UNDERSTANDING THE AGING PROCESS

Aging is a process of gradual change over time. People reach their peak physical functioning and ability in their 20s and early 30s. These are the years that our bodies are the strongest, our senses are the keenest, and our minds are the sharpest.

Factors affecting the rate of aging are:
1. Lifestyle choices
2. Genetics
3. Environment

People who are said to age ‘successfully’ are:
1. Physically active
2. Socially engaged – being involved with friends and family
3. Able to manage long-term illness – adjusting to age-related challenges
4. Feel good about themselves – being able to take care of one’s self and have the ability to meet one’s needs and some wants

Expected Age-Related Changes

**Physical change:** Bones become brittle, muscles become weaker and bodies become frail. A fall can lead to loss of independence, and even death. Fractures do not heal as fast or as well for seniors. Age spots and wrinkles are most visible on the arms, face and neck. In terms of senses, the most noticeable changes impact our vision and hearing; however, our sense of smell, taste and touch (including temperature sensitivity) all change with age.

Want to better understand some of the changes that accompany aging?
- Look through a pair of glasses sprayed with hairspray.
- Put un-popped popcorn kernels in your shoes.
- Wear a blindfold and a nose-clip and try to tell the difference between a barbecue potato chip and a plain one.
- Turn the pages of a book wearing cloth gardening gloves.
- Look through the wrong end of binoculars and try to follow a right turn line on the ground.

Being physically active can help reduce or slow down the physiological decline that comes with aging.

**Physiological Changes in Sedentary (Inactive) Adults**
- Aerobic capacity decreases 10% per decade.
- Pulmonary function decreases.
- Maximal cardiac output decreases.
- Muscular strength is reduced.
- Substantial loss of muscle mass.
- Number of muscle fibers decrease 10% per decade.
- Size of muscle fibers decrease.
- Movement time and reaction time decrease.
- Bone mass decreases.
- Body fat increases.

**Cognitive Change:** Cognitively, older adults experience changes in memory, judgment, learning, reasoning, ability to process information and more. Aging comes with loss of short-term memory, or ability to recall recent activities or events. Long-term memory tends to cover a longer span of time, be of greater importance or is referred to more often and is retained longer.

Older adults are more likely to maintain the ability to perform tasks that are routine and require less memory. On the other hand learning new tasks or even attempting familiar tasks in new and unfamiliar environments become a struggle as more memory effort is required.

**Behavioral Change:** Three of the most common conditions that are accompanied by significant changes in behavior are:

1. Dementia - mental decline and impairment
2. Depression - intense sadness that impacts a person’s ability to lead a normal life
3. Delirium - disorientation, disorganized speech and an inability to comprehend what’s being said

**CLINICAL DEPRESSION**

Depression is a disorder that involves feelings of sadness, lasting for 2 weeks or longer, often accompanied by a loss of interest in life, hopelessness and decreased energy, to the point of affecting one’s ability to perform usual tasks and activities of daily living.

**Causes**

**Heredity/Genetics:** People with a close relative who has had depression are twice likely to develop depression themselves than people who don't have familial history

**Biochemical:** Nerve cells are the most basic units in the brain. Neurons are separated by gaps called synapses. Chemical substances, called neurotransmitters, carry messages or signals across these gaps to various nerve cells. Some neurotransmitters (i.e., serotonin, dopamine, and norepinephrine) are believed to be responsible for moods and emotions. A disturbance in these chemical substances has a profound negative effect on mood and emotions.

**Stressful life events:** Stressful life events can plunge a person into clinical depression, especially if a person is at risk for depression due to other factors. Stressful life events include, but are not limited to:

- Prolonged medical illness
- Illness or death of a loved one
- Divorce, ending a close relationship
- Loss of a job
- Moving to a new home
- Financial or legal problems
Fluctuating hormone levels: In women, fluctuating hormone levels can contribute to depression. Conditions linked to hormones in women are:

- Depression after pregnancy
- Depression in menopause

Other Factors:

- Alcohol or drug abuse
- Use of certain medications, such as steroids and some blood pressure medications
- Underlying general medical conditions (i.e., hypothyroidism, chronic fatigue syndrome)
- “Burnout” a depletion of mental and physical energy usually stemming from prolonged overwork and/or an overload of demands and obligations placed upon an individual

Signs and Symptoms (of a clinical depression)

Depression is the diagnosis when one has at least five of the following nearly every day for at least 2 weeks:

- Depressed mood
- Persistent feelings of hopelessness, guilt or worthlessness
- Fatigue or lack of energy
- Slowed behavior (feeling of “dragging one’s self around”)
- Reduction or loss of pleasure in life
- Decreased motivation
- Negative or pessimistic thinking
- Loss of interest in friends, activities, hobbies or work
- Change in eating habits; weight gain or loss
- Sleep problems, including waking up early
- Frequent crying
- Difficulty concentrating, remembering, or making decisions
- Irritability
- Being anxious or worried a lot
- Thoughts of death or suicide
- Suicidal thinking or suicide attempts

Management/Treatment

Management or treatment can be one or a combination of the following, depending on the severity or cause:

- Psychotherapy (counseling)
- Medication - to restore proper chemical balance in the brain
- light therapy
- electroconvulsive therapy
- regular exercise (specially for milder forms of depression) can help to uplift mood

Depression is Treatable

Most depressed elderly people can improve dramatically from treatment. In fact, there are highly effective treatments for depression in late life. Psychotherapy can play an important role in the treatment of depression with, or without, medication. It is important that the depressed person find a therapist with whom he or she feels comfortable and who has experience with older patients. This type of treatment is most often used alone in mild to moderate depression.
Antidepressants work by increasing the level of neurotransmitters in the brain. A frequent reason some people do not respond to antidepressant treatment is because they do not take the medication properly. Missing doses or taking more than the prescribed amount of the medication compromises the effect of the antidepressant. Similarly, stopping the medication too soon often results in a relapse of depression. In fact, most patients who stop taking their medication before four to six months after recovery will experience a relapse of depression.

**An Overview on Suicide**

- Suicide occurs almost twice as often as murder.
- Suicide is the third leading cause of death for people ages 15-24 and the second leading cause for people ages 25 - 34.
- A gun is the most common method of suicide.
- Suicide rates have increased for adults older than 65. One suicide death occurs for every 4 suicide attempts.
- Women try suicide more often, but men are 4 times more likely to die from a suicide attempt.
- (Most people who seriously consider suicide do not want to die. Rather they see suicide as a solution to a problem and a way to end their pain, because they feel hopeless, helpless and worthless.)
- Talk of suicide or about wanting to die or disappear must be taken seriously. More so if the patient has a suicide plan - meaning, (1)one has the means, such as weapons or medications, available to commit suicide, (2) having set a time and place to commit suicide, (3) there is no other way to solve a problem or end the pain. If this happens, report to somebody right away, (who does one report to? hierarchy if there is any?) and stay with the person at all times, making sure the means are out of reach.

Suicide attempts or severe thoughts or wishes by older adults must always be taken seriously. It is appropriate and important to ask a depressed person:
- Do they feel as though life is no longer an option for them?
- Have they had thoughts about harming themselves?
- Are they planning to do it?
- Is there a collection of pills or guns in the house?
- Are they often alone?

Most depressed people welcome care, concern and support, but they are frightened and may resist help. In the case of a potentially suicidal elder, caring friends or family members must be more than understanding. They must actively intervene by removing pills and weapons from the home and calling the family physician, mental health professional or, if necessary, the police.

**Suicide Prevention Guidelines**

To help deter potential suicide attempts in a patient with depression, keep these guidelines in mind:

- **Assess for clues to suicide:**
  Watch for such clues as communicating suicidal thoughts, threats and messages, hoarding medication, talking about death, wanting to disappear, or feelings of hopelessness, helplessness, and worthlessness, giving away prized possessions, and having a suicide plan.

- **Provide a safe environment:**
  Check patient areas and correct dangerous conditions such as exposed pipes, windows without safety glass and access to the roof or open balconies
• **Remove dangerous objects:**
  Remove all sharps (i.e., razors, knives, glass, files, clippers), belts, suspenders, and light cords from the patient’s environment.

• **Consult with staff:**
  Recognize and document verbal and nonverbal suicidal behavior, and keep your supervisor informed.

• **Observe the suicidal patient:**
  Patient should be on constant one-on-one supervision. Be alert when the patient is using sharp objects (shaving), taking medication, or is using the bathroom (to prevent hanging or other injury).

• **Maintain personal contact:**
  Help the suicidal patient feel that he isn’t alone or without resources or hope. Building emotional ties to others is the ultimate technique for preventing suicide.

### DEMENTIA

Dementia is a loss of mental skills that affects your daily life. It can cause problems with your memory and how well you can think and plan. Usually dementia gets worse over time. How long this takes is different for each person. Some people stay the same for years, others lose their skills quickly. The chances of having dementia rise as you get older. This does not mean that everyone will get it. It is NOT a normal part of aging. People rarely have dementia before age 60. But after age 85, up to half of all adults have it.

#### Causes

Dementia is caused by damage to or changes in the brain. The following conditions are some of the common causes:

- Alzheimer’s disease - most common cause (see below for definition)
- Strokes - second most common cause (the type of dementia it causes is called vascular dementia)
- Head injuries
- Parkinson’s disease
- Dementia with Lewy bodies - protein deposits in the brain that causes dementia symptoms
- Frontotemporal dementia - parts of the brain that are concerned with social skills and behavior shrink, causing changes in personality and behavior

#### Stages of Dementia

Dementia can be divided into seven stages which are similar to those in Alzheimer’s disease. The seven stages of dementia are as follows:

1. **No impairment of normal function:**
   No sign of memory loss is visible to a medical professional nor does the patient experience any symptoms.

2. **Very mild cognitive decline:**
   People may experience some loss of memory such as forgetting familiar words, names, or the location of wristwatches, eyeglasses or other objects of daily use. Family, friends or colleagues may observe these signs.
3. **Mild cognitive decline:**
   Early stage dementia can be diagnosed only in some individuals with the following symptoms:
   - The patient has trouble remembering words or names.
   - The patient loses the ability to remember names of individuals newly introduced to him or her.
   - Difference in performance can be easily noticeable in work environment, social environment by family, friends or colleagues.
   - Less retention from articles or stories read in a magazine or book.
   - The patient misplaces or loses valuable objects.
   - Decreased ability to plan or organize.

4. **Moderate cognitive decline** (Late Confusional):
   It is a mild or early stage dementia with the following clear cut deficiencies being observed:
   - The patient fails to recollect recent incidents or current events.
   - The patient cannot perform some challenging mental arithmetic such as counting backwards from say 100 by 7s.
   - The patient is not able to plan or organize complex tasks such as arranging a party, planning a picnic etc.,
   - The patient would remain socially withdrawn and silent in challenging situations.

5. **Moderately severe cognitive decline** (Early Dementia):
   It is a moderate or mid-stage AD with major gaps in memory and deficits in cognitive function. Assistance with daily activities may be required and following deficiencies are observed:
   - The patient fails to recall current address, telephone number and name of the college or school from which they graduated.
   - The patient is in a confused state of mind with regards to their current location, date, day of the week, season, etc.
   - The patient fails to perform even lesser challenging mental arithmetic such as counting backwards from 40 by 4s.
   - The patient requires help in choosing the appropriate clothing for a particular season or occasion.
   - Generally, the patient retains substantial knowledge and can tell his/her own name, names of their spouse or children.
   - The patients do not require any assistance for eating or using toilet.

6. **Severe cognitive decline** (Middle Dementia):
   It is the next to the last stage and is also called the moderately severe or mid-stage of dementia with memory difficulties continuing to worsen, personality changes emerging substantially and the patient’s requiring a considerable amount of help for carrying out their day-to-day activities. The following symptoms are observed:
   - The patient loses track of some of the most recent experiences, events and even their surroundings. The patient cannot recall personal history exactly, though they can recall their name perfectly. The patient can distinguish familiar faces from unfamiliar faces.
   - The patient requires help to dress appropriately, since they tend to create errors such as wearing shoes on the wrong feet etc.
   - The patient experiences a disturbance in normal sleep/waking cycle.
   - The patient requires help with handling the details of toileting such as flushing the toilet, wiping and proper disposal of tissue paper.
   - There are increasing episodes of urinary or fecal incontinence.
   - Changes in behavior including suspicion and delusions such as suspecting the caregiver as an impostor, hallucinations, repetitive behavior such as hand wringing, etc.
   - The patient tends to wander and become lost.
7. **Very severe cognitive decline** (Late Dementia):
   It is the ultimate stage and is called severe or late-stage with the patient losing the ability to respond to the environment, unable to communicate orally and unable to control movements.
   - Very often patients in this stage lose the ability to communicate in a recognizable speech though they utter phrases occasionally.
   - Patients need assistance in eating and toileting with “general incontinence of urine.”
   - Patients gradually lose the ability to walk without support, to sit, to smile and hold their head up. Muscles become rigid and reflexes abnormal with swallowing becoming impaired.

**ALZHEIMER'S DISEASE**

It is the MOST COMMON FORM of DEMENTIA and is marked by memory loss in older people. Alzheimer’s Disease is characterized by progressive impairment in memory, cognitive functions, language, judgment and ADLs. It is a disease wherein patients will ultimately be unable to perform self-care activities and become dependent on caregivers.

**The Four A’s of Alzheimer’s Disease**
- AMNESIA: Memory loss
- AGNOSIA: Inability to recognize common objects or people
- APHASIA: Inability to use or understand language
- APRAXIA: Inability to coordinate purposeful movement

**Stages of Alzheimer’s Disease**

1. **Mild Alzheimer's disease**
   People with mild Alzheimer's disease may:
   - Have memory loss
   - Have trouble naming common items
   - Ask or say the same thing over and over
   - Get lost easily
   - Lose interest in things they once liked to do
   - Lose things more often than normal
   - Have personality changes

2. **Moderate Alzheimer's disease**
   People with moderate Alzheimer's disease may:
   - Have poor memory of recent events
   - Have trouble with tasks such as washing dishes or setting the table
   - Have a hard time dressing for the weather or occasion
   - Forget to shave or shower
   - Argue more often
   - Believe things are real when they are not
   - Wander, often at night
   - Be worried or depressed
   - Need close supervision
3. **Severe Alzheimer's disease**

People with severe Alzheimer's disease may:
- Have problems with eating
- Have problems with speech or not speak at all
- Not recognize you or other family members
- Not be able to control bowels or urine
- Have problems with walking

**Sundowning**

The term "sundowning" refers to the condition of becoming increasingly confused at the end of the day and into the night. Sundowning isn't a disease, but a symptom that often occurs in people with dementia, such as Alzheimer's disease. The cause isn't known. But factors that may aggravate late-day confusion include:

- Fatigue
- Low lighting
- Increased shadows

To reduce the chances of late-day confusion, encourage the patient to have an afternoon nap, or quiet time. Other manifestations of sundowning may be being able to eat breakfast by themselves, while being unable to do so for lunch and dinner. Or, they may know how to ask for a sweater in the morning when they are cold, while being unable to do so in the evening. The brain is an amazing thing - even with erosion, it will still try to get information from one part to another so as to be able to complete a task. One may observe a patient who has been a feeder for sometime suddenly be able to eat one meal by himself, but then go back to being a feeder again.

**Care for the Client with Alzheimer’s / Dementia**

- Ensure safety by non-slip mats, tub seats and handholds.
- Schedule bathing when client is least agitated. Be organized so the bath can be quick. Give sponge baths if the client resists a shower or tub bath.
- Always use the same steps explaining the same way every time.
- Assist with grooming. Help the people in your care feel attractive and dignified.
- Layout clothes in the order which they should be put on. Choose clothes that are simple to put.
- Set up a regular schedule for toileting and follow it. Never withhold or discourage fluids because a person is incontinent.
- Check skin regularly for signs of irritation.
- Document bowel movements.
- Observe the person’s physical health. Report any potential problems. People with dementia may not recognize their own health problems.
- Maintain a daily exercise routine.
- Maintain the best nutrition.
- Schedule meals at the same time each day. Serve familiar foods. If restlessness prevents getting through an entire meal, try smaller, more frequent meals. Finger foods can allow eating while moving around.
- Offer one course at a time. If a client needs to be fed, do so slowly. Offer small pieces of food.
- Encourage fluids.
- Keep nutritious bite-sized snacks nearby, especially favorites.
- Observe and report changes or problems in eating habits.
- Maintain self-esteem by encouraging independence in ADLs.
- Provide a daily calendar to encourage activities.
- Share in enjoyable activities, looking at pictures, talking, and reminiscing.
- Reward positive and independent behavior with smiles, hugs, warm touches, and thank yous.

**Lifestyle Changes that Aid in the Prevention/Delay of the Onset of Alzheimer’s Disease**

*Mental Stimulation:* Some simple intellectual pursuits you could engage in regularly are reading challenging books, doing crossword puzzles as well as playing mentally stimulating games like chess and Scrabble. Later studies however, have shown that while intellectual stimulation doesn’t necessarily aid in the prevention of Alzheimer’s disease, it does in fact delay the onset and the progression of symptoms.

*Physical Activity:* Activity does not need to be extremely strenuous or intensive; it is most important that it be regular and consistent. A daily walk, swim, or game of golf will help to ward off a great variety of health concerns, including Alzheimer’s.

*Social Interaction:* Since early Alzheimer’s can often include symptoms such as anxiety and depression, maintaining contact with friends can also help to relieve some of these symptoms and increase quality of life.

*Diet:* Still being studied is the effect of diet and nutritional supplementation in the prevention of Alzheimer’s disease. Promising work has shown the helpfulness of antioxidants, such as vitamins C and E, and fish oil.

**CAREGIVING FOR THOSE WITH DEMENTIA, ALZHEIMER’S DISEASE & DEPRESSION**

**Daily Activities/Tasks**

As Alzheimer’s disease and dementia progresses, activities like dressing, bathing, eating, and toileting may become harder to manage. Each patient has ups and downs. Some may find activities like bathing, dressing, or eating confusing or challenging. Others may not. To make the best of the time spent with your patient, you need to be flexible and understanding.

It may be helpful to:
- Observe your patient’s day to see if you can develop a routine that makes things go more smoothly.
- Look for times when your patient is less confused or more cooperative and plan your routine to make the most of those moments.

**Bathing**

Remember that bathing can be the most difficult task caregivers face. People with Alzheimer’s may fight it or perceive it as threatening.

If your patient is upset by bathing, advanced planning can help make bath time better for both of you. Schedule a bath or shower during the time of the day that your patient is calmest. Try to plan your patient’s baths or showers when you are not in a hurry. If you try to hurry the shower or bath, you may end up making it more confusing. Try to help your patient feel in control as much as possible and help as far as their abilities allow. Most importantly, never leave the person alone in the bathroom.
**Dressing**
For a person with Alzheimer’s or dementia, getting dressed may be a series of problems. Reducing choices may help make dressing easier. Encourage your patient to dress independently if they are able. Present a limited selection of outfits. Choose clothes that are comfortable, easy to get on and off, and easy to care for. Elder people have less internal temperature control mechanisms, and therefore have feel colder than a younger person. People with Alzheimer’s would feel colder than normal elderly people. Most of the time, they also do not have the skills to communicate verbally that they feel cold. Body language is a good indicator of how warm or cold they are (putting their hands under their armpits, etc). Also, a good measure is if we need to wear a shirt, the patient will need a polo and another shirt, or if we need a shirt and a light sweater, they will need a shirt, sweater and a jacket.

**Eating**
Eating can be hard for people with Alzheimer’s. Some may want to eat all the time, while others may have to be encouraged to eat. Make sure to serve meals in a quiet, calm place. Noise may prevent your loved one from focusing on the meal. Eliminate any distractions, such as a table centerpiece or excess utensils. Avoid patterned dishes or tablecloths. Serve only one or two food items at a time. Don’t worry about manners, just try to encourage them to chew thoroughly and take their time. Loss of peripheral vision is a marker for the progression of the disease. This means, he/she can only see parts of the visual field. Because of this, the client with Alzheimer’s may not see clearly all the food that is on his/her plate, and will not finish his/her food. If a patient is only eating food on one side or one spot of the plate, it would help if the caregiver rotates the plate, to give the client a better view of his/her food.

**Toileting**
As Alzheimer’s or dementia progresses, people may lose control of their bladder and/or bowels. This can be upsetting to them and their caregivers. Try to be calm when these accidents happen. If you get upset it could make them feel worse. Sometimes incontinence is due to illness or a recently developed condition, so be sure to talk about it with your patients medical staff or family members.

**Vision Issues**
Problems with vision can cause a lot of problems with clients who have dementia/Alzheimer’s. These patients will not see caregivers approaching them from the sides until they’re too close, which can startle them and cause them to strike out. This can be seen and reported as combativeness by caregivers. This can be avoided by walking directly to the resident (in full front view), announcing your presence by talking while you are still walking toward them, and, while still a hand’s reach away, tap them on their shoulder to help them pinpoint where you are.

**Hearing /Verbal Communication Difficulties**
Many elderly people have difficulty hearing, and this is also true with Alzheimer’s patients. Often times, they cannot remember to wear their hearing aids. Shouting to them can be misinterpreted as anger, and can cause them react similarly. They will hear and be more prone to reacting positively if a calm demeanor and a low but audible voice is used. Background noise which normal elderly can blot out, can be cause for overstimulation of patients with Alzheimer’s and lead to emotional or physical outbursts, as well as not eating because they cannot concentrate on the task (as mentioned in another part of this packet).
Residents with Alzheimer’s or dementia will gradually lose their language skills, and may use words of the same family interchangeably. For example, a client saying “It is raining” on a sunny day, may mean, “I need a drink” or “I need to go to the bathroom”. Calling his/her son “Dad” or referring to a husband “brother” are other examples.
Loss of Taste
Weight loss is of special concern with clients who have Alzheimer’s/dementia or depression (especially elderly ones). Most of them only retain only the sense for sweet tastes, so adding applesauce, or sugar, and giving them chocolate milk instead of whole milk can help slow weight loss (as long as no other condition prevents the use of added sugar to the diet, or the supervisor clears the usage of such).

Behavior Issues
Disruptive behavior in a patient can be confusing and disconcerting. Here are some tips that may help you cope with the most common problems, including combative behavior. Be sure to talk to medical staff and family members if your patient is experiencing behavior problems.

Apathy
Although most people associate Alzheimer’s Disease and dementia with memory problems, apathy is the most commonly reported symptom. It is characterized by loss of motivation, being withdrawn, and lack of emotion. If your patient experiences apathy, try to engage them in an activity. Try to choose an activity that your patient enjoys. You might even simplify the activity so that your patient feels comfortable and can participate easily.

Combative Behavior
Some people with Alzheimer’s or dementia may seem belligerent. If this is true of your patient, there are some steps that may help. The first step is to make sure your patient is not angry due to pain or illness. Talk to a doctor to rule out other health conditions. Be sure to let the doctor know of sources of stress in your client’s life. These might include a move to a new home or sleep problems. When your patient becomes combative, try to:

- Stay calm and avoid arguing.
- Reduce noise and other distractions to help your patient focus.
- Reassure your patients that they are safe.
- Offer your patient a choice of relaxing activities like taking a nap or going for a short walk.
- Avoid crowding or "cornering" your patient.

Sleep Problems
For someone with Alzheimer’s, getting to sleep may not be easy. If your doctor approves, add gentle exercise to patient’s daily routine. It can help with sleep problems. You can also:

- Set a calm, quiet tone in the evening to encourage sleep.
- Keep the lights dim.
- Try playing soft music.
- Stick with a bedtime routine.

Wandering
- As Alzheimer’s progresses, wandering and restlessness are common for some people. To help make sure your loved one is returned home safely, put labels in their clothes with their name and your contact information. You may also consider getting a Medic Alert bracelet. It can be engraved with medical conditions, an ID number, and a 24-hour emergency response center number. If your patient tends to wander, consider a service such as the Alzheimer’s Association’s Safe Return program. This program helps find people with Alzheimer’s if they get lost.
- To help stop wandering:
  - Ask your doctor if light exercise may help your patient sleep.
  - Consider putting locks on all windows and outside doors. But make a plan for fire safety first.
- Install a keyed deadbolt or a new lock up high or down low on the door, since your patient may not look for them there.
- Place bells on doors to wake you if your patient tries to leave.

**Hallucinations and Delusions**

With Alzheimer's Disease and dementia, your patient may suffer from hallucinations or delusions.

- Hallucinations occur when someone sees, hears, smells, tastes, or feels something that is not real.
- Delusions are false beliefs that the person believes are true.

Here are some tips that may help you deal with, or avoid, hallucinations or delusions:

- Some people with Alzheimer's confuse TV and reality. So try to avoid violent or disturbing TV shows.
- Try distracting your patient with a short walk.
- If you can, turn your patient's attention to a favorite activity.
- Make sure your patient is safe. Be sure your patient cannot hurt themselves or others.

**Quality Time**

When you look for things to do, don't forget that Alzheimer's or dementia makes it hard for a person to focus or learn new skills. Some people with Alzheimer's like to spend time on things that they enjoyed in the past. With your help, your patient may still enjoy a hobby or pastime that was once a favorite. When you can, try to build on current skills. This may work better than trying to teach new skills.

**Enjoying Time Together**

Here are some things you and your patients may enjoy:

- Looking at photos
- Talking about family history
- Making a scrapbook
- Playing simple games
- Cooking
- Playing an instrument
- Listening to music together
- Taking walks and being outside in the fresh air

It may also help to add light exercise to your patient's day. Be sure to partner with medical staff first. It may help your patient sleep better, and it might be helpful to their mood.

- No matter what you choose, try to:
- Break each task into small steps
- Give praise each step of the way
- Watch for signs that your patient is tired, so you can take a break
- Make time to enjoy simple moments together at the same time each day