

Complete Summary

GUIDELINE TITLE

Dementia care practice recommendations for assisted living residences and nursing homes.

BIBLIOGRAPHIC SOURCE(S)

Tilly J, Reed P, editor(s). Dementia care practice recommendations for assisted living residences and nursing homes. Washington (DC): Alzheimer's Association; 2006 Sep. 28 p.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Alzheimer's Association. Dementia care practice recommendations for assisted living residences and nursing homes. Chicago (IL): Alzheimer's Association; 2005. 15 p.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Dementia

GUIDELINE CATEGORY

Evaluation
Management
Prevention
Risk Assessment

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Nursing
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Occupational Therapists
Physical Therapists
Physician Assistants
Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

To enhance the quality of life of people with dementia by improving the quality of dementia care in assisted living residences and nursing homes

TARGET POPULATION

Residents of assisted living facilities and nursing homes

INTERVENTIONS AND PRACTICES CONSIDERED

Dementia Care

1. Holistic assessment
2. Regular formal assessments
3. Refer to other professionals as appropriate
4. Care planning involving resident, family, and staff
5. Provide person-centered care
6. Provide opportunities for residents to express themselves
7. Medication and non-pharmacological treatment
8. Training and management of staff
9. Provide positive and safe environment

Food and Fluid Consumption

1. Nutrition screening and thorough assessment
2. Ongoing monitoring of food and fluid intake
3. Staff engagement in mealtime experience
4. Provide pleasant, familiar dining environment and positive social environment
5. Provide opportunity for residents to drink fluids throughout the day

Pain Management

1. Pain assessment
2. Referral to other health care professional, as appropriate
3. Staff documentation of pain assessment
4. Pain prevention with medication or non-pharmacologic approaches
5. Analgesics or narcotic pain medication

Social Engagement

1. Formal initial assessment
2. Staff involvement in resident's social engagement
3. Social engagement plan
4. Encourage activity through environment
5. Encourage use of remaining skills in daily activities

Management of Wandering Residents

1. Assessment of resident's history and patterns of wandering and associated risks
2. Care planning that promotes patient mobility and safety
3. Additional staff assistance for newly admitted residents
4. Ensure that wandering residents have adequate nutrition and hydration
5. Accompany wandering residents to ensure safety
6. Staff training on the consequences of unsafe wandering
7. Create substitute physical activities

Management of Resident Falls

1. Resident history and patterns of falling and initial assessment
2. Identification of resident risk factors
3. Evaluation of environmental conditions related to falls
4. Care planning that promotes patient mobility and safety
5. Refer to other professionals as appropriate
6. Staff training on fall prevention
7. Promote a regular sleep-wake cycle
8. Exercise programs to maintain or improve resident function, posture, and balance
9. Modify environment to prevent falls

Physical Restraint-Free Care

1. Initial assessment and history
2. Regular comprehensive assessment
3. Residents' self-assessment of their capacity to provide a restraint-free environment
4. Care planning
5. Staff and family education
6. Developing restraint-reduction plan
7. Modify environment to eliminate restraints

MAJOR OUTCOMES CONSIDERED

- Effectiveness of interventions to alleviate psychiatric and behavioral symptoms
- Effectiveness of interventions to minimize limitations in activities of daily living
- Effectiveness of interventions to prevent falls and unsafe wandering
- Effectiveness of interventions to reduce and eliminate use of restraints
- Quality of life

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline authors reviewed articles in the peer-reviewed literature from 1994-2003. To identify potentially useful items, the authors conducted a comprehensive search of Medline, CINAHL, and PsychInfo, using various combinations of relevant search terms, such as dementia, quality, long-term care, nursing homes, assisted living facilities, and manual searches of all relevant articles' reference sections; these methods resulted in the collection of 325 articles.

These articles were reviewed and appear in the literature review only if they focus on long-term care facility residents with dementia, report on use of experimental or quasi-experimental methods, and report the statistical significance of findings. Trials are not included in the review if they have poorly defined interventions, fewer than 10 participants, or no control condition. Literature reviews and consensus statements, which reported systematic methods of analyzing extant studies, were included in the review if they were no more than five years old to ensure that valuable information published before 1994 could be included. This selection process resulted in the inclusion of 101 studies and review articles. Review of articles on assessment instruments and comparisons of the efficacy of different medications in the management of dementia symptoms are outside the scope of this review. The literature on special care units as an intervention is not in the review because the definition of such units varies considerably and results have been inconclusive.

2007 Update

The authors reviewed articles from 1994 to August 2006. To identify potentially useful sources, the authors relied on a comprehensive search of PubMed, CINAHL, PsychInfo, and Ageline databases, using various combinations of relevant search terms, such as dementia, falls, restraints, wandering, nursing homes, assisted living facilities, as well as manual searches of articles' reference sections; these methods resulted in the collection of 109 articles.

These articles were reviewed and appear in the literature review only if they include long-term care facility residents with dementia, report on use of experimental or quasi-experimental research, and report the statistical significance of findings. Trials are not included in the review if they have poorly

defined interventions, fewer than 10 participants or no control condition. Literature reviews were included in this review if they were no more than five years old and reported systematic methods of analyzing studies.

NUMBER OF SOURCE DOCUMENTS

101 studies and review articles were included.

2007 Update

28 studies and review articles met the inclusion criteria

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Alzheimer's Association conducted a comprehensive literature review, *Evidence on Interventions to Improve Quality of Care for Residents with Dementia in Assisted Living and Nursing Homes*, which critiques evidence on interventions designed to improve dementia care. Dementia care experts and professional staff from the Alzheimer's Association and 26 other national organizations representing providers, professionals, consumers, and workers, used this evidence and a consensus-building process to translate the research into specific recommendations for dementia care practices.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Not stated

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not applicable

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommended Practices for Effective Dementia Care

Assessment

- A holistic assessment of the resident's abilities and background is necessary to provide care and assistance that is tailored to the resident's needs.
- A holistic assessment includes understanding a resident's:
 - Cognitive health
 - Physical health
 - Physical functioning
 - Behavioral status
 - Sensory capabilities
 - Decision-making capacity
 - Communication abilities
 - Personal background
 - Cultural preferences
 - Spiritual needs and preferences
- Assessments should acknowledge that the resident's functioning might vary across different staff shifts.

Example: Residents may become confused, disoriented, or more active as evening approaches or during staff changes.

- Thorough assessment includes obtaining verbal information directly from residents and from family when possible.

Example: Staff can ask residents about their reactions to care routines, and staff can provide feedback on successful techniques to the entire care team.

Example: Family members can help develop a "life story" of the resident, offering detailed background information about a resident's life experiences, personal preferences, and daily routines.

- If obtaining information from a resident or family is difficult, staff can still learn about the resident through other sources, such as medical records, and by observing the resident's reaction to particular approaches to care.
- Resident behaviors can be seen as a form of communication and an expression of preference.

Example: *A resident repeatedly refusing a certain food may simply not like that particular food.*

Example: *A resident who consistently resists entering the shower room may need another method of keeping clean.*

- Regular formal assessment, as required by federal or state regulation, is key to appropriate management of residents' care. Equally important is ongoing monitoring and assessment of residents, particularly upon return from the hospital or upon a significant change in their conditions.
- If assessment identifies problems requiring consultation with health or other types of professionals, making the appropriate referrals can help mitigate these problems.

Example: *Professionals such as physical or occupational therapists can help people with dementia regain physical health and improve their performance of daily activities.*

- Obtaining the most current advance directive information (e.g., durable health care power of attorney or living will) as well as information about a resident's preferences regarding palliative care and funeral arrangements helps ensure that the resident's wishes will be honored.

Note: While residents possess the capacity for decision making, they have the legal right to review and revise their advance directive.

Care Planning and Provision

- Effective care planning includes a resident and family, when appropriate, as well as all staff (including direct care staff) who regularly interact with the resident throughout the process.

Example: *By asking staff and family members who have the best relationship with the resident to describe how they elicit cooperation regarding necessary care activities, those techniques can become a routine part of care.*

- An effective care plan builds on the resident's abilities and incorporates strategies such as task breakdown, fitness programs, and physical or occupational therapy to help residents complete their daily routines and maintain their functional abilities as long as possible.
- When all staff involved in a resident's care are familiar with the care plan, they will be better equipped to provide appropriate care to the resident.

Note: Assessments, care plans, and life stories will be most beneficial if they are accessible to all staff.

- Care plans will remain current and most useful if they are regularly updated in conjunction with periodic assessments.
- Care plans need to be flexible enough to adapt to daily changes in a resident's needs and wishes.

Behavior and Communication

- Residents need opportunities and sufficient time to express themselves.

Example: *Speaking in simple, direct language to residents, potentially accompanied by gestures, pictures, written words, or verbal cues, may help staff communicate with residents when involved in daily activities.*

Example: *Residents may need to work with a speech-language pathologist to maximize their communication skills.*

- The behavior and emotional state of people with dementia often are forms of communication because residents may lack the ability to communicate in other ways.
- Staff need initial and ongoing training to identify potential triggers for a resident's behavioral and emotional symptoms, such as agitation and depression.

Note: Triggers may include visual or hearing impairments, hunger, thirst, pain, lack of social interaction, or inappropriate strategies for care activities by staff.

- When staff recognize these triggers, they can use environmental and behavioral strategies to modify the triggers' impact.
- Staff actions can elicit positive behavioral responses as well.

Example: *Positive staff actions include providing relaxing physical contact like hand holding, apologizing if a resident complains of pain during a care activity, listening to resident concerns, and providing reassurance.*

- Information about a resident's life prior to admission, such as his or her culture and role within the family, may provide clues about effective approaches to care.

Example: *Knowing a resident's morning rituals, such as how they like coffee or tea and what time they prefer to wake up, can provide insight into how to care for a resident.*

- If non-pharmacological treatment options fail after they have been applied consistently, then introducing new medications may be appropriate when residents have severe symptoms or have the potential to harm themselves or others.

Note: Medication and non-pharmacological approaches are not mutually exclusive. At times a combined approach might produce the greatest benefit for the resident.

- When considering new medications, consider the presence of any other potential problems, such as depression.

Note: Continued need for pharmacological treatment should be reassessed by a qualified health professional according to the medication regimen or upon a change in a resident's condition.

- Staff communication with a resident's family is critical to helping the family understand the progression of the resident's dementia, particularly as he or she approaches the end of life.

Staffing

- Staffing patterns should ensure that residents with dementia have sufficient assistance to complete their health and personal care routines and to participate in the daily life of the residence.
- Consistent staff assignments help to promote the quality of the relationships between staff and residents.
- Direct care staff need education, support, and supervision that empowers them to tailor their care to the needs of residents.

Example: *Direct care staff could learn when residents wish to get up and how they wish to be bathed.*

Example: *Provide constructive feedback on staff interactions with residents.*

- Staff supervisors may need ongoing coaching to help them empower and support the direct care staff to be decision makers.

Note: Facility and staff managers serve an important function as role models in providing good dementia care.

- Administrators have the role of evaluating facility policies and procedures to ensure that they support direct care staff decision making during real-time interactions with residents.
- Staff who understand the prognosis and symptoms of dementia and how this differs from normal aging and reversible forms of dementia are better prepared to care for people with dementia.
- Effective initial and ongoing staff training addresses:
 - Dementia, including the progression of the disease, memory loss, and psychiatric and behavioral symptoms
 - Strategies for providing person-centered care
 - Communication issues
 - A variety of techniques for understanding and approaching behavioral symptoms, including alternatives to restraints
 - An understanding of family dynamics
 - Information on how to address specific aspects of care (e.g., pain, food and fluid, social engagement)
- Staff need (1) recognition for their use of problem-solving approaches to providing care and (2) emotional support as they deal with their own emotional reactions to the decline of residents over time and eventual death.

- Staff should acknowledge and accept a resident's experience and should not ignore a resident's report of an event or his or her feelings and thoughts.

Example: *When a resident is complaining of pain, staff could tell the resident that they understand it hurts and then report the pain to a staff member who can address the resident's pain experience.*

Environment

- The physical environment can encourage and support independence while promoting safety.

Example: *A positive environment has recognizable dining, activity, and toileting areas as well as cues to help residents find their way around the residence.*

- The optimal environment feels comfortable and familiar, as a home would, rather than a hospital. The environment should be less about physical structures and more about the feeling inspired by the quality of the place.

Example: *A home environment provides opportunities for residents to have privacy, sufficient lighting, pleasant music, and multiple opportunities to eat and drink, and also minimizes negative stimuli such as loud overhead paging and glare.*

Example: *When appropriate, a home environment might entail a private room and bathroom and the opportunity for residents to have personal furnishings, pictures, and other items in their living area.*

- Providing easy, safe, and secure access to the outdoors while maintaining control over unauthorized exiting enhances the environment.

Note: Residents who have elopement behaviors need opportunities for safe wandering.

Recommended Practices for Adequate Food and Fluid Consumption

Assessment

- Nutrition screening and thorough assessment are the foundation for providing optimal nutrition care.
- Assessments need to address nutritional problems and resident characteristics such as poor dental health, swallowing difficulties, or distractibility during meals that may affect food and fluid consumption.

Example: *Set up referrals to a registered dietitian for residents who are at high risk for nutritional problems, in compliance with regulatory requirements. Registered dietitians can prioritize nutritional problems and interventions by verification, evaluation, and interpretation of physical, chemical, and behavioral information.*

Example: *Those who have swallowing difficulties may need assessment by a qualified professional familiar with dysphagia.*

- Difficulty with eating may also be the result of residents having impairments of balance, coordination, strength, or endurance.

Note: Ensure that seating adequately compensates for these impairments.

- Ongoing monitoring of residents is necessary to discover changes in food and fluid intake, functional ability, or behaviors during meals. Any changes should be reported to dietetic staff and care planners.
- Adequate assessment to minimize mealtime difficulties includes observing residents for warning signs such as:
 - Difficulty chewing and swallowing, or changes in swallowing ability
 - Poor utensil use
 - Refusing substitutions
 - Low attentiveness to a meal or wandering away during the meal
 - More than 25 percent of food uneaten during a meal
- Regular monitoring and recording of a resident's weight helps ensure that staff recognize and address the cause of any changes.

Staff Approaches

- Various activities can engage residents in the mealtime experience and stimulate appetite.

Example: *Create opportunities for residents to help plan the menu and set the table; stimulate olfactory senses by baking bread or a pie prior to the meal.*

Example: *Create a "happy hour" to encourage increased fluid intake.*

- When practical, residents can choose the time when the meal is served. Mealtimes may need to be rescheduled for a different time of day if a resident exhibits time- or light-dependent agitation, distraction, or disorientation.
- During the meal, residents often require assistance to maximize their own ability to eat and drink. Encouraging residents to function independently whenever possible can help prevent learned dependency.

Example: *If assessment shows that a resident can eat independently, but does so slowly, the resident can eat at his or her own pace, perhaps with verbal reminders to eat and drink. Mealtimes can be extended for slower-eating residents.*

Example: *Adaptive utensils and lipped plates or finger foods may help individuals maintain their ability to eat.*

Example: *For those residents who manage better if they face fewer choices, serving one food item at a time is preferable.*

Example: *If residents need hand feeding, guide the resident's hand using the "hand-over-hand" technique.*

- It is ideal for staff to sit, make eye contact, and speak with residents when assisting with meals.
- Fortified foods and supplements may become necessary, but first try other food approaches such as favorite foods and food higher in nutrient density, calories, and protein.
- Residents with severe and irreversible dementias may no longer be able to eat at the end of life and may need only comfort care.

Note: Residents at the end of life need their mouths moistened and good oral care.

Note: When residents are near the end of life, artificial nutrition and hydration may be withheld, in accordance with their wishes.

- Weight loss is often expected at the end of life, but should still be assessed.

Note: Residents should not be forced to eat beyond what they desire.

- When considering tube feeding as an option, one should be aware of the potential consequences. Tube feeding could have many serious side effects for residents with dementia, including aspiration, infections, and resident removal of tubes.

Environment

- Residents should have a pleasant, familiar dining environment free of distractions to maximize their ability to eat and drink.

Example: *Distractions during meals should be limited by avoiding mealtime interruptions and by reducing unnecessary noise and the number of items on the table.*

Example: *Serving residents with dementia in smaller dining rooms can minimize distractions.*

Example: *A resident's attention to food can increase through visual cues, such as ensuring visual contrast between plate, food, and place setting.*

Example: *Present a variety of foods in attractive ways.*

- A positive social environment can promote the ability of residents to eat and drink.

Example: *Consider where residents are seated to construct the most appropriate arrangements given relative need and personalities.*

Example: *Provide small tables that encourage conversation among tablemates.*

Food and Fluid

- Residents need opportunities to drink fluids throughout the day.

Example: *Incorporate fluids into activities and have popsicles, sherbet, fruit slushes, gelatin desserts, or other forms of fluid always available to residents.*

- Nutritional requirements need to be met in the context of food and cultural preferences.
- As a resident's functional ability declines, food should be prepared to maximize the food's acceptance.

Example: *If a resident cannot handle utensils, try modifying the shape of food so it can be picked up with the fingers.*

Recommended Practices for Pain Management

Assessment

- Pain assessment should occur routinely, including when residents have conditions likely to result in pain and if residents indicate in any manner that they have pain.
- Effective pain assessment addresses:
 - Site of pain
 - Type of pain
 - Effect of pain on the person
 - Pain triggers
 - Whether pain is acute or chronic
 - Positive and negative consequences of treatment
- For those residents who cannot verbally communicate, direct observation by staff consistently working with them can help identify pain and pain behaviors.

Example: *Observing residents when they move may uncover problems that may not occur when they are at rest. The problems may require referrals to occupational or physical therapists.*

Example: *Observation may uncover behavioral symptoms, such as agitation and mood changes, or verbal and physical expressions of pain, such as sighing, grimacing, moaning, slow movement, rigid posture, and withdrawing extremities during care.*

- When pain occurs and the cause is not known, conduct a thorough assessment of the resident's condition and contact family, if available, to collect background information on the resident's past pain experiences.
- When residents are in pain, appropriate referrals to a qualified health care professional can lead to effective treatment.

Example: *Pharmacists could be contacted when there are questions about the positive and negative aspects of employed pharmacological treatments.*

- All staff, including direct care staff, should be involved in pain assessment by being trained to record their observations and report signs of pain in residents to licensed nursing staff.

Note: Use of assessment tools.

- There are many pain scales and tools available, and staff may want to try various types to determine which ones work most effectively for any given resident with dementia.
- If an appropriate pain scale is determined, staff should be trained to use the same pain scale consistently with a resident.
- Periodic reassessment of a resident's pain experience should use the same assessment tool over time as long as necessary.

Staff Approaches

- Prevention of pain is the first defense against it.

Example: *Avoid conditions that cause pain, such as infections, fractures, pressure ulcers, and skin tears, through use of appropriate caution when caring for residents.*

- Pain can be prevented through the regular use of medications. Offering medications as needed (PRN), that is, only when the resident reports pain, may not be sufficient treatment for many residents.
- There may occasionally be valid clinical reasons for not wanting to mask acute pain with analgesics until a cause for the pain can be identified or ruled out.

Example: *It may be necessary to monitor acute abdominal pain to identify a surgical emergency.*

- When chronic pain occurs, non-pharmacological approaches are often helpful.

Example: *Useful strategies to ease pain and promote well-being include relaxation, physical activities, superficial heat, and repositioning.*

- Analgesics or narcotic pain medications may be necessary if non-pharmacological therapies are not sufficient.

Note: Licensed practitioners should determine the type and amount of medication based on the severity of the resident's pain and his or her past experience with analgesics. When deciding on pharmacological treatments, consider all medication side effects, including those affecting dementia and cognitive functioning.

- Residents and their families should receive information about palliative care options, including hospice, when residents appear to have entered the final stages of dementia.
- When appropriate, work with a resident's physician to enroll a resident who is in the final stages of dementia in hospice.

Note: Signs that a resident may be in the final stages include a resident's inability to walk without assistance and to sit up without support, inability to smile, unrecognizable speech, and swallowing problems.

Note: Entry into end-of-life care programs can help promote effective use of pain medication and ease the end of life process.

Recommended Practices for Social Engagement and Involvement in Meaningful Activities

Assessment

- A formal initial assessment that involves family, when available, and ongoing interaction with a resident promotes understanding of the activities that would be meaningful to the resident.
- Assessments will help determine various resident characteristics relevant to social engagement and activity participation. To involve residents in the most meaningful activities, assess a resident's:
 - Capacity for physical movement
 - Capacity for mental stimulation
 - Interest in social interaction
 - Desire for spiritual participation and fulfillment
 - Cultural values and appreciation
 - Various specific recreational interests and preferences
- At the time of admission, families and residents should be invited to provide staff with "a life story" that summarizes the resident's past experiences, personal preferences and current capabilities.

Staff Approaches

- Social engagement of residents is not the sole responsibility of the activities staff. Every staff member has the responsibility and the opportunity to interact with each resident in a manner that meets the resident's needs and desires.
- A plan for social engagement and meaningful activity is a critical part of the care plan.
- Staff can achieve both brief and extended interactions with residents throughout the day. Brief but meaningful encounters may greatly enhance a resident's life.

Example: *It takes very little time to share something personal with a resident, such as family photographs, or to approach a resident in a hallway and compliment her on her dress.*

- Lack of verbal communication skills does not prevent residents with dementia from being socially engaged. On the contrary, staff may play an even more important role by initiating an engagement.

Example: *If a resident's life story indicates that the resident enjoys music, play music or sing a song.*

- Activities need to acknowledge that some residents with dementia experience increased confusion, agitation, and movement at the end of the day.
- Appropriately trained staff and volunteers can facilitate group activities.

Note: Staff training can include methods of adapting activities for the needs of each resident with dementia to maximize participation and engagement.

Environment

- Elements in the structure or layout of assisted living residences or nursing homes can create opportunities for meaningful activity.

Example: *Develop walking paths that encourage exploration and strolling when the home's facility layout permits.*

Example: *Develop interest points such as a fish tank or a colorful tapestry that encourage visual or tactile stimulation.*

- Activity materials can be available at all times for use by non-activity staff and visitors.

Note: These materials may include such things as baskets of fabric swatches, greeting cards, calendars with attractive photos, and tactile items such as aprons, hats, and fishing gear.

- Resident functioning can improve when the environment minimizes distractions that can frighten or confuse residents, while maximizing environmental factors that promote independence.

Example: *Hold an activity in a quiet room free of distractions or noise.*

Example: *Ensure appropriate lighting, temperature, and comfort for residents.*

Activities

- Residents should be encouraged to use their remaining skills in their daily activities. Use techniques that encourage residents to be as independent as possible
- Frequent, meaningful activities are preferable to a few, isolated programs.
- Activities should proactively engage residents.

Example: *Having residents watch staff make decorations for a party is not as meaningful as asking residents to help make the decorations.*

- The outcome of an activity or social interaction is not as important as the process of engaging the residents.

Example: *A gardening activity can be pleasant whether or not a plant grows.*

- Offering activities that accommodate the resident's level of functioning can promote participation in them.

Example: *Word games may be highly successful for residents at one cognitive level and highly frustrating for residents at another.*

- When an activity includes multiple participants, consider the group dynamic and the overall mood of the group, and be flexible in adapting the focus and purpose of the activity.
- Opportunities for involvement in the community are important for the sake of feeling part of the greater society.

Example: *Consider attending a concert at a local theater, participating in a community service project, or playing with local children through an intergenerational program.*

- Staff can offer opportunities for families to be involved in activities.
- Group sizes and lengths of time for the activity need to be tailored to the functional level of residents.

Example: *Ideal group sizes range from four to 10, depending on the activity and abilities of the residents.*

Example: *Thirty minutes or less of one specific activity or task is appropriate for most individuals with dementia before transitioning to another task.*

Example: *Residents who are not ambulatory can be meaningfully engaged and stimulated by such activities as massages, music, and storytelling.*

Recommended Practices for Resident Wandering

Assessment

- Before admission, collect information from family, friends or the transferring facility about the resident's history and patterns of wandering and strategies the family used to prevent unsafe wandering or successful exiting.
- Assess each resident's desire and ability to move about, and associated risks, such as becoming lost, entering unsafe areas or intruding on another resident's private space. While evaluating the triggers of wandering and a resident's wandering patterns, it is essential to determine:
 - Whether wandering is a new occurrence
 - Wandering patterns
 - Medical conditions that may contribute to wandering, such as urinary tract infections, pain and constipation
 - Cognitive functioning, especially safety awareness and being impulsive
 - Vision and hearing
 - Functional mobility status: balance, gait and transfer abilities
 - Sleep patterns
 - Resident life history, including past occupation, daily routines and leisure interests
 - The resident's own toileting routines

- Emotional or psychological conditions that may be related to wandering, such as depression and anxiety or need for companionship
- Social considerations, such as interest in involvement with others
- Environmental hazards (e.g., poor lighting and uneven floors)
- History of recent falls or near falls
- The resident's footwear and clothing
- The resident's access and response to safeguards (e.g., video monitors, sensors, door alarms, access to handrails and places to rest)
- Determine if unsupervised wandering presents a risk or benefit to the resident and others in the residence.
- Assess the residence to determine if it can meet the needs of a resident who wanders. An adequate environment involves:
 - Physical and social environments that provide activities appropriate for a resident's cognitive functioning and interests, as well as opportunities for walking, exploring and social interaction
 - Communication and search plans in the event of successful exiting

Staff Approaches

- Develop a care plan, based on resident assessment, which promotes resident choice, mobility and safety. Update the plan as the resident's wandering patterns change with the progression of dementia. Involving family or other caregivers in planning will help them understand the resident's condition as it changes.
- Assign staff to work with residents in ways that support consistent relationships so that each resident develops a sense of safety and familiarity with staff.
- Ensure that staff understand whether a resident has a propensity to wander and the conditions under which this occurs.
- Staff need to understand and recognize the consequences of limited mobility.
- Ensure that residents are able to move about freely, are monitored and remain safe.
- Residents who have just moved into a new area or home may need additional staff assistance until they are comfortable in their new environment.

Example: *Have specific welcome activities for new residents to help them feel comfortable and part of the community. These activities should avoid overwhelming the residents with new situations and people. Involve family members or previous caregivers to ease the transition.*

- Communicate regularly with families of residents who wander regarding their need for movement. Describe resident behaviors and discuss measures to support their continued mobility, while protecting them and other residents with whom they may have contact.
- Help residents who do not have cognitive impairment understand wandering as a symptom of dementia.
- Ensure that residents who wander have adequate nutrition and hydration, which may include offering food and drinks while they are "on the go."

Note: This is particularly important for residents who are unable to remain seated during mealtime.

- Staff may use various approaches to minimize unsafe wandering. These approaches include:
 - Identifying resident needs and wishes, and then offering to help the resident engage in related, suitable activities
 - Using a preventive approach to unsafe wandering

Example: *For those who wander when needing to use the toilet, schedule toileting according to the resident's patterns and use cues to help the resident find the bathroom quickly.*

Example: *Engage the wandering resident with food, drink or activities that promote social engagement and purposeful tasks, such as sorting, building or folding.*

Example: *Provide regular exercise and stimulation for residents through programs tailored to a resident's level of cognitive and physical functioning. Balance physical activities with regular quiet time to allow for rest. Consider involving family or friends in these activities on a voluntary basis.*

Example: *Take residents outside regularly, preferably daily except during adverse weather.*

Example: *For residents who are awake during the night, make activities available with an adequate level of staffing to provide encouragement and supervision.*

- Accompany wandering residents on their journeys when supervision is required to ensure safety or encourage a meaningful alternate activity. Companionship is an added benefit.

Resident Example: *A resident heads for an exit door at 3:00 p.m. when she sees nursing staff leaving the facility. She states that she must get home to meet her daughter after school.*

DO: Begin by *offering to help* the resident. Ask about her daughter, or ask what kind of snack she would like to prepare and offer to help her with the preparation. The goal is for the resident to perceive the staff person as a friend and advocate.

DON'T: Begin by *telling her that she can't go out* or that her daughter is now grown up. The goal is to avoid having the resident perceive staff as an adversary.

DO: Develop a longer-term approach to avoiding exit-seeking behavior. For example, involve the resident in a 2:30 p.m. activity in a location where she doesn't see the staff preparing to leave when shifts change.

- If an alarm system is used to alert the staff when a wandering resident is attempting to leave the facility, choose the system that is least intrusive and burdensome.

Note: For some residents, chair and personal alarm systems are a burden (as evidenced by the resident's protests or attempts at removal) and in some cases may lead to an increase in agitated behavior.

Note: Chair, bed, and personal alarms that are audible to the resident may discourage all movement, not just unsafe attempts to stand or walk unassisted.

- Train all staff on the consequences of unsafe wandering, the protocols to follow to minimize successful exiting and the procedures to follow when a resident is lost.
- Promote identification of residents who are at risk of successful exiting:
 - Keep photographs of residents who wander in a central, secure location and ensure that receptionists, security staff and others in a position to help can prevent successful exiting by recognizing these residents.

Note: Care should be taken to ensure confidentiality and compliance with any relevant federal and state requirements.

- Provide opportunities for everyone to get to know these residents.
- Have a "lost person" plan to:
 - Account for each resident on a regular basis, such as during mealtimes, and when shifts change.
 - Establish a sign-in and sign-out policy for families and visitors when taking residents out of the residence.
 - Have recent photographs of residents and former addresses on file to provide to law enforcement personnel in case of successful exiting.

Note: Care should be taken to ensure confidentiality and compliance with any relevant federal and state requirements.

- Notify management, family, law enforcement personnel, and state and local agencies as required immediately when a resident is missing and ensure that personnel receive information such as the resident's photo, home address, description of clothing worn and other relevant information.
- Carry out an organized search plan of the facility and its immediate vicinity and understand that a person with dementia may not respond when his or her name is called.
- Maintain local telephone numbers of nearby bus terminals, train stations or taxi services in case the search expands beyond the residence.
- Prepare a report that describes the resident's successful exit so the residence can learn from the experience as part of a quality improvement program.
- Organize routine practice searches.

- Enroll residents in the Alzheimer's Association Safe Return® program, which the Association operates with funding from the U.S. Department of Justice. Safe Return is a nationwide program that helps identify, locate and return people with dementia to their homes.

Environment

- Work to eliminate non-emergency paging-system announcements and other institutional features that make the residence feel foreign or different from one's home.
- When possible, create indoor and outdoor pathways which are free of obstructions and have interesting, safe places to explore and comfortable places to rest along the way. Pathways need to be well-lit without shadows or pools of bright light. Install window coverings to eliminate glare in key rooms and passageways. Ensure that transitions from pathways onto grass and other areas are smooth with no uneven surfaces.
- Create activity zones with recreational opportunities, such as multi-sensory theme boxes, that residents can explore with staff encouragement.
- Create a low-stimulus setting for periodic rest breaks, perhaps playing music or nature sounds that have been observed to calm the person who wanders.
- Provide substitute physical activities, such as dance, exercise or rocking.

Example: *Encourage use of safe gliding chairs that have a wide base and do not tip over easily.*

- Provide cues to help residents who wander orient themselves to the residence. Cues can include memory boxes by a resident's door, personal furnishings that residents will recognize or large visual signs or pictures for bathrooms.
- Consider the following approaches to minimize the risk of successful exit seeking. Before implementing them, check with fire marshals and other relevant officials regarding safety regulations, which vary by state.
 - Make exits less obvious to reduce visual cues for exiting so the resident who wanders does not realize exiting is possible.

Example: *When designing a new residence or unit, place doors parallel to the walking path with no windows in or beside the doors.*

- Install non-intrusive alarm systems that alert staff to resident exiting.
- Post signs at exterior doors to alert visitors that people with dementia might try to leave when they do.

Recommended Practices for Resident Falls

Assessments

- Before admission, collect information from family, friends or the transferring facility about the resident's history and patterns of falling and strategies the family used to prevent falls.
- Initial resident assessment is critical in the first few weeks after entering a residence because of a resident's potential confusion due to relocation. After a

reasonable adjustment period, ongoing assessment addresses the changing risk of falls as dementia progresses.

Example: *Newly admitted residents with dementia require close monitoring. The first 24–48 hours after an admission to a new setting are critically important because staff and surroundings are unfamiliar to the resident.*

- A comprehensive assessment includes both identification of resident risk factors and evaluation of environmental conditions related to falls. It also includes collecting information from a resident as well as his or her family or caregivers about the history of falling and any other factors that may contribute to falls.
- Effective resident assessment includes:
 - History and patterns of near-falls, recent falls and fall-related injury
 - Cognitive impairment and capacity for safe and proper use of adaptive equipment and mobility aids, such as walkers
 - Functional status and factors that affect mobility, including muscle tone and strength, transfer ability, balance, stance, gait and ambulatory ability
 - Sensory function, including vision, ability to sense position of limbs and joints, and tactile senses

Note: Visual impairment may be related to contrast sensitivity, field loss, and use of glasses with incorrect prescriptions. A new prescription for corrective lenses may cause falls. Residents with cognitive impairment may be unable to use bifocals or trifocals properly.

- Medical conditions that may contribute to falls, such as pain, infections, cardiovascular disease, osteoporosis, deconditioning, and nighttime urinary frequency and urgency
- Hallucinations and delirium
- Presence of restraints
- Nutritional status and recent weight loss
- Current medication regimen and use or recent change in medications
- History or presence of substance abuse or withdrawal symptoms
- Psychological conditions such as depression and anxiety
- Aspects of a resident's life history, professional and personal occupations, and daily routines could lead a resident to attempt activities that might result in falls

Example: *A resident previously in the furniture business might try to move heavy furniture, thus increasing the risk of falling.*

- Environmental assessment includes:
 - Environmental layout (shape of space and ease of getting around)
 - Lighting and glare
 - Presence of obstructions in both resident rooms and common areas
 - Accessibility, visibility and safety of bathroom and dining room
 - Sturdiness and visibility of handrails and furniture
 - Contrast of the toilet and sink from the wall and the floor
 - Safety and working condition of equipment and fixtures (e.g., bedside commodes, shower chairs, adequacy of brakes on wheel chairs)

- Appropriate use of personal safety devices, such as canes, walkers or wheelchairs
- Bathing facilities with non-slip surfaces
- Floor surfaces, textures and patterns

Example: *A blue-and-black border may look like a river or a hole.*

- Fit and use of resident footwear

Example: *Examine shoes and slippers regularly for potential poor traction.*

- Use of housekeeping equipment

Example: *Ensure that machines like floor buffers are run when residents are not likely to be moving about. However, they should not be used at night when residents are sleeping.*

- Use documentation and a tracking tool to identify falls, fall patterns and patterns of risky movement. Follow up with a family care plan meeting to evaluate options, such as use of an individual caregiver or presence of family and friends to help during peak activity times.
- If necessary, refer the resident to a qualified professional for evaluation using a more in-depth assessment of the resident's functional mobility, and ability to use safety awareness and compensatory strategies. Upon admission to the residence, refer residents to appropriate professionals if they have any of the following:
 - History of recent falls
 - Existing or new gait disorder or other condition that may be related to falls
 - Need for restorative activity to support mobility by strengthening muscles, improving balance, stabilizing gait and increasing physical endurance

Note: Professionals can help identify creative, individual solutions to minimize the number of falls and injuries.

Staff Approaches

- Based on the resident assessment, develop a care plan that promotes resident mobility and safety while preventing or minimizing injuries. Update the plan as the resident's falling patterns change with the progression of dementia. Involve family or other caregivers in planning to help them understand the resident's condition as it changes.
- Dementia care training is the first step to ensuring effective staff approaches to reducing risks and managing falls. Effective staff training on fall prevention addresses:
 - Resident risk assessment
 - Identifying and monitoring resident needs that may increase risk of falls or fall-related injuries

- Identifying and monitoring behaviors that increase fall risk, such as wandering patterns
- Understanding risks and benefits of potential interventions to prevent falls
- Understanding the benefits of exercise for improving a resident's strength and endurance
- Proper use of safety equipment and personal safety devices
- Safe techniques for lifting and transferring residents
- Some key points related to falls that staff need to understand include the following:
 - Because maintaining mobility is important, resident movement should be encouraged. The more a resident is immobile, the more he or she is at risk for injurious falls.

Example: *Exercise that promotes sit-to-stand activities and walking as part of the daily routine can help preserve a resident's mobility.*

- It is necessary to follow existing organizational policies and procedures relating to fall management and response.

Example: *Perform fall event assessments at the time of the fall to identify and address the specific cause for a fall, such as water on the floor or resident dizziness after standing up.*

- A range of interventions are available to individually tailor preventive strategies for residents at risk of falling.

Note: Strategies informed by thorough resident assessments have the highest likelihood of reducing falls.

Example: *To reduce falls associated with urgent trips to the bathroom, consider using an individual toileting schedule or a bedside commode. Consider clothing that is easy for residents to remove when they have to go to the bathroom.*

- Ensure staff are available to help those residents who need assistance with ambulation, dressing, toileting and transferring. Consistent staff assignment increases staff familiarity with individual residents.
- Eliminate physical restraints, unless needed for medical treatment in an emergency.
- Promote consistent and appropriate use of assistive devices, such as a walker.

Note: Some residents may always need staff to walk with them to prevent falls.

- Promote a regular sleep-wake cycle by keeping bedding dry and ensuring residents are exposed to sufficient daylight, identifying a resident's regular bedtime routine, and matching the sleep-wake cycle to lifelong sleep habits.

Example: *Ensure a comfortable sleeping environment with a good quality mattress, optimal temperature and minimal noise.*

Example: *Ensure that residents who like to bathe or read before bed can do so.*

Example: *Help a resident choose between extended-wear absorbent incontinence products to promote uninterrupted sleep or an individual toileting schedule.*

- Have a scheduled and structured exercise or walking program for those residents who can safely participate in order to maintain or improve function, posture and balance.

Example: *Develop walking programs around a resident's need to get someplace, such as walking to and from the dining room, instead of using a wheelchair.*

Environment

There are various ways to modify the environment to help prevent falls.

- Adjust bed, wheelchair, other chairs and toilet heights when indicated to help prevent falls.

Note: Existing safety guidelines recommend that toilet height be at about knee height.

- Understand that a person with loss of balance will grab onto anything within reach. Ensure that stable handholds are available by providing such items as grab bars and railings.
- Make sure furniture is sturdy and in good condition and adjust furniture location to match as closely as possible the resident's previous bedroom-to-bathroom path.
- Create and maintain a clear path to the bathroom.
- Whenever possible, provide non-slip floor treatments throughout the residence, especially in bathrooms and next to beds.
- Encourage use of footwear that is non-skid and provides a wide base of support.
- Ensure good lighting.

Example: *Increase resident ability to turn on lights by installing motion-activated lighting or sensor lights.*

Example: *Install nightlights between a resident's bed and bathroom.*

- Use silent alarms to alert staff when a resident at risk of falling attempts to leave a bed or chair.

Caution: Alarm systems can inadvertently restrict a resident's movement, in which case the systems function as restraints. For example, some residents

may become afraid to move for fear of setting off an alarm. Staff need to respond to alarms by providing the assistance needed to help the resident to move.

Recommended Practices for Physical Restraint-Free Care

Assessment

- Using assessment to find out each resident's life history, habits and preferences is critical to restraint-free care.
- Ongoing assessment is an essential strategy for identifying use of restraints and alternatives to their use, as well as to support restraint-free care.
- Residents need regular, comprehensive assessment so that their individual care plans address needs and prevent use of restraints for conditions such as frequent falls, behavioral symptoms or wandering.
- Residences need to assess their own capacity to provide a restraint-free environment. Self-assessment includes:
 - Extent to which restraint-free policies exist and are implemented
 - Level of staff training and understanding of restraint-free care
 - Circumstances under which restraints are used inappropriately
 - Identification of residents with restraints
 - Identification of conditions that might trigger use of restraints

Example: *Review medications because some can cause dizziness, loss of balance or delirium; others can reduce psychotic symptoms and the perceived need for physical restraints.*

Staff Approaches

- The key to eliminating use of restraints is individualized care, which depends on staff knowing the resident as a person. Consistent assignment of staff to residents promotes individualized care.
- Effective care planning involves knowing a resident's remaining abilities and understanding how to make use of them to avoid conditions such as wandering and falls that can lead to inappropriate use of restraints. Care planning staff are responsible for trying and documenting various options to avoid use of restraints.
- Staff at all levels need to understand the hazards of using restraints and the process of individualized assessment and care planning to meet each resident's unique needs.
- Effective staff education about restraints includes:
 - Definition of restraints
 - Restraint-free care and reasons why restraints are unacceptable
 - Myths and misconceptions about restraints, including, for example, the misconception that restraints are an effective and acceptable approach to ensuring resident safety
 - Negative impact of physical restraints on residents and staff
 - Restraint-related assessment strategies
 - Appropriate care for residents with behavioral symptoms
 - Residents' rights and legal aspects of restraint use
 - Residence restraint policy and protocol for use in emergency situations
- Families need education about restraints to develop an understanding of:

- The harmful consequences of restraints
- Why restraints are unacceptable
- Legal aspects of restraint use
- Support of resident autonomy and freedom of movement

Example: *Provide written educational information regarding restraint use to families upon resident admission.*

- Staff, sometimes with the assistance of consultants, can implement creative solutions for identifying and meeting individualized care needs regarding safety, behaviors and postural support.

Examples:

- *Respond promptly to resident calls and minimize their waiting times.*
- *When residents repeatedly slide out of their wheelchairs in an attempt to self-propel, place them in lower height wheelchairs without footrests or with footrests in the closed position that allow their feet to touch the floor.*
- *Assign staff to identify and help fatigued residents go to bed when they need rest so they won't attempt to get into bed unassisted.*
- *Use individualized day and nighttime activities to increase resident contentment and decrease behavioral symptoms.*
- *Seek assistance from a professional to help reduce use of restraints through evaluation and treatment of physical, cognitive or sensory impairments.*
- *Camouflage and protect areas of active wound care so the resident will not disturb dressings or the healing process.*
- *Encourage family members and friends to sit with the resident and provide support or reassurance.*
- When using restraints during a medical emergency, staff need to obtain orders from the resident's physician and notify the designated family member or surrogate decision-maker as soon as possible. Staff should begin medical evaluation and appropriate treatment as ordered, call emergency services or transfer the resident to an appropriate health care facility.
- If the residence uses restraints, senior staff need to establish an interdisciplinary team to develop and implement a plan for reducing use of restraints and working toward eliminating restraints.

Note: Nursing homes must have an interdisciplinary team for assessment and care planning. Designing alternatives to using restraints is an integral part of these processes.

- Make the restraint-reduction plan part of the residence's quality improvement program and include baseline collection of data, measures of progress and rewards for progress.

Note: Elimination of restraints requires that staff are adequately trained, alternative programs are in place, and adequate resources are available to implement individualized care plans.

Environment

- The environment can be modified to move toward a restraint-free environment. Examples of such modifications include:
 - Using chairs that are at the right height, depth and level of backing for each resident to have comfortable and safe seating; individualize the time a resident spends sitting up in a chair.
 - Individualizing each chair a resident uses in his or her room, public place or dining room.
 - Using a wheelchair only when needed for transportation.
 - Providing visual cues that are meaningful to a resident to deter him or her from entering the rooms of other residents.

Note: Please see the recommendations concerning the basics of dementia care, wandering and falls for additional examples of helpful environmental modifications to enhance safety and avoid use of physical restraints.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The Dementia Care Practice Recommendations are based on two comprehensive literature reviews that provide the latest evidence in dementia care research and the experiential evidence of dementia care experts.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Improved quality of life for persons with dementia through adequate food and fluid consumption, improved pain management, appropriate social engagement, prevention of unsafe wandering and falling, and elimination of restraints

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Patient Resources
Resources
Staff Training/Competency Material

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Tilly J, Reed P, editor(s). Dementia care practice recommendations for assisted living residences and nursing homes. Washington (DC): Alzheimer's Association; 2006 Sep. 28 p.

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 (revised 2006 Sep)

GUIDELINE DEVELOPER(S)

Alzheimer's Association - Disease Specific Society

SOURCE(S) OF FUNDING

Alzheimer's Association

GUIDELINE COMMITTEE

Alzheimer's Association Campaign for Quality Residential Care

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

ENDORSER(S)

AARP - Private Nonprofit Organization
American Assisted Living Nurses Association - Medical Specialty Society
American Association of Homes and Services for the Aging
American College of Health Care Administrators - Professional Association
American Health Care Association - Professional Association
American Medical Directors Association - Professional Association
American Occupational Therapy Association, Inc. - Professional Association
American Physical Therapy Association
American Seniors Housing Association
American Society of Consultant Pharmacists
American Therapeutic Recreation Association - Professional Association
Assisted Living Federation of America - Professional Association
Catholic Health Association
Consumer Consortium on Assisted Living - Professional Association
Hartford Institute for Geriatric Nursing - Academic Institution
National Association of Activity Professionals - Professional Association
National Association of Directors of Nursing Administration in Long Term Care - Professional Association
National Association of Social Workers
National Center for Assisted Living - Professional Association
National Hospice and Palliative Care Organization
Paralyzed Veterans of America - Private Nonprofit Organization
Service Employees International Union - Professional Association

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Alzheimer's Association. Dementia care practice recommendations for assisted living residences and nursing homes. Chicago (IL): Alzheimer's Association; 2005. 15 p.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Alzheimer's Association Web site](#).

Print copies: Available from the Alzheimer's Association, National Office, 225 N. Michigan Ave., Fl. 17, Chicago, IL 60601-7633, Phone: 1-800-272.3900

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Evidence on interventions to improve quality of care for residents with dementia in nursing and assisted living facilities. Chicago (IL): Alzheimer's Association; 2004. 20 p. Electronic copies: Available in Portable Document Format (PDF) from the [Alzheimer's Association Web site](#).
- Falls, wandering, and physical restraints: interventions for residents with dementia in assisted living and nursing homes. Chicago (IL): Alzheimer's Association; 2006 Aug. 11 p. Electronic copies: Available in Portable Document Format (PDF) from the [Alzheimer's Association Web site](#).

Print copies: Available from the Alzheimer's Association, National Office, 225 N. Michigan Ave., Fl. 17, Chicago, IL 60601-7633, Phone: 1-800-272.3900

Checklists and staff training materials are also available from the [Alzheimer's Association Web site](#).

PATIENT RESOURCES

Fact sheets and brochures on daily living; financial, legal and insurance issues; and home and residential care are available from the [Alzheimer's Association Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on September 23, 2005. The information was verified by the guideline developer on October 25, 2005. This NGC summary was updated by ECRI Institute on May 29, 2007. The updated information was verified by the guideline developer on June 7, 2007.

COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at <http://www.guideline.gov/about/inclusion.aspx>.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

© 1998-2008 National Guideline Clearinghouse

Date Modified: 11/10/2008

