (sans names) on wall-mounted digital scoreboards, compliance zoomed to nearly 90%.

Another hospital in Queens, N.Y., after learning the results, also wanted to see if video monitoring could improve how the ORs were cleaned between procedures. Before they started monitoring, compliance was 0%. Now they’re close to 100%. Monitoring also ensures that overnight cleaning processes are followed, another important factor in reducing risk of site infections.

Behaviour changes
“The hand-washing program helped teach a powerful lesson say Di Capua: “People change behaviours when they know they’re being monitored; but they must be permitted to see the results of compliance.”

Source:
Why are older people at increased risk for cancer? According to a study by the U.S. National Institutes of Health (NIH), it’s the accumulation of age-associated changes in a biochemical process that controls one’s genes.

DNA methylation
Researchers suspect that DNA methylation, an essential process during embryonic development, may be involved. DNA methylation, which occurs throughout life, is the stable altering of gene expression when cells divide and differentiate from stem cells and into specific tissues. Genes hold the information to pass on genetic traits and to build and maintain cells.

Zongli Xu, Ph.D., and Jack Taylor, Ph.D., researchers from the NIH, identified DNA methylation sites across the human genome that changed with age. (The human genome holds the genetic information for humans. It refers to the complete set of genetic information that each human possesses, information that is encoded as DNA sequences within the 23 chromosome pairs in the nuclei of cells).

The NIH researchers demonstrated that a subset of those genome sites - the ones that become increasingly methylated with advancing age - are also disproportionately methylated in a variety of human cancers. Their findings were published online in early February, 2014, in the journal Carcinogenesis.

“Compared to those who are young, older people have different DNA methylation patterns. This is surprising,” said Jack Taylor, Ph.D., in a statement.

The researchers also said their studies were significantly increased methylation in all seven cancer types. Taylor suggests that age-related methylation may disable the expression of certain genes, making it easier for cells to make the transition to cancer.

Annual occurrence
The research also determined how fast these methylation events accumulate in cells. They occur at a rate of one per year, according to Xu.

On your 50th birthday, you would have 50 of these sites (from the subset of 749), Xu explained. “The longer you live, the more methylation you will have.”

DNA methylation is one of several epigenetic mechanisms that can control gene expression without changes in DNA sequence. This study is part of a broader research effort to understand how environmental and other factors affect epigenetic mechanisms in relation to health.

Sources:

Why laughter is not really the best medicine - but it can help!

Why is laughter good for you? Scientists have identified a variety of human cancers. Their findings were published online in early February, 2014, in the journal Carcinogenesis.

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Why laughter is not really the best medicine - but it can help!

The ability or disposition to laugh - risibility, or laughter - is one of the most ancient and universal behaviors in human societies. It is a protective mechanism that can help reduce the risk of heart attack, reduce tension (psychological and cardiovascular), reduce anger, anxiety, depression and stress, reduce blood sugar levels in diabetics, and increase energy expenditure.

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Sources:
High levels of viral and bacterial infections in blood may be linked to cognitive problems

The virus that causes cold sores, along with other viral or bacterial infections, may be associated with cognitive prob-
lems, according to a new study published in a recent issue of the journal Neurology.

The study found that people who have had higher levels of infection in their blood (measured by antibody levels), meaning they had been exposed over the years to various pathogens such as the herpes simplex type-1 virus that causes cold sores, were more likely to have cog-nitive problems than people with lower levels of infection in the blood.

Women more vulnerable

"We found the link was greater in women, in those with lower levels of education and, most prominently, in people who do not exercise," said author Mira Katan, M.D., who is associated with the Northern Manhattan Study at Columbia University Medical Center in New York.

Low 3-MS Score

For the study, researchers tested thinking and memory in 1,625 people with an av-
age age of 69 from northern Manhat-
tan in New York. Participants gave blood samples that were tested for five common low grade infections:
- three viruses: herpes simplex type-1 (oral); herpes simplex type 2 (genital); and cytomegalovirus (a form of herpes virus affecting salivary glands);
- chlamydia pneumonia (a respiratory infection); and
- helicobacter pylori (a stomach bacteria).

The results showed that the people who had higher levels of infection had a 25% increase in the risk of a low score on the Mini-Mental State Examination.

The memory and thinking skills were tested every year for an average of eight years. But infection, over time, was not associated with changes in memory and thinking abilities.

"While this association needs to be further studied, the results could lead to ways to identify people at risk of cogni-tive impairment and eventually lower that risk," said Dr. Katan. "For example, exercise and childhood vaccinations against viruses could decrease the risk for memory problems later in life."

Source

• Katan, M. et al., Infectious burden and cog-

Women live longer because their immune systems age more slowly, says Japanese study

A Japanese study last year set out to investi-
gate the controversial question of whether age-
related changes in the immune system could be responsible for the difference in average life ex-
pectancy between men and women.

White blood cells and cytokines

Professor Katsuaki Hirokawa of the Tokyo Medical and Dental University and colleagues analysed blood samples from 356 healthy men and women aged between 20 and 90 years. They measured levels of white blood cells and mole-
cules called cytokines which interact with cells of the immune system to regulate the body’s re-
sponse to disease.

In both sexes, the number of white blood cells per person declined with age as expected from previous studies. However, closer examination revealed differ-
ences between men and women in two key com-
ponents of the immune system:
- T-cells (lymphocytes), which protect the body from infection; and
- B-cell (lymphocytes), which secrete antibod-
ies - large Y-shape proteins produced by B-cells that are used by the immune system to identify and neutralize foreign objects such as bacteria and viruses.

The rate of decline of most T-cell and B-cell lymphocytes is faster in men than women, while men also showed a more rapid age-related decline in two cytokines (for cell signalling):

F or the caregiver who has spent years meeting the heavy care demands of a family member with dementia, the transition to long-term care can be bitter-sweet. Family caregivers may experience relief after years of caring that leaves them ex-
hausted and in a vulnerable mental state. They may also feel at a loss due to the de-
clining health of the care recipient who will no longer be residing at the family home.

Primary family caregivers lose control of the role they have been playing over the years, as they now have to adapt to a supporting role alongside a team of care providers at a long-term care home.

Situation loss

The loss experienced by the family care-
giver during the transition follows a contin-
um of situation losses that are experienced over the years of providing care.

Situational loss is defined as “the loss of a person, thing, or quality, resulting from alteration of a life situation, including changes related to (in addition to death) illness, body image, and environment” (Mossby’s Medical Dictionary, 2009).

From the early to later stages, there are a significant number of situational losses experienced, from ‘loss’ of a family member as he or she was before becoming ill, to loss of freedom, role, financial status and social network, to name a few.

In the early stages of dementia, symptoms may start with sporadic incidents of memory loss. In time, there can be loss of language ability, which means loss of communication. When the later stages arrive, there is loss due to symptoms of physical health decline and heavier demands to meet activities of daily living.

Release
The grief of losing a loved one is difficult to suppress; in fact, the grieving emotions experienced can be overwhelming. After a long and difficult journey with their loved one, the family caregiver has to make the decision about long-term care.

Caregiving Roles

When the decision is made to move a loved one with dementia from the family home to a long-term care home, chances are the family caregiver has struggled with feelings of guilt and apprehension. She or he may also be grieving several losses related to the decision (i.e., anticipatory grief and ambiguous loss), not to mention the struggles involved in having to adjust to unexpected lifestyle changes. And just because the caring duties are formally passed on to others, there’s still an important caring role that the family caregiver can play. These and other issues, as discussed by a specialist in grief education, are designed to make the transition to nursing home care as fluid and psychologically smooth as possible.

By Eleanor Silverberg, B.A. Psychology, M.S.W., R.S.W.

Unmasking caregiver grief: Acknowledge, Assess, Assist

One in three caregivers meet medical diagnosis for depression

Conflicting emotions associated with being a family-based Alzheimer’s caregiver can be difficult for someone who is already stressed and vulnerable. This conflict may explain why nearly one in three caregivers meet the medical diagnosis for depression, according to a study over ten years ago.


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I just read a book about a woman whose husband had ALS. After he died, she became suicidal because her main reason for being. When he died, she had a good hole she had to fill. Just because someone feels relief doesn’t mean they also don’t feel huge amounts of grief, loneliness, and abandonment.”


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there are no rituals, and they do not receive condolences. The losses remain ambiguous, with the person with dementia physically present but mentally a different person. Despite the ambiguity, the grief the caregiver experiences is still as real as if the person had died. Their grief reaction is disenfranchised - and often not even personally recognized - especially in those who fail to appreciate that there need not be a death for a person to be grieving. Consequently, family caregivers are often deprived of the benefits that the grief process can provide.

Training in The 3-A Approach

Acknowledging the gap in addressing situational losses and the grief reactions, this writer developed The 3-A Grief Intervention Approach for Care Providers: Acknowledge, Assess, Assist®. As a professional and personal development coach, this writer provides training for professional and family caregivers on applying the components of The 3-A Approach, namely, to acknowledge loss, assess reaction, and assist with strategies to strengthen the well-being and resiliency of the caregiver.

For family caregivers, an 8-week group setting is well suited for caregivers having difficulty with day-to-day coping, with dealing with issues such as guilt, anger or frustration, with feeling overwhelmed and/or the need for strategies that will strengthen the behaviour of family caregivers as this behaviour relates to the situational losses and grief they are experiencing.

For formal healthcare providers in long-term care, training in The 3-A Approach offers another tool to promote compassionate practice through understanding the behaviour of family caregivers as it relates to strengthening resiliency and processing benefits are extended beyond just death-related circumstances.

About the author
Eleanor Silverberg, B.A. Psychology, M.S.W., R.S.W., works privately as a professional development coach for care providers, specializing in grief education as it relates to strengthening resiliency and well being.

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Experimental program keeps people out of LTC longer

An 18-month pilot program that brought resources and counselors to elderly Baltimore residents with dementia and other memory disorders significantly increased the length of time they lived at home and out of long-term care, according to Johns Hopkins researchers.

"The project demonstrated that we were able to help such people age in place without sacrificing their quality of life," says Quincy Miles Samus, Ph.D., an assistant professor of psychiatry at the Johns Hopkins University School of Medicine in Baltimore.

Maximizing independence

The trial, known as Maximizing Independence (MIND) at Home, involved 303 people 70 years and older with memory disorders, primarily dementia and mild cognitive impairment. One hundred and ten of them received an in-home visit from a memory care co-ordinator and nurse that assessed a range of care needs including diagnosis of memory problems, review of medications, behaviour problems, daily activities, and untreated medical problems such as hearing or vision deficits, and high blood pressure or diabetes. The care team then developed a personalized care plan and worked with the family over time to oversee progress.

The goal was to see if a dementia care co-ordination model could delay or prevent the need to move from home to other settings like nursing homes or assisted living facilities.

In a report published online in The American Journal of Geriatric Psychology (February 13, 2014), the Johns Hopkins investigators say that those prospective residents who got 18 months of care co-ordination with home visits were able to safely stay in their homes a median of 288 extra days, or around 9.5 months over a median follow-up period of about 2 years. "This can make a huge difference in terms of comfort, money and quality of life for those involved," says Quincy Samus, who acted as study leader.

Improved quality of life

The researchers found that participants who met regularly with co-ordinators were significantly less likely to leave their homes or die than those in the control group (who received minimal visits). Also, they had fewer unmet care needs, particularly for safety and legal/advance care issues, and enjoyed improved quality of life.

In the trial, co-ordinators checked for home safety, nutrition and food availability and whether patients participated in meaningful or purposeful activities beyond simply watching TV for much of the day. The program also provided education about dementia and memory problems, as well as informal counseling.

Home and personal safety issues affected 90% of the participants at the start of the trial, the researchers report; some 65% needed general medical care, 52% showed a lack of meaningful activities and 48% needed legal/advance care planning.

Care co-ordinators, besides receiving 4-weeks of intensive training, were also able to receive hands-on support from a nurse and a physician, with the team meeting weekly to discuss their cases. Results suggest that wider application of the model should be evaluated in the future.

About the author
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Contrasts with the underlying structures of the brain. Axons are the primary transmission lines to pass quickly from place to place. Electrical insulation allowing the messages to pass between different areas of gray matter neuronal tissue through which messages can be functionally passive until recently, is the white matter there are different kinds of nerve tracts, or bundles of axons, which connect one part of the brain to another part, and to the spinal cord.

**Diffusion MRI**

Diffusion Tensor Fiber Tractography Imaging Software has been used by Dr. Maxime Descoteaux, Ph.D., head of the Sherbrooke Connectivity Imaging Laboratory (SCIL), to assist in understanding the architecture of the brain, particularly as it relates to white matter.

This SCIL (laboratory) focuses on brain connectivity and utilizing state-of-the-art diffusion Magnetic Resonance Imaging (dMRI). The overall objective of the SCIL is to better understand anatomical connectivity between cortical regions, and characterize 'white matter' integrity.

It was this imaging technology at SCIL that was used in the creation of the current front cover of Canadian Nursing Home. Our thanks to colleagues from neurology, namely, Caroline Presseau, Genevieve Noelz Charron, and Christian Bocci.

In recent years, the new imaging technologies referred to have enabled the medical and scientific communities to better understand the functioning of the human brain. They have allowed scientists to peer deep into the hidden structures of the brain. For example, Dr. David Fortin, neuro-oncologist and neurosurgeon at the Centre hospitalier universitaire de Sherbrooke (CHUS), has described the vital importance of this technology in "Secrets of the Brain," a special editorial presentation that appeared in the February, 2014, issue of National Geographic.

**Real time images**

In his practice, Dr. Fortin uses medical imaging tools developed by doctor Maxime Descoteaux, who is also a researcher at the Centre hospitalier universitaire de Sherbrooke's Centre de recherche clinique Etienne-Le Bel (CHUS-CRCELB); Descoteaux is also a professor in the computer science department of the Faculty of Science at the Université de Sherbrooke (UdeS).

The use of these highly precise, three-dimensional, real time images enable a better assessment of the trajectory of neurons in a brain that may be affected by a tumour, thereby providing the neurosurgeon with essential data. The images illustrate not only the connections leading to a tumour, but also where they originate. This connectivity, revealed by scans of the nerve fibre tracts (or nerve bundles) infiltrating regions of the brain, is analyzed by Drs. Descoteaux and Fortin before the operation. In this way, neurological function can thus be better preserved, which has significant repercussions on quality of life for the patient.

**Cutting edge technology**

To ensure leadership in the field and serve as a regional and supra-regional reference in neuro-oncology, Dr. David Fortin’s team has cutting-edge technology at its disposal, including ‘the gamma knife’ for penetrating the blood-brain barrier, and diffusion Magnetic Resonance Imaging (dMRI).

The combination of these, and other technologies, facilitates the treatment of brain tumours and establishes Centre hospitalier universitaire de Sherbrooke (and the associated laboratories) as a unique institution in Canada.

**Grey matter/White matter**

The major part of the cerebral cortex is the neocortex which consists of up to six horizontal layers, with each layer having a different composition in terms of neurons and their connectivity (linkages and communications). This is the grey matter and contrasts with the underlying white matter.

White matter, which was long thought to be functionally passive until recently, is the neuronal tissue through which messages pass between different areas of gray matter within the neocortex.

This white matter is white because of the fatty substance (myelin) that surrounds the nerve fibers (axons). Myelin is found in almost all nerve fibers, and acts as an electrical insulation allowing the messages to pass quickly from place to place.

Axons are the primary transmission lines of the nervous system; however, when they become enclosed in cable-like bundles, they are known as nerves. Within the white matter there are different kinds of nerve tracts, or bundles of axons, which connect one part of the brain to another part, and to the spinal cord.

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An innovative technology to provide evidence-based continence planning TENA® Identifi's revolutionary technology represents a shift in continence care planning and resident care in both acute and long-term facilities across Canada and the globe. It marks a revolution in how caregivers are able to deliver improved quality of life for residents.

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- Improved quality of life for the resident
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**TENA® Identifi** electronically tracks voiding patterns as they occur over 72 hrs. and graphically converts the data into actionable, evidence-based reports to help you effectively optimize individualized continence care in terms of:

**NEW**

- **Identifi`s**
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  - encompasses the entire voiding pattern
  - electronically tracks continence events
  - electronically tracks voiding patterns as they occur over 72 hrs.
  - graphically converts the data into actionable, evidence-based reports to help you effectively optimize individualized continence care in terms of:

**Improved quality of life for the resident**

- **Optimized products selection**

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