Promoting positive approaches to dementia care in nursing


Summary
This article provides an overview of factors relevant to dementia care today. The number of people experiencing dementia is increasing and dementia is at the forefront of health policy. The evidence base for person-centred approaches and interventions in dementia is expanding and nurses are central to implementing these across care settings. This is an exciting and challenging time for dementia care and nursing has a major role in leading and developing these changes in practice. The article discusses the importance of wellbeing and the Mental Capacity Act in assessing and caring for people with dementia. Psychosocial and pharmacological approaches to dementia care are described and the need to support carers of people with dementia is emphasised.

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Carers, dementia, older people, psychosocial interventions
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Aims and intended learning outcomes
The aim of this article is to provide an overview of the issues relevant in dementia care for nurses working in any setting. After reading this article and completing the time out activities you should be able to:

- Understand the impact of dementia on society and the implications for health resources.
- Outline the signs and symptoms of dementia.
- Explain the importance of promoting wellbeing in dementia.
- Identify the legal and ethical issues around mental capacity and consent.
- Describe the therapeutic interventions for dementia.
- Discuss the impact of caring for someone with dementia on the caregiver.

Introduction
With the growth of the ageing population and the predicted rise in numbers of people experiencing dementia, the need to ensure that nurses in a variety of clinical settings have an understanding of dementia has become more evident. In the next ten years, the number of people aged over 65 will increase by 15% and the number of people aged over 85 years will increase by 27% in the next ten years (Department of Health (DH) and Care Services Improvement Partnership (CSIP) 2005). There are 820,000 people with dementia living in the UK (Luengo-Fernandez et al 2010) and, as dementia affects one person in 20 aged over 65 and one person in five over 80 years, this number is expected to rise (DH and CSIP 2005, Knapp et al 2007). It is estimated that 24 million people worldwide have dementia and that this figure will double every 20 years to 42 million in 2020 and 81 million in 2040 (Ferri et al 2005). Therefore, it is increasingly likely that nurses will be in contact with someone who has dementia, particularly in acute care settings where 97% of nurses already care for someone with dementia (Alzheimer’s...
There are particular challenges in acute settings as the environment is often not conducive to nursing people with dementia. The speed and pace of care delivery can increase patients’ disorientation and confusion, and their needs can go unrecognised (Dewing 2001, Edvarsson et al 2008). It is vital that nurses have an understanding of dementia and the impact this disease has on patients and their families. Nurses should be able to respond more knowledgeably and effectively to the needs of the person with dementia.

Dementia policy

A number of policies and reports written over the past decade have shaped how dementia services have been developed. The Dementia UK report (Knapp et al 2007) highlighted the growing numbers of people with dementia and recommended that it become a national health and social care priority. A more recent report, Counting the Cost (Alzheimer’s Society 2009), suggested that the care of people in acute care settings needed to be improved, as 47% of carers reported that being in hospital had a significant negative effect on the health of the person with dementia and 77% were dissatisfied with the quality of dementia care. Moreover, in the same report, 54% of nurses had not received any training on dementia.

In response to concerns raised about the quality of care in dementia (National Audit Office 2007, 2010), England, Scotland, Wales and Northern Ireland are developing strategies to advance improvements. All of these strategies are based on extensive consultation with professionals, people with dementia and their family and carers, and have identified similar themes:

- Raising awareness and improving understanding.
- Enabling earlier diagnosis and developing specific treatment or care pathways.
- Improving quality of care in all settings.

Initial developments include the piloting of dementia care adviser roles to enable access to care and support following diagnosis; the development of structured peer support and learning networks for people with dementia and their carers; the launch of a public awareness campaign; and consideration of workforce development needs (DH 2009).

The remit of dementia strategies is far reaching, complex and will require significant investment and leadership to enable improvements in all dementia care settings. Nurses have a key role in the care of people with dementia and their families. They are in a good position to support the improvements outlined in policies.

Defining dementia

Dementia has been defined as ‘an acquired global impairment of intellect, memory and personality’ (David 2009). It is considered to be a collective term that refers to a clinical syndrome, rather than a specific disease entity. It also describes a variety of pathological processes with common features. The presence of dementia implies a global deterioration in a person’s mental abilities due to underlying brain disease that is usually progressive and chronic in nature (Cooper 1997).

Diagnosing dementia

The diagnosis of dementia demands a broad range of clinical skills and relies on accurate clinical evidence gained through personal history, medical examination and investigation of the person (Burns and Hope 1997). Dementia is a complex disorder and the disease trajectory is not easy to predict (Sampson et al 2008). Despite being a degenerative and terminal illness, not all patients reach the end stages of the disease and symptoms vary. Furthermore, dementia needs to be distinguished from other conditions which may overlap or present similarly, including delirium and depression, as both of these conditions can improve with appropriate treatment (Adams 1997).

Table 1 outlines symptoms that may present at different stages of dementia. Mental and neuropsychiatric behavioural disturbances affect...
most people with dementia, irrespective of the cause and stage of the disorder (Lyketsos et al 2000). These include psychotic symptoms (delusions and hallucinations), mood disorders (anxiety and depression), behavioural changes (irritability, aggression, restlessness and wandering), and sleep and eating disorders. Increased behavioural disturbances add to caregiver burden and are associated with advancing age and poorer cognition (Craig et al 2005). Treatment of depression and anxiety in dementia can be effective and may help increase functional ability, improve quality of life and decrease caregiver burden (Shankar and Orrell 2000).

Types of dementia

There are two main classification systems for the diagnosis of dementia (World Health Organization 1992, American Psychiatric Association 2000 (shown in Box 1)). Dementia can be differentiated into four common types. Alzheimer’s disease is the most common cause of dementia, characterised by a history of gradual onset and decline in function incorporating amnesia (loss of memory), apraxia (loss of ability to perform activities), agnosia (inability to recognise and identify objects or people) and aphasia (loss of ability to communicate verbally) (McKhann et al 1984). Vascular dementia is characterised by cognitive impairment resulting from cerebrovascular disease (ischaemia or stroke). It is defined by the presence of focal neurological signs (perceptual or behavioural impairments, for example rigidity, unsteadiness, paralysis), gait disturbance, incontinence and mood lability (Román et al 1993). Dementia with Lewy bodies is characterised by fluctuating cognition, recurrent visual hallucinations and spontaneous features of parkinsonism (McKeith et al 1996). Frontotemporal dementia is characterised by behavioural disorder and affective symptoms: personal neglect, disinhibition, perseveration (repetition of speech or movement) and apathy, with intact visual and spatial abilities (The Lund and Manchester Groups 1994). Alzheimer’s disease is diagnosed in 50-60% of all cases; vascular dementia in 10-20% of cases; dementia with Lewy bodies in 10-15% of cases and

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Different stages of dementia</th>
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<tbody>
<tr>
<td>Mild</td>
<td>Significant memory deficits:</td>
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<tr>
<td></td>
<td>Lack of recognition of close relatives.</td>
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<td></td>
<td>Loss of familiarity with well known places or routes.</td>
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<td></td>
<td>Disorientation in time and place.</td>
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<td></td>
<td>Decline in cognitive ability – impaired decision making, judgement and problem solving.</td>
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<tr>
<td></td>
<td>Problems with verbal communication.</td>
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<td></td>
<td>Personality and behavioural changes.</td>
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<td></td>
<td>Disinhibition – inappropriate responses, lack of emotional control.</td>
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<tr>
<td></td>
<td>Abandonment of hobbies and interests.</td>
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<td></td>
<td>Difficulty in completing routine tasks, such as household and self-care tasks.</td>
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<tr>
<td></td>
<td>Evident neglect of personal hygiene and appearance.</td>
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<tr>
<td>Moderate</td>
<td>Severe memory deficits.</td>
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<tr>
<td></td>
<td>Disorientation: time, place, person.</td>
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<td></td>
<td>Thinking is slow and content is impoverished.</td>
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<tr>
<td></td>
<td>Limited verbal communication – fragmented speech or monosyllabic responses, poverty of speech, perseveration (repetition of speech or movement).</td>
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<tr>
<td></td>
<td>Aggression, restlessness and wandering.</td>
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<tr>
<td></td>
<td>Hallucinations and delusions.</td>
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<tr>
<td></td>
<td>Marked decline in physical health.</td>
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<tr>
<td></td>
<td>Increased assistance required with activities of daily living.</td>
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</table>

The criteria for diagnosis of dementia should include:

1. Memory impairment (impaired ability to learn new information and to recall previously learned information).
2. Impairment of one or more of the following functions:
   - Language – misuse of words or inability to remember and use words correctly (aphasia).
   - Motor activity – unable to perform motor activities even though physical ability remains intact (apraxia).
   - Recognition – unable to recognise objects, even though sensory function is intact (agnosia).
   - Executive function – unable to plan, organise or think abstractly.
3. A clinical course characterised by gradual onset and continuing cognitive decline.
   (American Psychiatric Association 2000)
Wellbeing and dementia

The symptoms of dementia are often seen to lead to destruction of the individual through loss of autonomy and personhood. The term ‘personhood’ refers to the state or condition of being an individual, and in dementia this is seen to diminish as the disease progresses. It is important that personhood is maintained in dementia by recognising and respecting the identity of the person (Kitwood 1997).

While an accurate diagnosis of dementia is essential, the experience of the individual must also be understood. The adoption of person-centred approaches to dementia care allows for a psychological interpretation of the experience of the person with dementia (Miesen 1993, Kitwood 1996). The care provided in dementia is considered meaningless if aspects of personhood are diminished and care is delivered in a repetitive and unemotional way. It is therefore important that the person with dementia is recognised and accepted as an individual and that a positive self-image is reinforced.

Developing person-centred approaches to assessment are essential in ensuring appropriate care and treatment are achieved. Kitwood’s (1996) enriched model of care in dementia challenged the negative view of cognitive impairment and is based on the idea that wellbeing in dementia is influenced by neurological impairment, physical health and the individual’s biography and personality, as well as the social environment in which they live. Application of the VIPS model may also be useful in providing individualised person-centred care (Brooker 2007):

\[ V = A \text{ value base that asserts the absolute value of all human lives regardless of age or cognitive ability.} \]
\[ I = \text{An individualised approach, recognising uniqueness.} \]
\[ P = \text{Understanding the world from the perspective of the service user.} \]
\[ S = \text{Providing a social environment that supports psychological needs.} \]

Memories of the person’s life, achievements and personal characteristics give value to the person and their family and help map perceptions of who the person is (Jenkins and Price 1996). The measure of a person’s wellbeing is an important contributor to their quality of life, as it reflects his or her level of interaction with others and engagement with the environment. Table 2 provides a framework for person-centred care in dementia.

### TABLE 2

#### A framework for person-centred assessment in dementia

<table>
<thead>
<tr>
<th>Factors affecting dementia</th>
<th>Considerations for assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological and/or cognitive impairment.</td>
<td>Assess the level and extent of impairment of the person’s abilities to function, plus the type of dementia, if possible.</td>
</tr>
<tr>
<td>Health and physical fitness.</td>
<td>Assess physical health and consider the person’s previous experience and response to ill health. Establish possible influencing factors such as infection, constipation, medication, pain, eyesight or hearing loss.</td>
</tr>
<tr>
<td>Biography and/or life history.</td>
<td>Gather information about the person’s biography: family and friends, occupation, interests, likes and dislikes, achievements.</td>
</tr>
<tr>
<td>Personality.</td>
<td>Gather information about person’s personality before the onset of dementia, including coping style, psychological needs and preferences for care.</td>
</tr>
<tr>
<td>Social psychology and environment.</td>
<td>Assess and consider the impact of interactions with others, both positive and negative, from the individual’s perspective. Assess and consider the effect of the environment – the level of noise, signage, colours – on the person, taking into account the person’s preferences.</td>
</tr>
</tbody>
</table>
assessment. It has been adapted from Kitwood’s (1996) enriched model and Brooker’s (2007) VIPS model, and considers the impact of the physical environment on the person.

**Time out 4**

Consider a time when you were faced with making a choice on behalf of someone with dementia. This might have involved giving someone a wash who was unwilling to accept support, preventing someone who was vulnerable from going outside or giving someone medical treatment against his or her will. Read the Deprivation of Liberty Safeguards (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476) and apply the principles of best interests to the situation. How would you approach this situation now and how would you involve family and/or friends in the decision-making process?

**Mental Capacity Act 2005**

The introduction of specific legislation for people who lack capacity (DH and CSIP 2005) has marked a significant change in the way assessment and care for people with dementia are viewed. It should not be assumed that people are incapable of making decisions based solely on a diagnosis of dementia. The act clearly sets out the need to assess capacity properly and to ensure the person’s decision making is supported for as long as possible. Although the Mental Capacity Act 2005 was implemented in England in 2007, with similar legislation being supported in Scotland, Wales and Northern Ireland, its implementation in practice is difficult to assess. Initial reports suggest that further work is required to ensure that capacity is understood and supported for this patient group (Manthorpe et al 2008, Thompson 2009).

Nurses working in various settings, including acute care, emergency departments, mental health, care homes and the community, are often required to make decisions for, and on behalf of, people with dementia. It is therefore essential that nurses are able to understand and are supported in assessing capacity for someone with dementia, enabling decision making, supporting the use of advocates and acting in someone’s best interests.

Examples of how the Mental Capacity Act 2005 might be applied in practice include:

- Supporting people to take medication or to accept other medical interventions.
- Helping people to get dressed or accept food and drink.
- Supporting/assisting people in making a decision about where to live in the future.
- Assisting people in making decisions about end of life care.

First nurses must consider whether the person has the capacity to make the decision. The act states that someone is unable to make a specific decision if ‘he/she has an impairment or disturbance in the functioning of the brain which leads to the person being unable to understand, retain, use or weigh up information as part of the decision making process’. If someone does not have the capacity to make a particular decision, it is important they are supported to do so in line with their best interests. A Lasting Power of Attorney order may have been made, appointing someone to act on the patient’s behalf, and this person should be involved in the decision making. If there is no Lasting Power of Attorney, efforts should be made to establish what the patient would have wanted, based on information gathered from relatives or friends about his or her previous preferences or wishes. It is important that any decisions are based on a team discussion and not on the view of one professional or family member. If necessary, a referral can be made to an Independent Mental Capacity Advocate, whose role is to ensure that decisions are made in a person’s best interests.

At times, it may be necessary to limit the movements of people with dementia, to protect them from harm or to provide care that is in the person’s best interests, for example:

- Using a code on a door to prevent someone from leaving a ward or care home.
- Holding someone while he or she has a blood sample taken or during personal care.

The Deprivation of Liberty Safeguards were introduced as an amendment to the Mental Capacity Act 2005 and set out limits for lawful restriction and restraint of someone who lacks capacity (DH 2007). Applications are made for those people in hospitals or care homes who are deprived of their liberty as a result of restrictions or restraints being used. Deciding what constitutes a deprivation of liberty, however, can be difficult for practitioners. Thompson (2009) recommends that practitioners consider the following factors for someone with dementia:

- The person, either by words or behaviour, repeatedly challenges the restrictions placed on him or her, for example repeatedly attempting to get out of a locked door or requiring frequent restrictive physical intervention.
learning zone older people

- There are significant restrictions on the person’s contact with family and friends, or the outside world.
- Significant people disagree with the person’s placement in the service or with any restrictions of their liberty.

Nurses are often involved in decisions about using restrictions or restraints for people with dementia who lack capacity, and should be familiar with the legal requirements. Nurses also need to recognise what is restraint and feel able to challenge restrictive practices in care. Good practice means determining whether care could be provided in a less restrictive manner. This requires a detailed understanding of the person and the condition, plus knowledge of evidence-based interventions and approaches used in dementia care.

Time out 5
List the key skills required for communicating with someone who has dementia. List the opportunities for and challenges to effective communication in your clinical setting. How can these be addressed?

Interventions for dementia

While it is important to develop a comprehensive assessment and understanding of the person with dementia, it is essential that nurses also have knowledge of therapeutic approaches used in treating them. Until recently research in dementia was dominated by the development of pharmacological interventions (Heller and Heller 2003). However, the evidence for non-pharmacological (psychosocial) approaches to dementia care is increasing.

Non-pharmacological interventions include the provision of therapeutic activities and education and psychological support; and there is increasing evidence of the benefits of psychosocial and behavioural interventions (Burns 2004). Therapeutic activities are undertaken to maintain or enhance cognitive functioning, promote independence, increase quality of life, provide enjoyment and meaningful activity, and encourage interaction with others and the environment (Marshall and Hutchinson 2001). Three broad categories of therapeutic interventions are described: social and diversional, cognitive, and alternative therapies (Pulsford 1997). Social and diversional activities incorporate recreational pursuits, current events, entertainment and physical exercise. Cognitive-based therapies include cognitive stimulation therapy, reality orientation, life review, reminiscence and validation therapy. Alternative therapies include multisensory environments, drama, and art and music therapy.

Communication strategies
Developing effective and supportive communication strategies is essential for nurses working with people with dementia. Communicating with people with dementia can bring many challenges because of the various ways in which usual communication patterns are affected. Cognitive impairment can result in poor comprehension, difficulty concentrating, memory loss, word finding problems and visual perceptual difficulties, all of which hinder a person’s ability to communicate (Saban and Harré 1992). In addition, older people with dementia may have hearing or visual impairments that can affect communication. Nurses therefore need to be skilled in a range of strategies that can facilitate and support communication.

General principles such as maintaining eye contact, speaking distinctly and clearly and paying attention to non-verbal cues are of particular importance for someone whose communication is impaired. Other considerations include reducing environmental stimuli (noise), allowing time for the person to respond and rephrasing statements that are not understood. Specific strategies such as breaking sentences down into simple phrases, giving one instruction or choice at a time and avoiding open-ended questions may all help to avoid stress or negative responses (Perry et al 2005).

Several therapeutic approaches to communication in dementia have been developed over the years including validation therapy, reality orientation and resolution therapy. All of these are useful, but more importantly nurses should assess each individual’s communication and adapt theirs accordingly. Walker (2007) described the need to develop a ‘toolkit of helpful responses’ to be used in different situations with different people that aims to ‘tune into a person’s feelings’. This toolkit requires an understanding of how communication can be affected by dementia, knowledge of different approaches and a desire to improve the person’s ability to communicate. Dementia can have a devastating effect on communication and it is essential that nurses try to connect with people in a meaningful way.

Cognitive stimulation therapy
This is an evidence-based, brief intervention for people with mild-to-moderate dementia (Spector et al 2005). It involves a number of structured group sessions aimed at actively stimulating thinking and social engagement for people with dementia. Themes include food, childhood, sounds, physical exercises, famous faces, word games, number
games and current affairs. Cognitive stimulation therapy has been shown to be effective in improving memory, judgement and use of language and reasoning, as well as providing benefits from interacting with others and having fun (Spector et al 2003).

Reminiscence Reminiscence is an opportunity to explore and share memories and get to know about other people’s lives. People with dementia often have clear memories of past events. Reminiscence therefore draws on their preserved abilities rather than emphasising their difficulties. In this way it can improve communication and confidence (Woods et al 2009). A lifetime of experiences can be explored, from childhood, school days and working life up to the present. Different media such as objects, photographs, role play and senses – sound and taste – can be used to stimulate memories. However, not everyone enjoys reminiscence. It is a skilled intervention and may provoke strong emotions, so it will need to be managed sensitively. Dementia can have a significant impact on close relationships and the current emphasis is on involving family carers and people with dementia in reminiscence activities to improve understanding and communication within relationships (Woods et al 2009). The book Remembering Yesterday, Caring Today details a reminiscence activity specifically established for people with dementia and family carers (Schweitzer and Bruce 2008).

Life story work This is an individual biographical approach to understanding the person. Information is gathered about a person’s life experience that can be used to help inform care. It is based on the principles of reminiscence and storytelling and involves reflection on past life events and present or future wishes. Life story work enhances person-centred care by allowing nurses to make the link between past and present (McKeown et al 2010), which can then promote nurses’ understanding of the person’s preferences. Information can be recorded in a range of different formats, including life story books, collages, memory boxes and/or electronic formats where photographs or videos can be held. The format chosen should be one that best fits the person and the situation. For example, collages can be developed as a shared creative activity and are useful in long-stay settings where visual images can be accessed easily. Life story books can provide more detail and may be transferred between different care settings, which is especially useful as the person’s illness progresses. Memory boxes are beneficial for those requiring more tactile cues.

Life story work has a number of benefits including promoting increased understanding of the person and supporting the delivery of person-centred care (Hansebo and Kihlgren 2000, Murphy 2000), as well as improving relationships between family carers and staff in inpatient settings (Clarke et al 2003). The launch of a leaflet, This is Me, for recording life story information to be used in general hospital settings is an example of how such work is being promoted (Alzheimer’s Society 2010).

End of life care Dementia is a degenerative and debilitating disorder that ultimately leads to death. However, end of life care in dementia is often poor (Sampson et al 2008). To deliver good quality end of life care, significant improvement is needed in recognising, understanding and including dementia in a palliative care approach (Harrison-Dening and Wharrad 2010). An emphasis on advanced care planning and partnership working with palliative care is also advocated (Gibson et al 2009). Recent initiatives in end of life care include adopting best practice tools such as the Preferred Place of Care document (Pemberton et al 2003), the Liverpool Care Pathway (Ellershaw and Wilkinson 2003) and the Gold Standards Framework (Thomas 2003).

There is still much work to be done in recognising the end of life pathway for people with dementia, because of its unpredictable trajectory, often described as being ‘prolonged’ or ‘dwindling’ (Murray et al 2005). As end of life care in dementia develops, clearer pathways may help nurses to plan and deliver supportive palliative approaches earlier, leading to improved involvement, better symptom control and a more positive experience at the end of life.

Medication The principal aims of treatment in dementia are to improve cognition, mood and behaviour, thereby promoting optimum functional performance and improving quality of life (Small et al 1997). Four medications are currently approved for the treatment of Alzheimer’s disease in the UK: acetylcholinesterase inhibitors – donepezil, galantamine and rivastigmine – and an N-methyl-D-aspartate (NMDA) antagonist, memantine (Overshott and Burns 2005).

Acetylcholinesterase inhibitors help delay the progression of Alzheimer’s disease in people with mild-to-moderate dementia and reduce neuropsychiatric symptoms and functional impairment (Clark and Karlawish 2003, Trinh et al 2003); in the UK their use is restricted to people with moderate dementia (National Institute for Health and Clinical Excellence (NICE) 2009). Memantine has shown improvements in functional ability and decreased care dependence in people with moderate-to-severe dementia (Forsil 2000). The benefits of acetylcholinesterase inhibitors are considered important because neuropsychiatric symptoms contribute to the loss of autonomy, morbidity
and need for long-term care placement (Trinh et al 2003). The guidelines for prescribing acetylcholinesterase inhibitors were revised as their cost effectiveness was questioned, and improved evidence of how they affect quality of life is needed (Overshott and Burns 2005, NICE 2009). Simpson et al (2005) reported that acetylcholinesterase inhibitors have shown benefits for people with dementia both in and outside of the established criteria and that stopping them increased the risk of mortality and led to a marked deterioration in patients.

Psychosocial interventions are considered the preferred option and pharmacological options should be introduced only when psychosocial treatments prove ineffective (Small et al 1997). Antipsychotic medications are a common treatment for the reduction of behavioural disturbance in dementia (Smith and Beier 2004). However, an increased risk of cerebrovascular adverse events has been associated with antipsychotic use in people with dementia and their prescription is now limited (Smith and Beier 2004, Overshott and Burns 2005). Acetylcholinesterase inhibitors reduce neuropsychiatric symptoms in Alzheimer’s disease and, although their use as an alternative treatment for the management of behavioural disturbances is indicated, they are not used routinely for this purpose in the UK (Clark and Karlawish 2003, Trinh et al 2003).

Quality of life

Quality of life is an established outcome measure for people with dementia as well as in assessing disease impact (Hoe et al 2010). The course of the disease is not straightforward and dementia can have significant psychological and social consequences. Measuring quality of life can assess the extent to which dementia is disabling and indicate the anticipated benefits of slowing disease progression or delaying its onset. As a wide range of therapeutic interventions and possible outcomes are available for the management of dementia, quality of life offers a common language for evaluating the effectiveness of treatment (Mack and Whitehouse 2001).

Quality of life in dementia is still a relatively new concept. In the context of dementia it has been defined as ‘the integration of cognitive functioning, activities of daily living, social interactions and psychological wellbeing’ (Whitehouse et al 1997). Psychological wellbeing is the most important element of quality of life measurement in dementia (Walker et al 1998). Measures of quality of life are fundamental in reflecting the effect of the disease on the individual and on those providing care for the person with dementia.
Conclusion

Meeting the needs of people with dementia and supporting their families can be rewarding for nursing staff. Having a sound knowledge and skill base and understanding the issues relevant to dementia is key. The broad scope of the disease means it is not possible to discuss all aspects currently affecting this patient group. This article does, however, provide an overview of factors that are relevant to dementia care today.

The number of people experiencing dementia is increasing and dementia is now at the forefront of health policy. The evidence base for person-centred approaches and interventions in dementia is expanding and nurses are central to implementing these. Although care in dementia is improving, considerable progress is still needed. Nurses have a responsibility to ensure that they keep abreast of the changes and that improvements are integrated into the clinical setting. This is an exciting and challenging time for dementia care and nurses have a major role in leading and developing these changes in practice.

References


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learning zone assessment

Dementia

TEST YOUR KNOWLEDGE AND WIN A £50 BOOK TOKEN

HOW TO USE THIS ASSESSMENT

This self-assessment questionnaire (SAQ) will help you to test your knowledge. Each week you will find ten multiple-choice questions that are broadly linked to the learning zone article. Note: There is only one correct answer for each question.

Ways to use this assessment

- You could test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- You might like to read the article to update yourself before attempting the questions.

Prize draw

Each week there is a draw for correct entries. Please send your answers on a postcard to Zena Latcham, Nursing Standard, The Heights, 59-65 Lowlands Road, Harrow-on-the-Hill, Middlesex HA1 3AW, or send them by email to zena.latcham@rcnpublishing.co.uk. Subscribers can complete the assessment at www.nursing-standard.co.uk by clicking on the CPD link on the left of the homepage.

Ensure you include your name and address and the SAQ number. This is SAQ no. 562. Entries must be received by 10am on Tuesday October 12 2010.

When you have completed your self-assessment, cut out this page and add it to your professional portfolio. You can record the amount of time it has taken. Space has been provided for comments.

You might like to consider writing a practice profile, see page 60.

1. How many people worldwide are predicted to have dementia by 2020?
   a) 2.4 million
   b) 4.2 million
   c) 24 million
   d) 42 million

2. Dementia is:
   a) A clinical syndrome rather than a specific disease
   b) A variety of pathological processes with common features
   c) Usually progressive and chronic
   d) All of the above

3. Alzheimer’s disease:
   a) Is the rarest cause of dementia
   b) Has a rapid onset
   c) Incorporates amnesia, apraxia, agnosia and aphasia
   d) Results from cerebrovascular disease

4. Which of the following is a sign of moderate dementia?
   a) Disinhibition
   b) Incontinence
   c) Delusions
   d) Wandering

5. Disinhibition is most likely to be caused by:
   a) Alzheimer’s disease
   b) Vascular dementia
   c) Dementia with Lewy bodies
   d) Frontotemporal dementia

6. Which intervention for mild-to-moderate dementia is effective at improving memory?
   a) Reminiscence
   b) Physical exercise
   c) Cognitive stimulation therapy
   d) Life story work

7. In which situation might the Mental Capacity Act 2005 be applied?
   a) Helping someone to get dressed
   b) Decisions about end of life care
   c) Supporting someone to take medication
   d) All of the above

8. Where are lawful restraint limits for someone who lacks capacity set out?
   a) Safeguarding Vulnerable Groups Act
   b) Protection of Vulnerable Adults

9. A patient must be assumed to have capacity unless:
   a) He or she makes an unwise decision
   b) It is established that he or she lacks capacity
   c) He or she has dementia
   d) He or she lives in a care home

10. Recurrent visual hallucinations are most likely to be caused by:
    a) Vascular dementia
    b) Alzheimer’s disease
    c) Frontotemporal dementia
    d) Dementia with Lewy bodies


Report back

This activity has taken me ____ hours to complete.

Other comments:

Now that I have read this article and completed this assessment, I think my knowledge is:

- Excellent
- Good
- Satisfactory
- Unsatisfactory
- Poor

As a result of this I intend to:

Answers to auditing hand hygiene questions

The answers to SAQ no. 560 on auditing hand hygiene, which appeared in the September 15 issue, are:

1. b 2. d 3. c 4. a 5. a
6. c 7. d 8. b 9. c 10. d

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