

WORK PROCESS SCHEDULE  
 CERTIFIED NURSE ASSISTANT, DEMENTIA SPECIALTY  
 O\*NET-SOC CODE: 31-1012.00 RAIS CODE: 0824D

**Description:** Performs duties of CNA, Advanced and/or Geriatric Specialty with proficiency and demonstrates competency in the core skill areas. Delivers direct resident care, therapeutically cares for, and interacts positively with dementia, Alzheimer’s disease, and other degenerative cognitively impaired residents by incorporating a higher level of knowledge and skills to maintain individual dignity, respect and well being. Interact effectively with members of the healthcare team, other caregivers, family members, and residents while utilizing therapeutic communication modalities and appropriate pleasant familiar activities to maximize resident function and well-being. Utilizes advanced knowledge of understanding resident behavioral changes and disease processes in order to effectively implement therapeutic interventions that minimizes adverse behaviors and maximizes quality of life within a therapeutic positive milieu.

**Term: Competency-based (Minimum 825 -1,125 Hours)**

**On-The-Job Learning:** The following core competency skill areas have been identified to increase the focus of providing higher quality care practices and to guide the direction of the occupational development of nursing assistants. The apprentice will attain a basic level of mastery across all competency areas before receiving certification. Basic mastery will be represented by the apprentices being able to articulate their learning within each core competency area and to demonstrate that they have successfully applied all the competencies of their work on-the-job. The order in which the apprentices learn will be determined by the flow of work processes on-the-job and will not necessarily be demonstrated in the order listed. Hours allotted to these work processes are estimated for the average apprentice to successfully demonstrate and develop mastery of each competency area of the occupation. These hours are intended as a guide to indicate the high-quality of training being provided to care for residents with dementia or other related cognitive impaired disorders and their families; and the ability of an apprentice to apply this training on-the-job in an average amount of time.

<b>Core Competency Skill Areas</b>	<b>Approximate Hours (Min/Max)</b>
<b>A. Incorporates an “Assisting” Role into Interventions for the Cognitively Impaired Resident to Facilitate Quality Care as a Member of the Healthcare Team.....</b>	<b>100-150</b>
<ul style="list-style-type: none"> <li>• Demonstrates patience, flexibility, sense of humor with team spirit and a desire to work on a dementia unit.</li> <li>• Provides considerate, dignified and respectful care for the cognitively impaired.</li> <li>• Provides personal freedom from restraints, mental and physical abuse.</li> <li>• Assists the resident to function at his/her optimal level of function and involves the resident as much as possible in the decisions/choices, according to his/her functional capacity.</li> <li>• Assists residents in meeting their psychosocial needs and by becoming knowledgeable of the residents’ background, interests, habits, family members, and functional needs and capabilities.</li> <li>• Involved in and assists with a variety of activity-focused care activities.</li> <li>• Observes resident behaviors to describe triggering events and results of the behaviors to the healthcare team.</li> <li>• Utilizes the ABC protocol in an attempt to problem-solve and discover effective interventions.</li> <li>• Monitors for changes in condition daily.</li> </ul>	

- Reports any changes in physical, social, behavioral or mental functioning to the charge nurse.
- Reports immediately any inappropriate aggressive, threatening, or sexual behaviors to the charge nurse, program director or social services.
- Utilizes the care plan for interventions and reports successful interventions to charge nurse and documents accordingly.
- Implements interventions to minimize the effects of disruptive behaviors and participates in care planning and/or behavior committees to evaluate effectiveness of these interventions.
- Assists/directs appropriate interventions of other caregivers including ancillary staff and family members.
- Recognizes signs of stress and strategies for coping with it in self and other caregivers and family members.
- Identifies and collaborates with the interdisciplinary healthcare team members and is aware of their functions on the unit: medical director, program director, recreational activity director, attending physicians, dietary manager, social work services, activity coordinator, and licensed nurses, nursing assistants, family members and residents.

**B. Demonstrate Effective Communication & Interaction with Cognitively Impaired Residents and Their Families ..... 150 - 250**

- Supports the resident's family members, as partners in care.
- Assists families to understand how to communicate in the remote past.
- Demonstrates effective communication skills by establishing good eye contact at eye level.
- Maintains good non-verbal behavior toward residents and family members (i.e., smiles, positive facial expressions, moves slowly, gentle touch, hugs, etc.)
- Shows respect for individual residents and family members and maintains compassion.
- Uses a warm and soothing tone in voice when responding with kindness and support.
- Makes a special effort to pay attention to and praise resident behaviors that are cooperative and pleasant.
- Makes allowances for cognitive, sensory, visual and hearing problems.
- Listens and responds to a resident without correcting or confronting.
- Listens for the "message behind the message" to validate feelings or needs.
- Allows enough time for effective communication to occur and gives the resident plenty of time to listen and respond.
- Uses non-threatening body posture to invite resident interest.
- Demonstrates the ability to use meaningful hand gestures to show the individual what you want them to do (i.e., hold the comb while mimicking hair combing).
- Speaks clearly, slowly, in short sentences, using familiar words, with an empathic tone of voice.
- Reminisces with a resident's past experiences to encourage feelings of security and joy.
- Distracts or redirects a resident with an appropriate activity.
- Communicates with the resident about what needs to be done.
- Uses task segmentation to break down tasks into small steps and provides one instruction at a time.
- Completes each segmented task before moving onto the next instruction.
- Provides "clues" and suggestive words that the resident is searching for.
- Eliminates background noise and modifies the environment to maintain a calm therapeutic milieu.

- Offers two simple choices (i.e., “Would you like to wear the red sweater or green sweater today?” “Would you like coffee or tea to drink?”).
- Shows the individual familiar objects.
- Demonstrates the ability to use reality orientation, redirecting and validation therapy with a resident to assist residents to regain awareness of the present time/situation.

**C. Demonstrates Effective Interventions for Managing Difficult Behaviors .....200**

- Provides comfort, physical gentle touch, and reassurance of safety, as necessary.
- Establishes and maintains a daily routine to avoid suspicious paranoia.
- Reduces “toxic” stress in the environment (i.e., noise, rush, clutter, glare, etc.).
- Removes “overload” or “noxious” stimuli from the environment.
- Prevents catastrophic reactions by attending to antecedents or causes.
- Uses validation therapy to redirect residents away from inappropriate situations.
- Verbalizes and demonstrates various approaches for a resident who is resisting personal care that will maintain resident dignity and respect.
- Demonstrates appropriate interventions for resident who is yelling or screaming.
- Demonstrates use of therapeutic activities to de-escalate a resident who is anxious (i.e., quiet/soft rooms, placements of familiar objects within vision, walking to the side of the resident, hand-holding, gentle touch, etc.).
- Demonstrates use of distraction strategies as a therapeutic intervention (i.e., walking, dancing, hair brushing, nail care, flowers, aromas, textures, etc.).
- Assists the resident in “way-finding” cues for “looking for” items (i.e., signs, pictures, and familiar objects).
- Demonstrates therapeutic communication with family members and significant others, during resident visits.
- Demonstrates coaching techniques to help other caregivers and family members cope with the dementia process.
- Ensures adequate lighting by increasing light, as needed.
- Provides activities to meet a resident need or personal background history.
- Redirects any sexually inappropriate activity, as care planned.
- Monitors for behaviors indicative of pain, constipation, infection, etc.
- Provides time for rest periods to reduce risk of fatigue.
- Checks care plan for resident limitations and strengths.

**D. Provide Assistance and Sensitivity with ADL’s, Mobility, and Therapeutic Activities that will Maximize Functional Well Being.....75-100**

- Implements therapeutic activities appropriate for early, middle, and late states of dementia, including end of life care.
- Demonstrates strategies for promoting independence in all ADL’s, as resident is capable.
- Allows the resident to do as much ADL care at his/her highest level of function.
- Participates in therapeutic approaches to care by assisting residents to carry out ADL’s, as well as recreational and social activities.
- Promotes resident identity through capabilities, strengths and self-esteem.
- Respects the resident’s dignity and desire for control.
- Involved in and adapts activity-focused care activities to be failure free.
- Implements care strategies that provide stimulation and encourage ADL’s without increasing resident anxiety or stress.
- Provides reassurance and gentle touch, as necessary during ADL’s.
- Assists in resident “way-finding” activities and “looking for” familiar items, during ADL’s.
- Moves slowly with each stage/phase of the ADL activity.
- Allows resident simple choices, when possible.

- Re-approaches at another time, if resident is not cooperative.
- Provides frequent rest periods.
- Offers fluid intake before and after ADL care activities.
- Demonstrates effective shower/bath techniques.
- Demonstrates effective dressing/undressing techniques.
- Demonstrates effective toileting techniques.
- Provides privacy during dressing, bathing, toileting and incontinent hygiene care needs.

**E. Apply Nutritional Interventions to Maximize/Maintain Nutritional Well Being in the Cognitively Impaired.....50-100**

- Promotes a calm and pleasant atmosphere that supports optimal functioning for eating activities or meal times.
- Maintains an environment which minimizes distractions during eating activities or mealtime.
- Demonstrates the ability to adapt to the dining experience that maximizes nutritional intake (i.e., offering small servings, introducing foods one at a time, etc.)
- Implements dietary modifications as may be needed to maintain nutritional status (i.e., food preferences, simplified table settings, physical/verbal cues, adaptive devices, small group seating, etc.).
- Provides high caloric nourishment and fluids to maintain appropriate weight and hydration in a way the cognitively impaired resident will accept (i.e., finger foods, frequent small meals, extra snacks, and frequent fluids.).
- Offers fluids mid-morning, mid-afternoon, and mid-evening, in addition to the mealtimes and recreational activities.
- Encourages residents at high risk for dehydration (due to pacing, medications, skin breakdown) to drink more fluids.
- Monitors and documents meal consumption and fluid intake.
- Monitors urinary output by observation and documentation.
- Monitors bowel movements by observation and documentation.
- Reports absence of bowel movements in 48 hours to the charge nurse.

**F. Demonstrates an Understanding of Effects of Psychoactive Medications and Observe for Side Effects .....150 - 200**

- Monitors number of behavior occurrences, as targeted behaviors or medication side effects.
- Reports target behaviors (i.e., aggression, anger, anxious behaviors, fear, exit seeking, excessive sleeping, sadness, crying, loss of appetite, insomnia, weakness, unsteady gait, abnormal facial/trunk/extremity movements, etc.).
- Documents episodes of targeted behaviors and/or new behaviors according to facility guidelines.

**G. Maintaining a Caring and Safe Environment for Cognitively Impaired.....150 - 200**

- Promotes a sense of belonging in a safe home-like environment.
- Limits noxious stimuli in the environment to minimize escalating behaviors or catastrophic reactions.
- Maintains a safe environment for residents and staff while de-escalating combative behavior.
- Implements appropriate interventions to minimize environmental stimuli that may increase a confused resident's agitation, (i.e., noise levels, large groups, television, radio, etc.)

- Maximizes safety and security to protect residents from physical harm: uncluttered walkways, conducts frequent observational rounding, ensures exit doors alarmed, staff sight lines to outdoor areas, etc.
- Demonstrates/verbalizes appropriate actions to take to protect residents from psychological harm (i.e. when a resident is striking out at another resident, behaviors are aggressively threatening to others, exposing self or sexually inappropriate in public etc).
- Demonstrates the ability to maintain a safe environment for the wandering resident (i.e., maintains functional key pad locking systems, 15 minute outdoor checks, outdoor seating, secured tables/chairs, level walkways, etc.).
- Provides attention and redirecting activities before aimless wandering behaviors begin.
- Encourages safe wandering activities through exercise programs, walking programs, adapted sports, and dancing.
- Checks feet and shoes to ensure good skin integrity and comfort.
- Implements and describes system/schedule to monitor resident location.
- Demonstrates knowledge of or use of elopement alarms, frequency of egress door checks, and other actions to prevent wandering.
- Demonstrate maintaining safety from potential toxic substances that the confused resident may attempt to ingest.

**Total Approximate ..... 825-1,200**

RELATED INSTRUCTION OUTLINE  
CERTIFIED NURSE ASSISTANT, DEMENTIA SPECIALTY  
O\*NET CODE: 31-1012.00 RAIS CODE: 0824D

**Description:** The following theoretical core competence standards represent the core learning objectives for safe competent practice in the occupation of Certified Nursing Assistant, Dementia Specialty. Competence implies transference of knowledge and development of understanding that transcends on-the-job competency skills in pre-nursing preparation. These Core Competency Standards are intended for theoretical related instruction and learning objectives which are designed to enhance the apprentice's performance and technical ability. It is through a combination of both on-the-job learning and related theoretical instruction that an apprentice can reach a **skilled level** in the occupation. The following are suggested core competence learning objectives that are to be completed during the term of apprenticeship:

<u>Core Competence Learning Objectives</u>	<u>Approximate Hours</u>
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|-----------|---|----------|
| <b>A.</b> | <b>“Assisting” Role of the CNA, Dementia Specialist as part of the healthcare team .....</b>  | <b>8</b> |
|           | <ul style="list-style-type: none"><li>• Reviews medical vocabulary pertinent to dementia. (i.e., abulia: the inability to hold a thought long enough to complete a sentence; agnosia: the inability to recognize familiar stimuli; anomia: the inability to recall the correct word or phrase to identify an object; aphasia: the inability to express self with speech or writing or to read or understand the speech of others; apraxia: the inability to carry out skilled and purposeful movement to make the body do what the mind wants it to; echolalia: meaningless repetition of words; word salad: a jumble of seemingly meaningless words and phrases containing small bits of meaningful communication; perseveration: the repetition of actions and/or sounds.).</li><li>• Discusses the qualities a dementia care giver should have (i.e., provides respect and caring attitude, gentle touch, patient and calm, makes special efforts to connect with the resident and family needs, acts as a therapeutic partner in care, adaptable and flexible, empathetic and sensitive, etc.).</li><li>• Defines each resident by recognizing his/her unique spirit, strengths and continuing sense of self.</li><li>• Lists members and functions of the dementia care team (i.e., medical director, program director, attending physicians, recreational activity director, activity coordinator, social work services, dietary manager, licensed nurses, nursing assistants, family members and residents).</li></ul> |          |
| <b>B.</b> | <b>Alzheimer’s disease and related dementias: stages, early signs, treatments, physical changes, end of life considerations, depression.....</b>  | <b>8</b> |
|           | <ul style="list-style-type: none"><li>• Defines dementia. (Originates from two Latin words meaning “away” and “mind”. It is a syndrome due to disease of the brain, progressive in nature, which has many causes and should not be confused with delirium. Dementia is a disturbance of multiple cortical functions, calculation, learning capacity, language and judgment proceeded by deterioration in emotional control, social behavior or motivation. Dementia is not a part of the normal aging process).</li><li>• Defines delirium and compares delirium to dementia. (Delirium is a temporary state of rapid acute reversible confusion that can last several hours to several weeks. Delirium and dementia can occur together when medical condition become unstable. Delirium stems from many underlying medical conditions including infections, fluid and electrolyte imbalances, dehydration, hypoxia, cardiovascular problems, adverse drug reactions, new medications, surgical anesthesia, relocation if living changes, etc. Delirium’s rapid on-set of confusion, disorganized thinking, or altered consciousness is unlike the gradual on-set and slow progressive course of dementia).</li><li>• Defines Alzheimer’s disease. (Leading cause of irreversible dementia in older adults. Confirmation of the disease or diagnosis requires an autopsy examination of the brain tissue after death. There is no cure).</li></ul>  |          |

- Explains the difference between dementia and Alzheimer’s disease.
- Recognizes different types of dementia (i.e., vascular dementia, HIV, front temporal dementia, Lewy body dementia, tumor, chemical damage) and lists possible causes (i.e., head trauma, Creutzfeldt-Jacob disease, Pick’s disease, Wernicke encephalopathy; Parkinson disease, Huntington disease, brain tumor, vascular infarction, chemical toxins, alcohol/substance abuse).
- Recognizes early Alzheimer’s disease signs and symptoms (i.e., asks repetitive questions or tells the same stories repeatedly; difficulty with name recall; tendency to lose objects or places items in inappropriate places; inability to remember parts of conversations and recent events; language problems, difficulty finding the right words; difficulty paying bills or balancing a checkbook; changes in personality, moods and behaviors; loss of abstract thinking, loss of good/safe judgment, loss of initiative, loss of enthusiasm and energy).
- Describes the seven stages of dementia, functional ages and their symptoms. (i.e., Stage I & Stage II are not discernable, some forgetfulness symptoms, functions as an adult at home; Stage III notices deficits in employment skills, early confusion and rapid changes in emotion symptoms, functions as a young adult; Stage IV progressive confusion requires help with complex tasks and communication skills, short-term memory loss, inability to handle finances with poor concentration symptoms, functions as 8 years to adolescence; Stage V moderately severe dementia, inability to recall major events, deficits in orientation to time, day of the week, season, functions as 5-7 years old; Stage VI severe dementia and requires assistance with care, personality changes, talks to imaginary figures, and obsessive symptoms, functions as 24 months to 5 years; Stage VII very severe dementia requires total assistance, increase in unwanted behavior symptoms, functions as 12 weeks to 15 months of age).
- Understands the parts of the brain affected by dementia and Alzheimer’s disease (i.e., limbic system, hippocampus, hypothalamus, motor cortex, cerebellum, frontal lobe, occipital lobe, temporal lobe, parietal lobe).
- Differentiates between reversible and irreversible dementia.
- Reviews brain deterioration gross neuronal loss, brain atrophy, amyloid plaques, and neurofibrillary tangles.
- Reviews progressive symptoms of cognitive impairment disorders and treatment strategies.
- Defines depression. (Depression is marked by changes in appetite, sleeping, fatigue, feelings of worthlessness, loss of interest in and the enjoyment in life. Clinical depression closely mimics Alzheimer’s disease but depression can be effectively diagnosed and treated.)
- Describes symptoms of depression (i.e., persistent sad, worried, or “empty” mood; feelings of guilt, hopelessness, helplessness, or worthlessness; loss of interest in pleasurable activities that were once enjoyed; appetite/weight loss; decreased energy, fatigue, feeling “slowed down”; restlessness and irritability; poor concentration, headaches, digestive disorders and complaints of pain).
- Lists some causes of depression (i.e., familial, low self-esteem issues, difficult relationships, financial problems, serious loss, or chronic illness).
- Discusses interventions to reduce feelings of depression (i.e., break cycle of inactivity, increase activities, reassure and encourage residents gently to motivate for participation).

**C. Common Nutritional Issues and Eating Difficulties.....8**

- Discusses changes in eating habits (i.e., pain, poor-fitting dentures, poor vision, overly stimulated by environment, feeling overwhelmed by eating, feeling rushed during meals, food no longer tastes or looks appetizing, etc.).
- Lists typical problems with eating (i.e., refusal to eat, eats all the time but insists he/she hasn’t been fed, takes food from other residents, mealtime is extremely messy, eats desserts and isn’t interested in main meal, and wanders during meal time).
- Lists reasons for wandering during meal time (i.e., restlessness, loss of appetite, too many distractions, too many people at one table, inability to focus on meal, etc.).

- Discusses alternative interventions when inability to use eating utensils appropriately is present (i.e., needs more “hand over” assistance and guidance when eating, offer finger foods as an alternative, utilization of adaptive feeding equipment, large handles to grasp easily, use mugs to serve soups, etc.).
- Explains how lack of understanding ‘how to’ eat affects eating and how to encourage an eating activity (i.e., offers one spoonful of food at a time, instructs resident what to do with spoon of food, wait/cue swallow before offering another bite; offer one food at a time, separate food into different bowls, remove inedible condiments, serve desserts after the main meal, project positive and relaxing energy during meal time).
- Discusses how color and texture aid as visual cues for interest in eating (i.e., use colorful placements that contrast sharply with plates so resident can see food, table cloths with contrasting borders helps to define the table settings, etc.).
- Describes an effective seating chart when residents take food from other residents (i.e., try smaller groups at table, supervision and assistance available, multiple finger foods available.).
- Discusses alternative approaches for residents who wish to eat all the time (i.e., try smaller meals through out the day, offer low calorie snacks, etc.).
- Discusses choking concerns. (i.e., an isolated difficulty swallowing or choking incident does not necessarily represent dysphagia, but rather cognitive dysfunction caused by poor feeding techniques, poor positioning, or reaction to stressors in the environment).
- Relates eating difficulties with high risk for weight loss (i.e., increased memory loss, no sense of time, increased confusion about eating, loss of orientation to dining room, visual filed neglect, appetite change, etc.).
- Discusses approaches for residents who refuse to eat (i.e., mimic what you want the resident to do, offer favorite foods, invite family to assist with meal time, etc.).
- Discusses the importance of integrating eating as an ADL activity. (i.e., activities make mealtime, mini-meals or snacks more meaningful and pleasant: placing chairs, sweeping floors, preparing food, folding napkins, walking to dining area, placing cutlery, setting placemats, arranging flowers, passing out warm wash cloths, saying grace, socializing, consuming meal, wiping off tables, placing dishes in bin, stacking dishes, sweeping floors, pushing in chairs, walking to room, resting after meal).

**D. Behavioral treatment and safety management.....16**

- Defines confusion. (Mental function is disturbed, information cannot be processed correctly and has many causes. If cause is eliminated or treated, confusion may disappear or become reduced. A confused person cannot follow conversation, answer questions correctly, pay attention, unable to orient or understand the environment around them, or remember information given them).
- Defines paranoid (suspicious) or delusional behaviors (false beliefs) and lists examples.
- Describes approaches in dealing with a resident’s suspicious feelings (i.e., avoids arguing, accept their truth, assist in finding lost item, validate feelings, end on a positive note, distract with a chore or activity, if necessary).
- Defines hallucinations (experiences that affect the five senses) and lists examples.
- Defines illusions (misperceptions of a real object) and lists examples.
- Explains the importance of maintaining the emotional stability of residents with impaired cognition.
- Compares effectiveness of using different approaches in caring for residents with dementia that matches the resident’s expectancies with capabilities, earlier life skills, and interests.
- Discusses interventions to use when a resident demonstrates a sudden change in behavior (i.e., making human contact, expressing individual positive recognition, treating individuals as adults, showing genuine care, speaking to individuals with respect, using an empathic tone of voice).

- Explores the dimension of “time” in the universe of dementia (i.e., no continuity and not sequential – can move from present at one moment to past at another or into the future).
- Explores the dimension of “memory” in the universe of dementia (i.e., intact one moment and absent the next, past is confused with present, may not recognize family members as family, as if the mind of a dementia resident plays tricks on reality and creates a new reality world for resident – whatever it may be at any moment in time).
- Explores the dimension of “emotions” in the dementia universe (i.e., reasoning abilities limited or gone, very sensitive and reactive to the care giver’s emotions,
- Defines “reality orientation” and lists examples.
- Defines “validation therapy” as conversation strategies to validate and accept the values, beliefs and the reality of the dementia resident.
- Role plays examples of validation therapy whereby care givers “agree” with a dementia resident through conversation while “steering” or redirecting the resident to do something else without causing stress or any care giver force.
- Examines “reality orientation” (regains awareness to person, place, time and what they need to do) versus validation therapy (safely redirecting the person to a new agenda).
- Discusses conditions when reality orientation is inappropriate (i.e., later stages of dementia; unable to reason or understand information; if the resident is distressed by reality, or becomes upset, sad or angry).
- Explores a resident’s potential range of feelings as related to their perceptions or beliefs about information being given to them that is contrary to what they perceive or believe is true ( i.e., “That is not your baby – it is a doll,” “Your wife is dead – she died last year,” “That is not your room- those aren’t your personal belonging).
- Discusses when validation therapy techniques are useful (i.e., to acknowledge feelings, redirect after feelings have been acknowledged, and to empathize with their feelings) and under what circumstances can they be utilized.
- Reviews and discusses the ‘Good, Bad & Ugly’ training handouts from the SunBridge Alzheimer’s Disease/Dementia Training Guide.
- Lists typical behaviors associated with Alzheimer’s disease (i.e., wandering, delusions, hallucinations, illusions, resisting care, sexually inappropriate or amorous behaviors, eating difficulties, aggression, catastrophic reactions, etc.).
- Defines “behaviors”. (Behaviors are actions that are observable, measurable, and describable. Defining behavior problems means gathering information. How often does the behavior happen? When does it happen? Where does the behavior most happen? Who is around when the behavior happens? What happens before/after the trigger event? etc.).
- Examine factors that influence behaviors (i.e., resident history, family life, occupation, physio-pathological deterioration of the brain, changes in dementia stages, medications, infections, spell of illness, hunger, fatigue, unmet needs, environmental stimuli, changes in routine, etc.).
- Describe levels in which behaviors can be changed (i.e., eliminated: behavior no longer occurs; decreased: behavior not happening as often; increased: behavior is happening more often.).
- Defines “agitation” behavior. (Inappropriate verbal or motor activity).
- Lists and compares non-aggressive (repetitive questions, babbling, pacing, wandering, repetitive body movements and hoarding represents boredom, confusion, frustration and fear) versus aggressive behaviors ( abusive language, hitting, scratching, and kicking is generally thought of as an inability to deal with stressors, expressions of depression or pain).
- Defines “catastrophic reaction.” (Sudden unexpected outburst that escalates into a spiral of tension that is often a catalyst for others to respond to and follow. Often thought of as herding or pack behaviors for example: one dog in the neighborhood barks then all the dogs in the neighborhood begin to bark).
- Lists typical problems that trigger catastrophic reactions (i.e., resisting bathing/dressing or personal care, fatigue, increased irritability at the end of the day, suspicious or paranoia of staff and visitors, anger outburst at other residents, variations in routine, etc.).

- List strategies to minimize catastrophic reactions (i.e., Identify stressors in the environment such as dark shadows or bright glare; monitor for confusion or fatigue; change in routine or environment like holiday decorations, visitors; excessive stimuli of noise and commotion, try calming soothing music, provide rest in a quiet/soft room, massage, etc.).
- Discusses behaviors that can be considered sexually inappropriate and factors contributing to (i.e., masturbating in front of others, climbing into the bed of another resident, attempting to indulge in non-consenting sexual intercourse, confusing another resident with a spouse, missing a spouse, seeking signs of affection, fondling/stroking/kissing in public places, desire for intimacy, makes inappropriate comments to staff and residents, misinterprets staff's actions, making sexual overtures, using sexually charged language, exposing self, etc.).
- Describes interventions that manage inappropriate sexually activities (i.e., monitor whereabouts, ensure privacy for harmless masturbation, keep room doors open if concerned about seeking sexual contact with others, room change, distract or redirecting the resident to another appropriate "hand holding" activity, consider putting clothes on backwards, place a pillow over the groin area or attach a fanny pack around the waist with interesting objects to handle, provide a stuff animal for touching/holding, etc.).
- Defines "sundowner's syndrome." (Agitation/hallucinations or delusions in the late afternoon or early evening with unknown cause. Thought to be caused by triggered light changes in the evening).

**E. Alzheimer's disease and communication challenges.....8**

- Lists and explains common types of communication difficulties caused by Alzheimer's disease. (i.e., empty speech, paraphasia, stereotypic language, speaks in jargon, inability to stay focused during conversation, no longer able to read or comprehend words).
- Lists communication strategies to enhance abilities (i.e., gentle tone of voice is understood even when words are not, reinforcing familiar life-long tasks; recalling/reminiscing remote memory; exchanging familiar greeting phrases or old adages, extending social compliments, encouraging song/ melody/lyrics, reciting verses or prayers, etc.).
- List non-verbal approaches to enhancing communication (i.e., aware of personal space, use direct frontal physical approach, establish good eye contact at eye level; avoid rushing or startling situations, demonstrate careful and meaningful hand gestures; use body language of nodding head, beckoning with outstretched arms, use gentle touch; avoiding sudden movements that startle or threaten, hold hands; project a calm and positive care giver demeanor).
- List verbal approaches to enhancing communication (i.e., use descriptive nouns instead of pronouns, speaking slowly and clearly; using a short descriptive sentence, phrase things in appositive instead of a negative, use closed-end "yes/no" questions, offering two simple choices, choosing familiar words, avoiding use of baby-talk or labeling individuals with "pet names").
- Role-plays the 'Changing Poor Communication to Good Communication' handout from the SunBridge Alzheimer's Disease/Dementia Training guide.

**F. Developing a safe and therapeutic environment for the cognitively impaired resident including culturally sensitive dementia care..... 8**

- Discusses the need for a calm, caring, structured activities-focused environment.
- Describe the benefits of an activity-focused care (i.e., fosters meaning and sense of purpose for the resident; provides the opportunity for the continuation of "themes" in life roles; opportunity for experiencing pleasure and gratification; provides the opportunity for success and accomplishment).
- Lists steps that help a dementia resident with activities (i.e., be prepared, step the stage, remove distractions, get the resident's attention, obtain interest and agreement to participate, identify the activity, break the activity down into simple components, communicate clearly, assist

the resident to finish the any part of the activity task, assist the person to their highest level of function, provide rest breaks, include nutritional foods/fluids during the activity, monitor for fatigue or stress, stop the activity or remove stressor, provide successful closure of the activity even if the activity task was not completed, celebrate the activity experience and praise/validate the effort).

- Explains how activities, contact with others, and opportunities for exercise are important (i.e., reduces boredom, reduces restlessness, decreases confusion, anxiety and agitation, encourages appetite, minimizes aimless wandering).
- Defines wandering. (Non-deliberate aimless or purposeful motor activity that can causes social problems with getting lost, leaving a safe environment, or intruding in inappropriate places common with middle-stage dementia).
- Lists causes of wandering behaviors (i.e., one way to express stress or anxiety, discomfort or emotional feelings; thirst, hunger, urinary or fecal urgency; a desire to fulfill former past obligations such as going to work, meeting friends/family or going home; side effects of medication, an inability to recognize the familiar causes fear and panic, the desire to go and find somewhere they do recognize, rummaging through personal belongings because of excessive energy, etc.).
- Discusses the types of wandering behaviors (i.e., exit seekers, circling pacers, following the crowd, and, searching for the familiar).
- Lists potential problems with wandering behaviors (i.e., increases fall risk, foot/gait problems, fatigue, little rest with compulsive pacing, risk for dehydration/weight loss, exit seeking, following others out doors, elopement, won't sleep at night, risk for intrusions on other residents, etc.).
- Lists environmental items/situations that attract attention of the cognitively impaired resident (i.e., sharps, laundry bins, medication or housekeeping charts, personal toiletries, cleaning supplies, containers, waste baskets, maintenance tools, open doors, dresser drawers, closets, reflective glass/mirrors, following groups of people, exit signs, pathways/walkways, etc.).
- Explores alternative approaches to minimize wandering behaviors (i.e., considers physical causes: hungry, toileting needs, use signs/pictures to find the familiar, provide opportunities to be outside: feed birds, sweep walkways, take a walk on a walking path, provide multiple seating areas, slide rockers offer movement in a seated position, provide an item to care for when walking like a stuffed animal, etc.).
- Defines a "wander guard" system and "secure unit" alarm codes (i.e., keypad security).
- Explains basic wander guard guidelines.
- Discusses how and why the environment may affect the cognitively impaired visual perception and cause problems or risks (i.e., type of floor patterns, high gloss waxed floors, ceramic tile glare, lightening, shadows, contrasts of light/dark colors, right-angle furniture placement, round out corners, etc.).
- Describes the need for a clutter-free, non-glare, solid beige colored walkways (i.e., avoids creating a waking maze, prevents falls, alters depth perception, eliminates fear or avoidance of walking on the illusion of water on floor, minimizes stooping posture to attempt to pick at "patterns" in carpets, etc.).
- Explains the need for conducting 15 minute safety checks outdoors and lists outdoor hazards.
- Explains how environmental or familiar pictures can assist the cognitively impaired find their way (i.e., resident photo at a resident's room door, picture of toilet on bathroom door, etc.).
- Defines "elopement." (Any resident escape from the facility or unauthorized departure, without staff knowledge).
- Examines the elopement/missing person policy and procedure.
- Describes procedures in searching for a missing person and the process of an elopement plan.

**G. Activities of Daily Living and Personal Care Issues ..... 6**

- Discusses how providing reassurance and touch is necessary.

- Explains why assistance in resident “way-finding” activities and “looking for” familiar items is helpful in care issues.
- Lists the benefits of providing frequent rest periods.
- Explores reasons for personal care challenges of bathing and dressing (i.e., not in the mood, doesn’t understand the process, triggers aggression, needs more assistance than being offered, too much assistance is being provided, physical/emotional pain or embarrassment may be associated with undressing, fear of water, doesn’t like a wet head, echo in bathroom is frightening, room is too cold or hot, etc.).
- Lists alternative approaches for bathing and dressing (i.e., bathe at a different time, offer simple choices, wash hair at a the beauty salon, change caregivers, play calm music during bathing/dressing time, bathe under a bath poncho, selects easy to don clothing with elastic bands, Velcro fasteners, zip up closures, etc.).
- Discusses shower/bath techniques (i.e., prepare shower room ahead of time, make sure room is inviting, provide calm “feel good” assurances, start with trickle of water, encourage resident to touch the shower water, gradually undress without rushing the resident, covers body parts not being bathed, encourage the resident’s involvement, assist resident to “soap” their arms/chest while care giver washes back, avoids showering the face, saves shampooing for last).
- Discusses undressing/dressing techniques (i.e., move slowly through the step-by-step dressing activity, gives one simple instruction at a time, lay out clothes in the order they are put on, provide cues, assists with buttons, zippers, tying shoes, talks gently, praising each step).
- Explains the importance of checking the feet and shoes of wandering residents (i.e., development of blisters and calluses).
- Describes the effects of medication may cause increase restlessness, wandering, and increased agitation.
- Discuss the importance of hydration. (i.e., a resident with dementia drinks insufficient quantities of fluid and behaviors like restlessness, wandering, and distress can result from thirst. Dementia residents may not recognize water pitchers, remember how to hold a glass or that the glass is placed at the mouth).
- Discusses the importance of maintaining continence and toileting activities (i.e., assists only with help required, caregiver placed at side of resident, practices as a quiet and invisible assistant, place gentle touch on shoulder if resident “pops” up and down during elimination).
- Lists creative solutions for organizing the toileting experience (i.e., place toilet paper in plain view, eliminate clutter in bathroom, place large toilet picture on door, maintain good lighting in the bathroom 24 hours a day).
- Describes developing a toilet routine (i.e., consult with family regarding elimination patterns, discreetly remind the resident to toilet before regular elimination times, rewards successful toileting experiences, minimize toileting accidents).

**H. Support and resources for family & caregivers.....6**

- Identifies compassionate person-centered care for residents with dementia and other cognitive impairments.
- Discusses the importance of getting detailed information from family (i.e., resident does better with a female caregiver, resident has a history of usually taking a sponge bath during their life span, resident always dresses after breakfast, resident has habit of bowel movements before breakfast, life-long occupation as a dairy farmer the resident is used to rising before sunrise, etc.).
- Examines resident life history in seeking clues about “familiar” activity traits that affect behaviors (i.e., dairy farmer rises before sunrise, motel manager seeking to unmake beds, auto mechanic seeking a parking lot of cars, accountant hoarding scraps of paper, housewife cleaning, mothers rocking babies, etc).
- Discusses the importance of developing rapport with family members (i.e., encourage flexible visiting hours, talk with family every time they visit, provide a special area for families to visit,

assists families in feeling comfortable on the unit, assists families in adapting to behaviors of other residents, always make time for family members, remember that a complaining family member is a “hurting” family member, encourage participation in educational information, Alzheimer’s disease/Dementia Workshops, share with families special moments experienced with their loved one, encourage family members to stay for a meal or special occasion, etc.).

- Explores family issues after placing a loved one in a nursing home (i.e., guilt, loneliness, sadness, grief, hopelessness, fear, anxiety, embarrassment, shame, anger, confusion about the role of the family in a nursing home, family members do not understand the disease process, concerned staff are not taking care of their beloved as well as the family can, family members deny the progression of the disease, etc.).
- Describes positive ways of involving family in the care of their beloved (i.e., referring family members to their local Alzheimer’s Association, provide local support group information, ask family members to help or volunteer time on the unit by assisting at mealtime or attending an activity, ask family members for ideas on how to care for their family member, encourage frequent visits, phone family and share positive events, etc.).
- Review staff and family role-play exercises.

**I. Psychoactive medications in dementias for cognitively impaired adults ..... 4**

- Explains psychoactive drug standards and practice guidelines (resident rights to be free from chemical restraints, physician authorized for a specified period of time, principle use to restore practical level of function, and monitored and evaluated for effectiveness related to discontinuance, dosage reduction or on-going use).
- Discusses the use of antipsychotic, anti-anxiety, sedative/hypnotics etc. drugs require specific target behavior monitoring to provide on-going assessment and efficacy of the drug’s medication therapy (i.e., monitor number of behavior occurrences/episodes; intervention attempted; outcome of intervention tired; side effects of the intervention implemented).
- Discusses the use of antidepressant medication only requires tracking side effects of the anti-depressant medication.
- Discusses medication therapy that is commonly used for mild-to-moderate stages of the dementia to slow cognitive decline and delays the onset of new behavioral symptoms.
- Lists common adverse effects to medication therapy (i.e., drug interactions, nausea, vomiting, diarrhea, dizziness, fatigue, headache, and constipation).
- Discusses benefits of antidepressant medication use.

**Total Hours of Employer Related Instruction..... 72**

**Total Hours of Supplemental (Pre-Nursing) Instruction .....45**

*Individuals who complete the CNA-Dementia Specialty OJL and related instruction components shall receive a “Certificate of Specialization” credential.*