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Long-Term Care Survey Alert

QUALITY OF CARE: Outmaneuver Common Obstacles To Rehabbing Residents With Dementia

Enlist cooperation, prevent behavioral symptoms.

A few smart moves can make all the difference in whether your cognitively impaired resident benefits from rehab therapy or battles the therapist every step of the way.

Start by getting rid of traditional thinking about deficits and strengths. For example, in the rehab arena, short-term memory loss can actually work in the therapist's favor if the person didn't enjoy the session the day before, notes **Shehla Rooney**, a physical therapist and president of **Premiere Therapy Solutions** in Cookeville, TN.

In fact, a cognitively intact patient who is not motivated to increase her walking ability can often be more "difficult to treat" than someone with dementia "for whom walking is a habitual task," Rooney says.

If therapists don't use the right techniques in caring for a resident with dementia, the person may refuse therapy or act out her resistance. In that regard, therapists can preempt agitation and aggression--and use such symptoms as a signal that they need to change their approach.

For example, residents with dementia may become agitated with sessions that last too long or aren't simple enough in focus. "Thirty minutes is pushing it where you'll probably start seeing that ... 'I want to get moving and change locations' impulse kick in," says **Pauline Franko**, a physical therapist and consultant in Tamarac, FL. She thus recommends providing two or three 20-minute sessions a day.

Break it down: Use "task segmentation" where you break down any task into its subcomponents. "Every resident with dementia should receive task segmentation to some exten--and certainly every therapy patient with dementia," says Rooney. The therapist should "break down commands: Stand up, sit down, stand up and walk over there."

Tap the Resident's Strengths

Make sure the goals and interventions fit the person's level of dementia and also tap into the person's strengths. For example, "you can't really do gait training for someone who can't follow simple commands," says Franko. "But you can build on the person's spontaneous memory."

Clinical examples: Franko recalls working with one cognitively impaired resident who had fractured her hip. "If we didn't provide therapy, she wasn't going to be able to walk again," Franko relays. Even though the patient could not follow a "single instruction," she still had the "basic reflexes" and that urge to keep moving. "So everything we did focused on eliciting those automatic responses."

People with Alzheimer's who are still in possession of their social graces may refuse to walk in therapy by saying to the therapist, "Oh no dear, you see to the others. I'm fine." But you can "play on that social proclivity by saying: 'I need you on the other side of the room because this person needs your chair,'" suggests Franko. "And the person will get up and walk."

In treating people with dementia, also look at what types of jobs the person used to do so you can integrate that type of activity into therapy, Franko advises.

Rooney agrees: "Women especially are used to being busy ... and taking care of people or things. We have residents in the therapy gym who fold laundry--one woman sweeps, another one likes to clean with a rag." All of that activity helps improve the residents' functional status and outcomes.