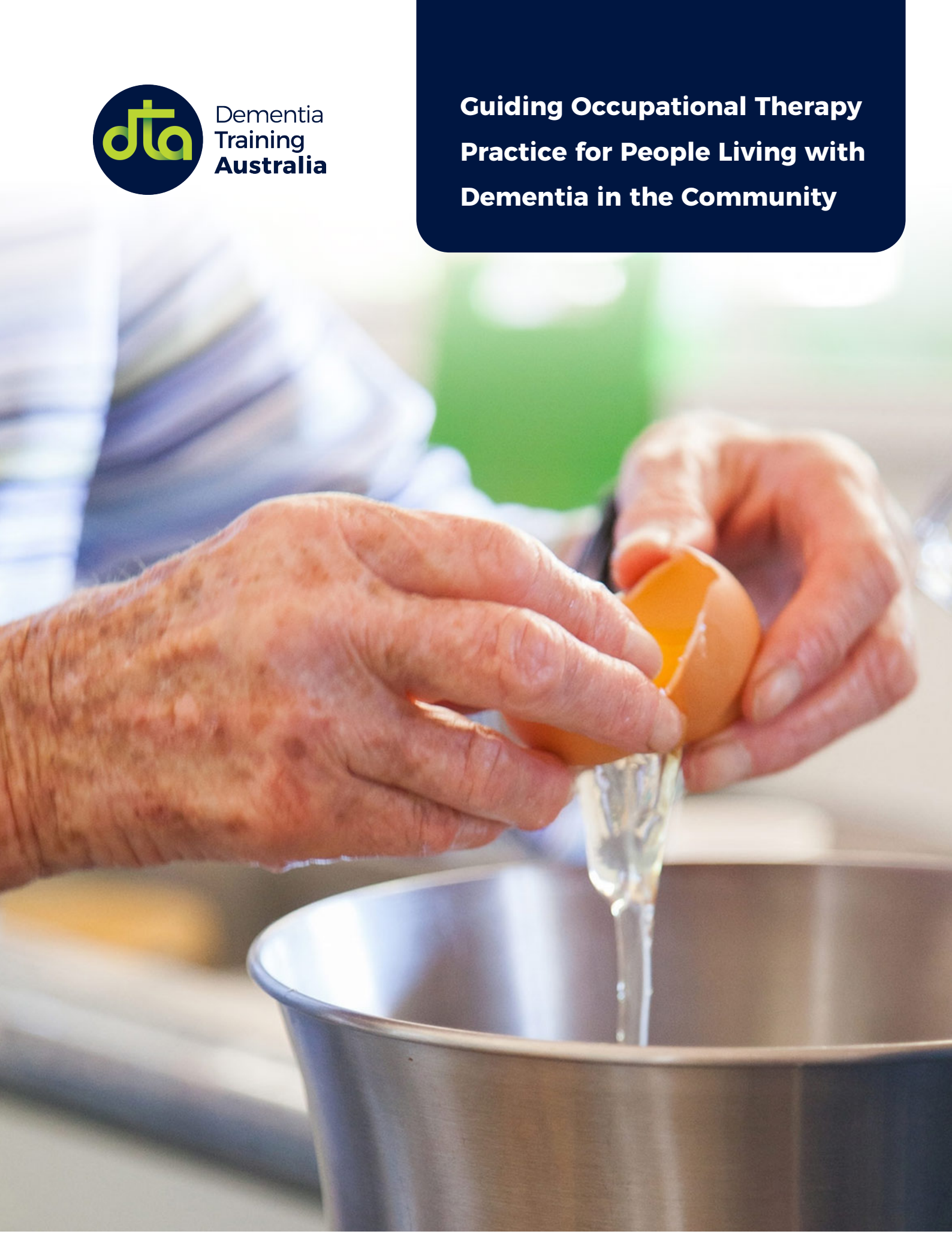
Dementia Training Australia

Guiding Occupational Therapy Practice for People Living with Dementia in the Community



Dementia Training Australia is supported by funding from the Australian Government under the Dementia and Aged Care Services Fund.

University of Wollongong Australia · dementia australia · La Trobe University · QUT Queensland University of Technology · University of Tasmania Wicking Dementia Research & Education Centre · The University of Western Australia · Western Australian Centre for Health & Ageing

Dementia Training Australia is supported by funding from the Australian Government under the Dementia and Aged Care Services Fund.

Acknowledgements

We would like to acknowledge the excellent work of Louise Phyland (nee Dougan) who sadly passed away in 2015, in researching and writing the original *Dementia: Osborne Park Hospital Guide for Occupational Therapists in Clinical Practice* with the assistance of the Osborne Park Hospital Occupational Therapy Department.

This document, *Guiding Occupational Therapy Practice for People Living with Dementia in the Community*, aims to further enhance occupational therapy clinical practice provided to people living with dementia and their care partners. The focus being on dealing with challenges in everyday life. Both authors have significant experience as occupational therapists in aged care and specifically dementia. Rewriting this document provided opportunity to focus on the contribution an occupational therapist can make to support a person living well with dementia.

The authors are very grateful for expertise and support provided during the writing of this document by a number of professional colleagues. Thank you to Dr Stephen Ho (Geriatrician), Katrina Cohen (Senior Occupational Therapist) and Kate Molony (Occupational Therapist / Registered Nurse) who gave their time to review the document and provide valuable feedback and guidance. Thank you to Anna Gatti (Senior Physiotherapist) for assistance with the 'Mobilisation' section and Miriam McCaffrey (Clinical Nurse) for assistance with the 'Toileting and Continence' section. Thank you to Katrina Fyfe (Manager, Dementia Training Australia) for initiating this project and managing the production process.

Original authors (2011):
Louise Phyland and Osborne Park Hospital Occupational Therapy Department

This edition (2018)
Vera Riley, Senior Occupational Therapist, Sir Charles Gairdner Hospital
Anne Pressley, Senior Occupational Therapist, Osborne Park Hospital

Contents

Tables

Introduction

Dementia: Osborne Park Hospital Guide for Occupational Therapists in Clinical Practice, published in 2011 by the WA Dementia Training Study Centre (now Dementia Training Australia), was created by occupational therapist Louise Phyland and the Osborne Park Hospital Occupational Therapy Department as an evidence based, easy reference guide for occupational therapists working in dementia care.

Guiding Occupational Therapy Practice for People Living with Dementia in the Community is a rewrite of this original guide and is the result of a partnership between the Sir Charles Gairdner and Osborne Park Hospitals Group Occupational Therapy Departments and Dementia Training Australia. It is intended as a resource to complement the array of published work available nationally and internationally by providing occupational therapists with a comprehensive guide to assist them in determining their scope of practice in their individual settings.

The content has been reformatted with an emphasis on activity analysis and strategies addressing challenges within the steps of the task. Every effort has been made to demonstrate inclusivity to multicultural, indigenous, religious, and lesbian, gay, bisexual, transgender and/or intersex (LGBTI) communities. It needs to be acknowledged that for the people with younger onset dementia there is a unique set of social, family and vocational challenges that may not be fully addressed in this resource[1]. The content also reflects the considerable advances in technology and design principles which have occurred since the original publication.

Understanding Dementia

Dementia is a progressive degenerative disease of the brain[2,3]. The signs of dementia show a gradual decline from previous levels of performance in cognition impacting increasingly on a person's ability in daily living activities[2]. Decline occurs in one or more cognitive domains: complex attention, executive ability, learning and memory, language, perceptual motor function and social cognition[3,4]. Consciousness does not tend to be affected[4]. Daily living activities impacted include those activities needed by a person to fulfil various life roles, including that of a self-maintainer, a family member, a friend, a work colleague and a community member[5].

The focus in this occupational therapy practice guide is on dementia as a phenomenological diagnosis, a syndrome. There are many different pathological causes of dementia, the most common in people over the age of 65 is Alzheimer's disease[2,6]. The different types of dementia will differ in their clinical manifestations according to the pathology, especially with respect to their affected cognitive domains, and their natural history. As a progressive debilitating condition, dementia is one of the major chronic diseases of the 21st century[2,6]. There are large health, social and economic costs associated with dementia, which will continue to grow in coming decades[7,8]. There is a significant burden from the disease for people with dementia and their families, the health and aged care systems and the economy as a whole[9].

In 2018, there were an estimated 436,366 people with dementia living in Australia[10]. This number is expected to increase by 90% over the ensuing 20 years[9]. Available statistics show that one in five people with dementia is from a cultural and linguistically diverse background, and that Aboriginal and Torres Strait Islanders have 3-5 times the risk of developing the disease compared to non-Indigenous people[9]. There is also significant number of people with younger onset dementia, and LGBTI people with dementia whose circumstances need to be taken into account when considering intervention and services[11,12]. Despite these statistics that present challenges to health care, there is research and conversation occurring about positive changes in survival of those living with dementia and the positive impact of efforts to prevent, detect and control

obesity, hypertension, diabetes and dyslipidaemia on brain health and dementia risk[13]. At present the evidence in this area is still very limited but is being addressed in research.

Dementia is an immense challenge in society, in that it affects not just the person with the disease but also the family and significant others[14]. For the person, the diagnosis of dementia confirms the reality of changing cognition but often also brings a change in how family and friends respond[11]. For many, a diagnosis of dementia is seen as an end to a meaningful life[11]. There is still a stigma that impacts on social inclusion and opportunities for a person with dementia, and negatively affects participation in all aspects of daily life[15]. The importance of the goals to create a 'dementia-friendly environment' and to promote people 'living well with dementia' cannot be underestimated. Society needs to learn more about dementia, the progression of the disease and how best to contribute to supporting the person with dementia and facilitating participation in daily life[6,11]. The aim needs to be a high quality of life with meaning, purpose and value.

Signs of Dementia

To explore the impact of dementia on daily life, and understand the challenges faced by people with the disease, it is helpful to consider cognitive decline in relation to activities of daily living. The six cognitive domains, as defined in the 'Diagnostic and Statistical Manual of Mental Disorders, 5th Edition', address the many aspects of cognition[5]. In Table 1 they are linked to examples of the functional challenges that may be experienced by a person living with dementia.

Table 1 Six cognitive domains linked to functional changes[5]

Cognitive Domains	**Examples of Functional Challenges**
Complex attention: • Sustained attention • Divided attention • Selective attention • Information processing speed	• Difficulty staying focused on a task until completion. • Difficulty walking and talking or talking while making toast. • Easily distracted from topic in conversation. • Needing to 'stop and think' during steps of a task.
Executive function: • Planning • Decision making • Judgement • Working memory • Responding to feedback • Inhibition • Mental flexibility • Reasoning	• Difficulty planning to prepare and cook a meal. • Difficulty choosing a meal from a menu or choosing appropriate clothing for the day. • Difficulty foreseeing consequences. • Difficulty following directions or instructions. • Difficulty managing a conversation in a busy environment. • Difficulty showing awareness of another's perspective.

Cognitive Domains	Examples of Functional Challenges
	• Difficulty solving problems, thinking of a new way to do when problems arise.
Learning and memory: • Free recall • Cued recall • Recognition memory • Semantic and autobiographical long-term memory • Implicit learning	• Difficulty knowing place and time. • Difficulty repeating instruction given regarding medication regime. • Difficulty knowing what to do next. • Needing a prompt to remember information given. • Difficulty recognising familiar faces. • Forgetting the rules of a familiar card or board game. • Difficulty with wayfinding in a familiar environment. • Difficulty learning new ways to do things, such as learning to use a new appliance.
Language: • Object naming • Word finding • Fluency • Grammar and syntax • Receptive language	• Difficulty naming household items. • In conversation getting stuck by not being able to come up with the needed word. • Seemingly needing to 'stop and think' when trying to describe an experience or explain something. • Difficulty in conversation producing complete sentences. • Difficulty making sense of verbal information given or not able to follow written prompts.

Cognitive Domains	Examples of Functional Challenges
Perceptual-motor function: • Visual and depth perception • Visuo-constructional reasoning • Perceptual-motor coordination	• Difficulty judging distance, difficulty reaching for things or pouring drinks. • Difficulty finding something in a busy drawer. • Mistaking images on TV for real people. • Difficulty assembling a torch when changing batteries or assembling a kitchen appliance such as a blender. • Slowed reaction time when moving through the environment. • Difficulty with handwriting.
Social cognition: • Recognition of emotions • Theory of mind • Insight	• Difficulty recognising family member's emotions from facial expressions. • Difficulty knowing own emotions, if feeling depressed or anxious. • Being socially inappropriate. • Misinterpreting someone else's opinion. • Not acknowledging difficulties such as forgetting to take medications, difficulty with cooking, difficulty paying bills. • Difficulty with reasoning through problems.

Course of Dementia over Time

Dementia is a general term referring to a range of subtypes, each with a somewhat different presentation, but involving gradual decline in brain function[4]. In each type of dementia, either the disease process or area of degeneration is

different[3]. Dementia being progressive means there is ongoing loss of abilities. Specifically, cognitive, perceptual, social, and emotional abilities decline over time and eventually there is also impact on physical ability[2-4]. A reflection of this decline is seen in the gradual loss of ability to initiate, plan, organise, and successfully perform tasks in everyday life[16]. There is great variation in the impact of the disease and its progression, both in terms of how rapidly it occurs and what abilities in the person's daily life are lost[11]. It is a different experience for every person and every care partner. A combination of the disease process, the person's individual strengths and coping strategies, as well as the individual lifestyle and social context contribute to the rate of decline in daily living abilities.

Mild Cognitive Impairment

In the context of a person's life, the first sign they may notice is a subtle cognitive decline. This may mean that memory is not as sharp as it once was, that learning to use technology may not be as easy as in the past or managing the finances for the household takes longer and is more challenging, or that reasoning through a discussion or debate in a social situation is more difficult and less satisfying. Early changes are often subtle, and not easy to distinguish from normal aging, especially as the person still remains independent in the activities of daily living. Life goes on and the person is still able to fulfil the many roles in their life, but there may be some frustrations or annoyances that impact on a person's emotional wellbeing. These difficulties may be evidence of 'mild cognitive impairment' (MCI), defined as an intermediate stage between the expected cognitive decline of normal aging and the decline seen in dementia where activities of daily living are significantly impacted. For a person with mild cognitive impairment there may be a subtle increasing difficulty in performing daily living task without loss of autonomy. For one person mild cognitive impairment may progress to dementia, but for others a progressive decline is not seen. The evidence indicates that people with amnestic mild cognitive impairment have been shown to have an increased risk for developing Alzheimer's dementia[17].

Early Dementia

With time, the person may show changes in cognition that are more significant and obvious to the family or significant others that share their life. The person though is still able to manage the essentials of day-to-day living and attend to the activities that are needed. The person may notice a 'forgetfulness' for new information, and have more difficulty in reasoning, decision making and problem solving. Examples of difficulties include, repeating the same question or story, misplacing things at home, accusing people of 'stealing' lost items, becoming less active, not initiating activity. These difficulties begin to impact on the activities of daily living and contribute to the evidence indicating emerging dementia or early dementia.

Moderate Dementia

As the disease progresses, the person will begin to need assistance due to increasing impact of cognitive deficits. A person may have awareness of no longer being able to do the things that once were done without much conscious thought, yet another may have no insight into declining abilities. These changes in abilities with activities of daily living indicate a moderate degree of dementia. Evidence of the increasing difficulty may be that the person needs prompting to shower regularly or take medications, is confused about time and place, gets lost away from familiar surroundings, forgets how to cook, needs assistance with the finances, misjudges clothing and ends up outside wearing a nightie. It is a time when a care partner may begin to jump in and 'do' for the person. With cues and prompting the person can however often still participate in many meaningful everyday activities. At this stage it may be that the person can no longer live alone without significant safety concerns.

Advanced Dementia

For the person living with dementia through to the advanced stages of the disease, the losses mount and this means high levels of support and care are needed. During the advanced stage of dementia, the person becomes increasingly frail. The damage caused to the brain means that the person can no longer do many of the things they used to do and is dependent on care in most

areas of activities of daily living (ADL). From the care partner's perspective, the impact of caring is great, not just in terms of the physical demands but also the emotional toll. The person with dementia often can only minimally engage and interact with the care partner and the environment. By this stage, responsive behaviours or behavioural and psychological symptoms of dementia [BPSD] often appear and may become a major challenge in the person's care.

Dementia, Delirium, Depression and Responsive Behaviours

Dementia, delirium and depression are all serious conditions that are particularly common in older people. The conditions are different from one another, but it can be hard to distinguish as they can all manifest with cognitive symptoms which overlap at times. It is vital that key risks, signs and symptoms associated with all three conditions are identified so that appropriate support, treatment and management can be given.

Delirium

Throughout the progression of dementia, challenges can increase due to illness superimposed on the condition. Illness can also impact more significantly on the person with dementia because there are fewer coping strategies for dealing with feeling unwell, or being in pain, or being more fatigued. Having dementia is a significant risk factor in developing delirium when a person is challenged with illness or injury. There is also an increased risk of a person developing dementia following an episode of delirium. Delirium refers to an acute change in mental status resulting in sudden (usually hours to a few days) decline in attention (reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment). A decline in cognition is evident. On medical assessment, the existence of a medical condition impacting on the physiological state is likely to be identified. The presence of delirium may be recognised by a sudden significant change in function in activities of daily living, compared to previous abilities. For the person and their family / care partner, a diagnosis of a delirium is often a frightening and isolating experience. At best, multidisciplinary assessment is needed to identify the contributing factors to a delirium and intervene to prevent or manage the condition. The evidence indicates that the duration of delirium varies, 60% lasts approximately one week,

5% more than a month. Impaired concentration and memory may persist for six to 12 months. For some, full cognitive and functional recovery to baseline may not occur. No formal assessment aimed at diagnosing dementia or assessing for progression of dementia should take place in the presence of delirium, as an accurate profile of a person's cognitive ability is impacted by the acute condition[18-21].

Depression

Depression is common in people with dementia and poses additional challenges. Depression can precede dementia or happen as part of the dementia. For the person diagnosed with dementia, the reaction may be one of experiencing loss of confidence and self-esteem and subsequently contribute to depression. Depression and dementia both have signs of memory, concentration and thinking problems and thus it can be difficult to distinguish. Symptoms of depression can include: change in appetite, loss of interest in activities that are normal enjoyed, change in sleep pattern, agitation, restlessness or lethargy. The person may be disoriented and unable to concentrate, and may appear sad and pessimistic, even express feelings of worthlessness. The key is to compare their ability and behaviour to what is normal for them and consider strategies that provide support to the person and encourage engagement in daily living are essential.

Responsive Behaviours (Behavioural and Psychological Symptoms of Dementia - BPSD)

Responsive behaviours may present throughout the course of the disease progression, and it must be said that for care partners, these symptoms linked to dementia have most impact on their quality of life. The symptoms may include apathy which is seen as a lack of motivation, loss of initiative, social withdrawal and lack of interest in social activities. Symptoms have similarities to those of depression. Impairment in verbal fluency and ideational fluency are significant predictors of apathy. Anxiety, for the person living with dementia may mean being worried and anxious but not sure why, hence they may be restless, or pace, or fidget, or follow the care partner closely (shadowing). Visual and auditory hallucinations may be experienced. For example, the person may experience

seeing people, situations or objects from the past, and this may be frightening. Delusions and suspicions may result in the person living with dementia accusing others of theft, infidelity or improper behaviour. These changes in mood and behaviour are outcomes of the disease and there may be many reasons for these changes. It is of great importance to properly diagnose mental health issues to ensure appropriate treatment can be accessed, and care partner education and support can be actioned[22].

Role of the Occupational Therapist

With expertise in activity analysis, the occupational therapist addresses dementia as a condition that affects occupational performance. A person-centred approach looks at the person's needs and wants in daily living activities, identifies the resources he or she has available in terms of abilities, supports and the environment, and aims to promote optimal independence and safety to allow meaningful engagement with life. Throughout the progression of the condition, the role of occupational therapy tends to focus on:

- Participation in personal and instrumental activities of daily living, leisure and social roles. Review of the evidence suggests that occupational therapy interventions should use assessment of function, recommendations to enable optimal participation in meaningful activities and the use of assistive equipment and environmental modifications[23]. Evidence of the benefit of problem-solving strategies to optimise performance in activities of daily living reinforces the person-centred approach[24].
- Interventions that are multicomponent in nature and include such approaches as errorless learning strategies, physical exercise and use of familiar or habitual activities[25].
- Interactive care partner skills training to assist family or significant others to provide optimal care for the person with dementia[24].
- Education regarding the disease process, strategies for addressing behavioural and functional changes and adjustment skills[26].
- Support for family / care partner wellbeing including offering stress management techniques and mindfulness training in addition to linking families with professional services such as those offering cognitive-behavioural therapy[27].

The National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines for Dementia in Australia[28] further support that people with dementia living in the community should be offered occupational therapy interventions including:

- Individualised programs to enhance independence in activities of daily living.
- Task adaption and skills education for families.

- Environmental assessment and prescription of modifications or assistive technology to minimise the impact of any disability.
- Social connection and strategies to promote optimal mobility, continence and nutrition as a priority.

Furthermore, the occupational therapist has a responsibility to ensure people living with dementia and their families access specialist programs and services for a coordinated approach to care[28]

- Access to Memory Assessment Clinics and services should be available and include a range of medical, therapeutic and rehabilitation programs[28].
- Family and significant others should have access to programs which offer ongoing education and support. This should include facilitating links to specific Australia-wide dementia and care partner organisations to assist in the maintenance of wellbeing[28].
- Access to intervention and support programs with a multidisciplinary team focus that provides a coordinated approach to care to address the individual's holistic needs. This team approach can vary depending on the team structure in various settings. The team approach should extend to include wider community agencies considered important in support and care provision[28]

Occupational Therapy Assessment

The occupational therapist assesses a person living with dementia to determine the impact of the cognitive decline on occupational performance in the context of daily life. Assessment guides person-centred goal setting and occupational therapy intervention planning. Enhancing ability in daily living activities, promoting relationships and social participation are key emphases of intervention[29]. When working in conjunction with a multidisciplinary team, the occupational therapist's assessment information may also contribute toward the medical specialist's assessment for and the diagnosis of dementia.

All occupational therapy assessment begins with an in-depth interview focusing on determining the person's current perceived abilities and disabilities. Questions during the interview with the person will explore 'what' is done in a day and 'what' barriers are there to daily activities. Discussion will address the person's goals. It is valuable to also have a family member or significant other provide

collateral history of their observations of the person's abilities and disabilities; they may also contribute to the goals that are set for intervention. The interview usually concludes with discussion around the need for further assessment by the occupational therapist. Further assessment may follow a top-down or a bottom-up approach. The top-down approach is one where assessment begins by identifying abilities and disabilities through observation and analysis of occupational performance, the focus is on 'how' the task is performed. Then, if needed, impairment-based cognitive assessment is used to assist in determining the cause of problems in the occupational performance. A bottom up approach to assessment begins with identifying cognitive deficits by administering impairment based cognitive assessment and then determining the impairments that are likely to impact on daily living activities through analysis of assessment results and knowledge of demands of daily living tasks. This may then be followed by further assessment of activity performance. The occupational therapist uses clinical reasoning to decide on the assessment approach.

The most appropriate assessment for a person with cognitive impairment is chosen by considering the reason for the assessment, and what needs to be known and why, which is usually gained from the referral and the initial interview. In addition, the occupational therapist must also consider assessments available in the clinical work place, clinical time available for assessment and the occupational therapist's experience and skill with the various assessments. This is not an exhaustive list of assessments, but outlines those assessments currently used most commonly, divided into performance-based assessments, assessments to screen cognitive ability and interview / informant-based assessments. Each assessment is only briefly described, so for further details of the assessment, administration processes and an evidence base please refer to the appropriate assessment manuals or web pages.

Standardised Performance-Based Assessments

Performance-based assessments provide information about 'how' a person carries out a relevant and meaningful daily living task. To demonstrate competence in a performance-based assessment involves maintaining a relevant and meaningful task over time in a logical and efficient manner, dealing with environmental

distractions and problems that may arise and knowing when the task is completed. There is a degree of unpredictability in this assessment process. Some common assessments are listed.

Assessment of Motor and Process Skills (AMPS)

An occupational therapy specific standardised person-centred observational assessment of occupational performance, measuring quality of performance, considering the effort, safety, and efficiency observed, and the assistance received. The assessment can be used with people older than 2 years without regard for diagnosis, gender and culture. The person chooses two familiar and relevant activities of daily living (ADL) tasks. Performance is assessed by the scoring of 16 ADL motor and 20 ADL process skill items. The assessment is carried out and results are analysed via computer software which places results on linear graphs in terms of ADL Motor and ADL Process ability measures[30].

Perceive, Recall, Plan and Perform Assessment (PRPP)

A standardised occupational therapy assessment measuring occupational performance. Used with people of any age, gender, diagnosis, or cultural background, where their performance is compromised by difficulties with the cognitive demands. The PRPP provides information about performance mastery and cognitive strategy application capacity. During Stage 1 of the assessment, task performance is observed, and errors noted. The outcome is a performance profile with error impact scores. Stage 2 provides information why errors occur. Task performance is analysed in 4 quadrants, that is, perceive, recall, plan and perform[31].

Kettle Test

A brief performance-based assessment of an instrumental ADL task that can be carried out at home or in a clinical setting. The assessment taps into a broad range of cognitive skills within a functional context to assist in determining the need for assistance in daily living skills of adults with suspected cognitive disabilities. The basic task is preparing two hot beverages, one for the person and one for the therapist. The occupational therapist scores the performance on 13

discrete steps of the task, each step is scored ranging from 0 to 4. Total scores range from 0 to 52 (higher scores indicate more assistance) and can be transformed to clinically meaningful categories of independence[32,33].

Functional Independence Measure (FIM)

The Functional Independence Measure (FIM) is an assessment that is a basic indicator of person's disability in basic activities of daily living, mobility, and cognition. The FIM is used to track the changes in the functional ability of the person over time in terms of level of independence or dependence on help from others. It comprises 18 items, grouped into 2 subscales - motor and cognition. Each item is rated on a 7-point scale, with a score of 1 representing total assistance with helper, to 7 representing complete independence with no helper. The FIM was originally developed for people who had been diagnosed with a stroke, but is also used to assess disability in other cases[34,35].

Non-Standardised Performance-Based Assessments

Non-standardised assessment of daily living skills is frequently used in occupational therapy practice in combination with the interview of the person with dementia and the care partner or family. A non-standardised performance-based assessment involves the person being observed by an occupational therapist while carrying out a task that is familiar and relevant. Examples of this include observing the showering and dressing routine or preparation of food or making of the bed. The outcome is a description of the performance with mention of assistance required, safety concerns and the impact of impairments on the performance. Non-standardised performance-based assessments are seen as less time consuming and don't require formal training, hence they can be used by occupational therapists broadly, but are limited in the objective data they provide and are limited when used in a test retest scenario[36].

Assessments to Screen for Cognitive Impairment

When planning to administer cognitive screening assessments, factors that need to be considered include years of education, cultural background, English as a second language, premorbid level of cognitive function, language skills

(dysarthria, dysphasia), hearing and sight, endurance, fatigue, pain and physical ability. Cut off scores may refer to normal adult population and care must be taken if applying these to older adult clients. These assessments are not occupational therapy specific. If the person is assessed in a Memory Clinic, the medical specialist may also use these assessments.

Mini Mental State Examination (MMSE)

MMSE is a simple screening measure of cognitive functioning[37]. It is a brief 30-point verbal and pen and paper test that is used to screen for and quantify cognitive impairment. It is commonly used as a tool to screen for dementia. It is also used to estimate the severity of cognitive impairment at a specific time and to follow the course of cognitive changes in an individual over time, thus it has often been used to document a person's response to treatment. It divides into five areas: orientation; registration; attention and calculation; recall; and language. The MMSE score ranges from 0 – 30 and a score of 24 or less indicates cognitive impairment[37,38].

Rowland Universal Dementia Assessment Scale (RUDAS)

The RUDAS is a short cognitive screening instrument designed to minimise the effects of cultural learning and language diversity on the assessment of baseline cognitive performance[39]. Items address executive function, praxis, gnosis, recent memory and category fluency. It can be directly translated to other languages without the need to change the structure or the format of any item. A score of 23/30 is the cut off indicating cognitive impairment[39].

Montreal Cognitive Assessment (MoCA)™

The MoCA™ assesses cognitive function via 10 subtests[40]. Visuospatial abilities are assessed using a clock-drawing task and a three-dimensional cube copy; short-term memory is tested with two learning trials of five nouns followed by a delayed recall task. Executive functions are assessed using a task adapted from the Trail Making B test, a phonemic fluency task, and a two-item verbal abstraction task. Attention, concentration and working memory are evaluated using an attention task, a serial subtraction task and digits forward and

backward. Language is tested with a naming task with low-familiarity animals, repetition of two syntactically complex sentences, and the fluency task. Orientation is evaluated by time and place. Scores can be interpreted using these ranges: 18 to 26 indicates mild cognitive impairment, 10 to 17 indicates moderate cognitive impairment and less than 10 indicates severe cognitive impairment[40]. A growing body of evidence is emerging to show that the MoCA™ has greater sensitivity than the MMSE as a cognitive screening tool[41,42].

Test Your Memory (TYM)

The TYM is a cognitive screening self-assessment and consists of a series of 10 tasks including ability to copy a sentence, semantic knowledge, calculation, verbal fluency and recall ability[43]. The ability to do the test is also scored. Each task carries a score with a maximum score of 50 points available. The assessment test can be completed under supervision from a health professional. The maximum score is 50/50. The average TYM score for normal individuals is 47/50. People with mild dementia on average score 33/50. A cut off of 42 has a sensitivity of 93% and specificity of 86% in the diagnosis of dementia[43,44].

Cognistat™

The Cognistat™ is a cognitive screen that explores, quantifies and describes performance in level of consciousness, orientation, attention, language, constructional ability, memory, calculations and reasoning[45]. The sub-areas of language are spontaneous speech, comprehension, repetition and naming. The sub-areas of reasoning are similarities and judgment. The test is more quickly administered to higher than lower-functioning individuals by providing a difficult screening item at the beginning of each section. The Cognistat™ uses a screen and metric approach whereby the metric tests are only conducted if the person fails the screening item. Each domain of cognitive function is scored individually and can be categorised in a range from no impairment through to severe impairment. The impaired range is broken down into mild, moderate and severe[45,46].

Kimberley Indigenous Cognitive Assessment (KICA)

A validated cognitive screening tool for older indigenous Australians living in rural and remote areas[47,48]. The KICA-Cog section is validated with Indigenous Australians aged 45 years and above. A score of 33/39 and below indicates possible dementia. Those with a low KICA-Cog score should be referred for medical screens to rule out other causes of cognitive impairment which may be reversible, or to substantiate dementia. Other sections of the KICA tool are for information gathering to assist in determining subtypes, severity, differential diagnoses and management. The KICA-Cog pictures and other KICA information can be found online. The KICA-Care partner assessment has been validated with a score of 3/16 or above indicating that further investigations are required[49].

Clock Drawing Test (CDT)

The CDT has been proposed as a quick screening test for cognitive dysfunction secondary to dementia, delirium, or a range of neurological and psychiatric illnesses[50]. A range of cognitive functions are assessed including visuospatial construction and executive function, both known to be impaired in the early stages of dementia. To complete the CDT, requires verbal understanding, memory and spatially coded knowledge in addition to constructive skills. Education, age and mood can influence the test results with people of limited education, advanced age and depression performing more poorly. Shulman scoring is used in some Memory Clinics, that is score 1 to 6. Higher scores reflect a greater number of errors and more impairment. A score of ≥3 represents cognitive deficit, while a score of 1 or 2 is considered normal[51,52].

Frontal Assessment Battery (FAB)

The FAB is an assessment that can be used to assist in discriminating between dementias with a frontal dysexecutive phenotype and dementia of Alzheimer's Type (DAT)[53]. The FAB has validity in distinguishing fronto-temporal type dementia from DAT in people with early dementia (MMSE > 24). Total score is from a maximum of 18, higher scores indicating better performance. A cut off score of 12 on the FAB has a sensitivity of 77% and specificity of 87% in differentiating between frontal dysexecutive type dementias and DAT[53].

Addenbrooke's Cognitive Examination - III (ACE – III)

The ACE-III is a cognitive screening tool recommended for people over 50 years old with suspected dementia, and assesses five cognitive domains: attention, memory, verbal fluency, language and visuospatial abilities[54]. The ACE-III replaces the previous Addenbrooke's Cognitive Examination-Revised (ACE-R) and was developed at Neuroscience Research Australia. The total score is 100 with higher scores indicating better cognitive functioning. The cut-off scores are 88 out of 100 for sensitivity and 82 out of 100 for specificity to indicate suspicion of dementia[46,55].

Alzheimer's Disease Assessment Scale – Cognition ADAS-COG

ADAS-Cog is a cognitive outcome measure for evaluating treatments in clinical trials of mild-to-moderate Alzheimer's disease[56]. The ADAS-Cog measures impairment across several cognitive domains considered to be affected early and characteristically in Alzheimer's disease. There are seven performance items and four clinician-rated items covering memory, orientation, language and praxis. Possible score range is from 70 (severe impairment) to 0 (no impairment), with higher scores (≥ 18) indicating greater cognitive impairment. A 6-point change is seen as clinically significant[56-58].

Trail Making A and B

This is a screening test of visual attention, working memory and task switching / mental flexibility[59]. A paper and pen test where the person is asked to connect numbers in Part A, and numbers and letters in sequence in Part B. If the subject makes an error, the test administrator is to correct them before the subject moves on to the next dot. The time taken to complete the test is used as the primary performance measure. Part A and B are scored separately. The score for each part is the number of seconds required to complete the task. Error rate is not recorded in the paper and pencil version of the test; however, it is assumed that if errors are made it will be reflected in the completion time. Scoring below the 10th percentile in the time (in seconds) taken raises concerns (50th percentile is given for comparison). Generally, time over three minutes is a failure. It can provide information about visual search speed, scanning, speed of

processing, mental flexibility, as well as executive functioning. It is also sensitive to detecting cognitive impairment diagnoses such as Alzheimer's disease and dementia. Part B, in which the subject alternates between numbers and letters, is used to examine executive function. Part A is used primarily to examine cognitive processing speed[59,60].

Interview /Informant Based Assessments

Information about a person's ability in ADL is commonly gathered via interview and use of informant-based ADL scales involving the person with dementia and the care partner / family. These subjective assessments are mainly focused on instrumental ADL, are interview based and are time efficient. It does allow the care partner / family to provide collateral information about ADL ability especially if the person with dementia lacks insight of the impact cognitive impairment is having on ADL. It must be recognised that the informant-based assessments do not assess the person's actual ability in ADL[61].

Australian Modified Lawton's Instrumental Activities of Daily Living (IADL) Scale

The Australian Modified Lawton IADL scale was developed to assess the more complex instrumental ADL skills of older adults living in the community. These skills are considered more challenging than the basic personal activities of daily living. The informant-based assessment is most useful for identifying how a person is functioning at the present time, and it can identify improvement or deterioration over time. There are eight domains of function measured with the Australian Modified Lawton IADL scale: telephone use, shopping, food preparation, housekeeping, laundry, use of transportation, medication management and ability to handle finances. Rating is done by selecting the criteria statement that most closely corresponds to the person's current functional ability for each task. The assessment is completed based on information from the person and a family member or other care partner. A lower score indicates a higher level of dependence[62]. The short form of the assessment, the Lawton IADL- 4 is seen to have predictive value of IADL disability, assessing four items of telephone use, use of transportation, responsibility for medication intake and handling finances[41].

Activities of Daily Living Questionnaire (ADLQ)

An informant-based assessment of abilities in activities of daily living (ADL) for people with probable dementia. The ADLQ measures daily living ability in six domains: self-care, household care, employment/recreation, shopping/money, travel and communication. Each domain contains three to six skill items rated using a 4-point scale, ranging from zero (no problem) to 3 (no longer capable), 4th point indicates the item has never been performed, or that no information to rate the item is available. If the 4th option is chosen, then the item is not counted. A score representing overall functional impairment in each of the six areas is calculated, plus a total overall score is calculated. Total scores range from 0%–33% indicating minimal impairment, 34%–66% moderate impairment, and ≥67% severe impairment[63].

Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

A tool used to assess cognitive impairment in older people. The tool requires an informant to rate cognitive change over time on a 5-point Likert scale. This tool compares patient's memory and social functioning 10 years ago to present time. The main advantages of using this tool include: it contributes care partner / relative information to the assessment process; it concentrates on change over a 10-year period, rather than an assessment of current functioning; and it is not contaminated by pre-morbid intelligence or ability. The score is intended as a continuous measure of cognitive decline. An arbitrary cut-off at 3.38 will give a sensitivity of 79% and specificity of 82% for a diagnosis of dementia[64,65].

Disability Assessment for Dementia™ (DAD)

The scale was developed and validated as a measure of functional ability in dementia. Basic and instrumental activities of daily living are assessed in relation to executive skills (initiation, planning and organisation) to determine difficulties in tasks. The DAD™ is administered via interview and information is based on observation by the care partner / family over a period of two weeks previous to the time of the interview. Scoring is converted to a percentage, with higher scores representing less disability, and lower scores greater disability[66-68].

Screening Assessment for Depression

Geriatric Depression Scale (GDS)

The GDS is used to identify depression in older people in hospital, residential aged care and community settings[69]. The 15-item version is most widely used with self-report or informant report and takes five to 10 minutes to complete. Sensitivity ranges from 79 to 100%. Specificity ranges from 67 to 80%. It is suitable for use with people with a Mini-Mental Status score of more than 14. It has questionable accuracy when used to detect minor depression. The GDS questions are answered "yes" or "no". This simplicity enables the scale to be used with ill or moderately cognitively impaired individuals. One point is assigned to each answer and the cumulative score is rated on a scoring grid. For the GDS 15, scores greater than 5 suggest the presence of depression. The GDS is available in many languages and can be accessed online.

Occupational Therapy Strategies

The majority of people living with dementia reside at home in the community[11] and their aim is to remain living there for as long as possible. Occupational therapy interventions assist and support the person living with dementia to manage daily living activities and be able to participate socially. Interventions take the form of education of the person, care partner and family, instigating home modifications, and linkage with appropriate community services. The first step to intervention is assessment to ensure a person-centred approach. Focusing on a person's strengths and abilities will have a positive impact on their self-esteem, on maintaining daily living skills and on encouraging acceptance of the suggested interventions. For the care partner and family, an understanding of the person's strengths and abilities will allow realistic expectations in the daily living activities. Ongoing occupational therapy education addresses how the social and physical environment influences function and what strategies will facilitate occupational performance[70].

Every person living with dementia is an individual and as such will present with a unique clinical picture, hence a person-centred approach is needed to determine interventions. All clinicians working with people living with dementia should be mindful that the person is not only experiencing the signs and symptoms of dementia but also the normal physical signs of ageing such as reduced vision, reduced strength, hearing loss and poor mobility. The following recommendations to manage difficulties in daily living activities due to dementia and ageing will not work for all people and scenarios. Recommending use of specific strategies will need clinical reasoning and discussion. The aim is to assist the person living with dementia and the care partners, including family, friends or paid care partners, to achieve optimal independence in daily life for as long as possible and to reduce the level of stress experienced by the care partners. The person living with dementia needs to be an active participant in deciding on strategies to encourage awareness of difficulties, ensuring that strategies are meaningful and relevant as well as practical. Ongoing evaluation by the occupational therapist to monitor the use and acceptance of strategies enables issues to be addressed to ensure daily living is optimised.

The environment can have a significant impact on a person with dementia. It can be supportive or can hasten a person's deterioration[71]. Problems associated with dementia such as memory loss, confusion and difficulty learning can result in the person living with dementia forgetting where they are, where things are and how things work. Environmental strategies can improve ability and safety in everyday activities. Attention to adequate lighting, contrasting colours, clear labels, safe floor surfacing and dementia-friendly household items, are examples of some of the strategies to promote function, decrease risk of falling, decrease dependency on others and address problem behaviours such as wandering or agitation.

Occupational therapists have expertise in activity analysis and hence look at everyday activities by considering the overall cognitive, physical and emotional demands of tasks, as well as environmental and cultural aspects. In promoting ability in daily living activities, it is important to identify appropriate activities that meet a person's needs and abilities, and also strategies that contribute to success in the activities. The strategies included here are not considered exhaustive and are addressed in occupational performance areas of daily living. They have been presented in tables separating general strategies and environmental strategies for ease of reference.

Communication and social interaction

Definition: Communication relates to the process of using words, sounds, signs, or behaviours to express or exchange information or to express your ideas, thoughts, and feelings, to someone else. It involves being able to give and receive information. Social interaction is the way people talk and act with each other[72].

Strategies to improve communication and social interaction

Table 2 Strategies to improve communication and social interaction

Strategies to improve communication and social interaction	
Challenge:	**Strategies:**
• Difficulty with word finding and speech fluency • Difficulty expressing own needs and wants	• Consider a speech pathology review. • Allow time for person living with dementia to speak and try to get the message across. • When in conversation ensure being at eye level. • If the person is unable to come up with the needed word, encourage him / her to describe the word. • As able, assist by prompting words that are difficult to access. • Ask yes / no questions to narrow down what the person wants to say. • Avoid open-ended questions. • Offer a limited number of options for the person to choose from. • Use a personalised communication book with pictures and symbols. • If the spoken word is too difficult, encourage hand gestures and facial expressions. Encourage pointing and demonstrating. • Respect all attempts at communication.

Strategies to improve communication and social interaction	
Challenge:	**Strategies:**
	• Observe body language. Be aware that own negative body language such as sighs and raised eyebrows are easily picked up.
• Decreased attempts at conversation, especially in a group setting • More of a listener than a talker, change in the person's previous behaviour	• Educate family / care partner about difficulties in group settings due to noise distraction, need for selective attention, higher demand on information processing. • Include in conversation as able, monitoring ability to contribute. • Ensure hearing aids and glasses are used. • Provide opportunity for one-on-one social interaction. • Use words of encouragement and positive statements when appropriate. • Avoid always asking questions as this can cause distress. Provide information. • Be aware of the person's title or description of themselves, especially relevant for LGBTI people or people from different social or cultural situations. • Be aware of the person's personal space. • Remember that conversation is cognitively stimulating, requiring attention, working memory, executive function and social cognition. • Educate about the value of staying cognitively and socially active.

Strategies to improve communication and social interaction	
Challenge:	**Strategies:**
• Difficulty comprehending and following conversation • Decreased information processing	• Keep conversation simple and concise, speak in a calm voice at a slower pace. • Focus on one idea at a time and allow time for processing. • Person may only be able to follow one or two stage instructions at a time, need to match amount of information to the person's ability. • Use person's name in conversation or instruction to assist with focusing attention. • Stay still while talking, it is easier to focus and follow what is said. Stay in person's line of vision.
• Difficulty communicating pain or discomfort	• Question about pain using simple concise language and indicating areas of the body. • Look out for changes in behaviour such as restlessness, irritability, pallor, decreased mobility, crying.
• Difficulty with judgement and reasoning	• In discussion, the person may not be able to understand a different point of view, try not to argue and don't be condescending or correcting. • Acknowledge the person's contribution. • Redirect or distract when the person is agitated or distressed.
• Decreased accuracy in content of conversation	• Make a judgement of the importance of correcting information stated. Accept inaccurate information when

Strategies to improve communication and social interaction	
Challenge:	**Strategies:**
	appropriate rather than argue or correct. • Don't be confrontational about inaccuracies. • Use humour appropriately.
• Alteration in hearing	• Check for hearing aids, ensure they are functioning. • Ensure facing the person when in conversation of giving instructions. • Encourage regular hearing checks.
• Difficulty writing messages, or appointments on the calendar or filling-in / signing documents or forms	• Encourage practice of writing short notes or greeting cards or lists of words also encourage practice of printing and signing the person's name. • With increasing difficulty, limit the demands on writing and signing. Fill out the calendar on their behalf.
• English is the second language	• Determine if the person has reverted to the primary language as their main communication. If so, signs and labels used need to be in that language. • Provide opportunity to engage in the primary language as a means to challenge cognition. • Ensure use of an interpreter in the primary language for the person living with dementia when there are discussions about health, financial or accommodation issues.

Strategies to improve communication and social interaction	
Challenge:	**Strategies:**
• Difficulty meeting cultural and religious needs • Difficulty meeting LGBTI needs	• Consider asking family or religion members' assistance in getting to/from the place of worship. • Consider need to participate in religious practices. If services are too lengthy seek shorter options with family or members of the religion. • Access culturally specific support services either in home or in the community. • Consider a LGBTI support group to assist in discussion of concerns.

Environmental strategies to improve social interaction and communication

Table 3 Environmental strategies to improve social interaction and communication

Environmental strategies to improve social interaction and communication	
Challenge:	**Strategies:**
• Decreased attempts at conversation, especially in a group setting • More of a listener than a talker	• Take into account how busy and noisy the surroundings are. Choose quieter venues for outings.
• Difficulty comprehending and following conversation • Decreased information processing	• Minimise competing sights and sounds, they can be distracting, for example turn off radio / TV. • Ensure adequate lighting so the person speaking can be clearly seen.
• Difficulty remembering appointments, social arrangements, messages	• Notice board (whiteboard or corkboard) or large diary in a room frequently used. Decide who can add to it to record messages, appointments, visitors, reminders. • Use post it notes, these can be stuck anywhere without damage to wall. • Have a clock that provides time but also day and date to assist with orientation to time. • If reading comprehension is reduced, use pictures/symbols on signs and noticeboards.
• Difficulty engaging spiritually and / or culturally	• Ensure hearing aids are worn. • Provide reminders about religious or cultural events coming up, such as Easter or Anzac Day. • Consider access to places of worship or a LGBTI support group.

Mobilisation

Definition: The action of purposeful movement from different surfaces and across distances to achieve a functional goal. Can include walking, with or without walking aid, wheelchair use and transfers to / from seating either indoors or in the wider community[72].

Strategies to improve mobilisation

Table 4 Strategies to improve mobilisation

Strategies to improve mobilisation	
Challenge:	**Strategies:**
• Balance impairment • Falls risk/history	• Medical review to determine if underlying medical conditions are impacting on mobility. Consider referral to a falls clinic or falls service. • Physiotherapy assessment to determine what improvements can be made and what compensations may be needed for safety. • Occupational therapy home environment assessment to address home hazards. • Podiatry assessment to consider possible interventions. Review footwear choices and encourage appropriate footwear choices. • Vision assessment to consider lens type in visual aid.
• Reduced depth perception and ability to judge space and distance • Reduced planning ability to complete a journey accurately • Disorientation • Forgetting well known routes	• Reduce cognitive load of mobility task, avoid multi-tasking (walking and talking) and consider complexity of terrain/journey. • Limit choices in distances and destinations. Encourage familiar routes.

Strategies to improve mobilisation	
Challenge:	**Strategies:**
• Agnosia: no longer recognising objects and their function	• Consider contrast colours for doors. • Use of phone or tablet with Global Positioning System (GPS) map to refer to route and assist with wayfinding. • If walking in the community, carry simple identification and next of kin contact details. • Use visual prompt/list with directions listed including landmarks to aid orientation. • Use of mobile phone or personal alarm with GPS locator to assist if the person gets lost or needs assistance.
• Reduced response rate to instructions • Difficulty with concentration and judgement	• Ensure slow and simplified communication. Concise instructions to assist with mobility and direction. • Allow adequate time for processing. Confirm understanding has occurred, use paraphrasing by asking the person to repeat the instruction. • Reduce distractions. • Provide guidance using verbal or visual prompts to help with judgement and decision making.
• Forgetting how to walk (consider dyspraxia as a cause) • Forgetting need for a walking aid and how to effectively use walking aid • Reduced insight into mobility limitations	• Encourage mobility throughout the day to maintain skills but supervision may be needed as skills decline and when safety awareness is lacking.

Strategies to improve mobilisation	
Challenge:	**Strategies:**
• Decreased awareness of centre of gravity within base of support • Tendency to lean backwards	• Encourage relevant and familiar mobility experiences to tap into automatic mobility skills. • Falls risk may increase when the dementia progresses, close monitoring and supervision, as well as addressing environmental falls hazards are needed. • Prompts to use and consistent placement of walking aid to encourage reliable use. • Walking frames can dissociate the person from their environment, as they are no longer using familiar patterns of touching furniture. In this case, the person may need additional guidance for route/directions.
• Inactivity resulting in reduced muscle strength and joint stiffness with reduced flexibility • Reduced motivation to walk • Resistance to transferring or mobilising	• Encourage daily activity and make movement enjoyable. • Capitalise on opportunities for incidental activity such as walking around gardens. • Provide instructions regarding destination rather than mobility, such as 'let's look out the window' rather than 'walk to the window' • Physiotherapy prescribed family assisted exercise program.
• Fear of falling	• Explore reasons for this and address concerns as a matter of priority. Improve environmental factors which contribute to the fear.

Strategies to improve mobilisation	
Challenge:	**Strategies:**
	• Access psychological support if needed. • Provide reassurance and support.
• Managing pain	• Medical review to ensure pain is appropriately managed. • Be mindful that a person's ability to clearly indicate pain may be diminished or may be indicated in different ways, by restlessness, agitation, withdrawal from activity. • If the pain has been addressed, then try to encourage the person not to fixate on it, through distraction and activity. • Consider non-pharmaceutical strategies, such as a heat pack, massage or soothing music.
• Medication side effects such as sedation	• Medical review to assess medications and sensitivities. Discuss priorities, weighing up benefits, such as need for sedation versus impact on mobility. • If medication is used to assist sleep, try sleep hygiene strategies instead. Consider if the problem is getting to sleep or staying asleep and appropriate strategies for the identified problem. • Reaction to new medication and its impact on mobility needs to be monitored, for example blood pressure medications may cause hypotension and subsequent light headedness.

Strategies to improve mobilisation	
Challenge:	**Strategies:**
• Physical limitations from co-existing medical conditions such as shortness of breath, sensory impairment, dizziness and joint limitations	• Physiotherapy assessment to determine what improvements can be made and what compensations may be needed for safety. • Be mindful of these as separate needs to dementia symptoms and make allowances for them. • Consider that compensation for any physical limitation increases the cognitive demand when mobilising. • Consider, is the person able to make safety judgements and adapt mobility in light of their physical limitations? Visual reminders of precautions in the form of signs and labels will guide.

Environmental strategies to improve mobilisation

Table 5 Environmental strategies to improve mobilisation

Environmental strategies to improve mobilisation	
Challenge:	**Strategies:**
• Uneven flooring • Clutter and restrictive furniture layout	• Repair and secure flooring. Use contrast strips to alert person to changes in flooring, edges of steps/thresholds. • Avoid heavily patterned flooring as may impact perception and judgement. • Remove excess furniture and belongings to minimise clutter. Use simple and consistent furniture layouts. • Remove loose mats/rugs.
• Poor lighting	• Make use of natural daylight wherever possible. Open curtains or blinds during the day. • Draw curtains and blinds at night to avoid reflections on the glass which may be disturbing. • Leave lights on during the day when natural light is insufficient. • Use automatic/sensor lighting at exit/entry points. • Minimise glare by monitoring lighting. • Ensure light globes are bright enough and resemble day light.
• Difficulty with ascending or descending stairs	• Contrast strips (tape or paint) to highlight the edges of steps. Yellow or white are best. • Install rails to at least one side of steps, observe preferred ascending and descending of steps in activity

Environmental strategies to improve mobilisation	
Challenge:	**Strategies:**
	context to identify priority side for rail. • If using walking frame or wheelchair, a ramp may be needed even if just for one step (ramps need to comply with Australian Standards). • Remove mats at top or bottom of steps as they are a falls hazard. • If stairs are unsafe, consider barriers such as furniture or a gate to prevent unsupervised use but ensure not to create hazards.
• Falls hazards on property outside home	• Remove large bushes and shrubbery from front and rear entrances that block view of the home. Ensure pathways are kept clear and in good condition. • Ensure external stairs are in optimal condition. Utilise railings and slip resistant surfacing. • Provide high hue and value contrast at the edges of stairs and level changes to prompt for safe mobility. • Use screens and large pot plants to discourage access to unsafe stairs and garden access points. • Place stickers on large windows/sliding doors to reduce the risk of walking into the glass. • Simplify key access to enable easy negotiation of doorways and thresholds i.e. one key for multiple doors. Consider use of key safe or

Environmental strategies to improve mobilisation	
Challenge:	**Strategies:**
	locked box to facilitate emergency access.
• Difficulty completing chair transfers	• Try to choose supportive and comfortable chairs with armrests of appropriate seat height and depth. • Chairs need to allow optimal foot position for transfers, “knees over toes” if possible. Chair is best if design has open space under seat. • Avoid chairs with castors and which swivel due to the risk of falls. • Provide simple concise movement sequence prompts.

Basic Activities of Daily Living

Activities that are performed usually daily, habitually and universally in a person's daily life. To be competent, there is requirement to be able, without prompting, to recognise that the task needs to be done and plan this to be timely and effective.

Bathing/Showering

Definition: Washing and drying parts or whole of the body using water and appropriate cleaning and drying products and techniques. Includes hands, face, feet and hair and use of a towel as a common method for drying self[7].

Strategies for bathing/showering

Table 6 Strategies for bathing/showering

Strategies for bathing/showering	
Challenge:	**Strategies:**
• Change in perception of hot or cold • Discomfort due to overall temperature of bathroom or feelings of claustrophobia	• Set temperature of hot water heater not to exceed 50 degrees C. • Use heat lamps to warm room prior to bathing. Use towel warmers. Bear in mind that some of these appliances can have poor energy efficiency. • Allow time to feel water and agree to temperature before commencing bathing / showering. • Set up environment in an open and ventilated way (leave screen/curtain open, bathroom door open). • Consider timing of shower to be at warmer times of the day.
• Fear or discomfort surrounding water, particularly if poured over head	• Allow time for person to feel water gradually across body before commencing bathing / showering.

Strategies for bathing/showering	
Challenge:	**Strategies:**
	• Use a flexible approach to bathing / showering structure and frequency. Interchange showering with sponge wash where appropriate. Sponge bathing can be completed in parts, to prevent the person being completely undressed. • Separate bathing / showering and hair washing activities. • Utilise rinse or water free hygiene products if anxiety with washing is high. • Consider regular hairdresser visits. Particularly if this has been a lifelong enjoyable activity. • Consider culturally specific grooming needs and try to maintain person's wishes regarding appearance.
• Overwhelmed by complexity of personal care tasks • Impaired sequence of tasks • Forgetting correct use of items involved in personal care tasks or using items incorrectly (ideational dyspraxia)	• Break tasks down into simple, manageable steps. Gently and concisely prompt each step. • Allow time and encourage the person to complete as many steps as possible independently. • Use simple, clear directions such as "lift your arm over your head". • Allow the person to complete tasks their own way if effective even if method is unorthodox. • Offer limited choices in the items used. • Consider using calming music/oils if appropriate. Familiar smells of

Strategies for bathing/showering	
Challenge:	**Strategies:**
	favourite soap or such may provide comfort. • Use laminated (matte finish) prompt cards to assist with sequencing and position in an appropriate place. • Position items required for the task in easy reach. • If assisting, hand needed items one at a time. • Demonstrate aspects of the task using hand over hand techniques. • If difficulty with sustained focus on washing and drying tasks is impacting on thoroughness, gently and concisely prompt step by step to attend to different body parts. • On completion, acknowledge success with encouragement and positive feedback. • Bathing/ showering is opportunity to check skin for pressure areas or injuries.
• Physical limitations impacting on ability to bathe	• Allow time and consider time of day, energy levels may vary during the day. • Place objects within triangle of efficiency (nose, right elbow, left elbow) to accommodate reach limitations associated with ageing. • If dexterity is a problem, use of a soap bag or liquid soap may assist.
• Privacy concerns	• Acknowledge the person's need for privacy and consider set up to maximise privacy as required.

Strategies for bathing/showering	
Challenge:	**Strategies:**
	• Take into account care partner's comfort or concern in dealing with nakedness of the person. • Consider issues of gender identity particularly Intersex or Transgender individuals who may have particular privacy wishes. • Consider religious or cultural privacy preferences.

Environmental strategies that affect bathing/showering

Table 7 Environmental strategies that affect bathing/showering

Environmental strategies that affect bathing/showering	
Challenge:	**Strategies:**
• Perceptual difficulties such as judging dimensions of plumbing fixtures	• Contrasting tiles to highlight grab rails/toilet/basin so items can be easily identified for use. Add coloured toilet seat to toilet. • Level floor surfaces, hob-less showers allow for easy access. • Use of rails and seating in the shower can decrease effort and increase safety. • Hand held shower hose is beneficial to care partner when assisting the person with showering. For person living with dementia it can be an additional item to handle while washing self, hence may hinder rather than help. • Consider environmental modifications. Some clients enjoying using the bath for therapeutic benefit even when they are physically unsafe with transfers. Consider bath lift to facilitate ongoing use of this preferred bathing method. • Removal of shower screen and use of curtain may be a safer option, and allow easier shower recess access. Curtain should not be too dark in colour, when drawn a dark coloured curtain can affect lighting for bathing.

Environmental strategies that affect bathing/showering	
Challenge:	**Strategies:**
• Difficulty judging variability in lighting. Shadows may be interpreted as objects and vice versa. • Low light levels or glare impacting on judgement perceptually and cognitively.	• Maximise natural light, encourage managing window dressing to let natural light in for greatest benefit. • Sheer curtains on windows to reduce glare but facilitate natural light. • Avoid vertical and horizontal blinds as the slits of light can be disorienting. • Reduce window obstructions. • Leave lights on during the day in areas where there is not sufficient light available. • Avoid using clear bulbs or light fittings with a shade as they reflect glare and create shadows. • Light is important, need globes which most closely resemble daylight. • Consider lighting design to promote uniformity of illumination throughout bathroom.
• Difficulty using taps and safe management of water	• Tap turners or lever style taps to decrease effort. • Tap modifications which limit the amount of turns required. • Tap caps to prevent use. • Automatic taps which turn off after a set time. • Plugs activated by pressure, can prevent flooding. Also floor drains and flood detectors assist in preventing flooding. • Thermostatic mixing or shut off devices installed by plumber assist in managing taps safely.

Environmental strategies that affect bathing/showering	
Challenge:	**Strategies:**
	• Food colouring in the water can improve contrast, hence provide feedback on water level in sink. Colour may also be misinterpreted.
• Fear of falls	• Powder coated grips on grab rails. • Keep access free from clutter. • Wide entry with outward swinging doors, hospital hinges or hinges which allow door to be removed in emergency situation. • Duress/personal alarm can provide a sense of security, but use should be practiced. • Slip resistant tiles. Non-slip strips in shower or bathing areas.
• Electrical safety	• RCD safety switches in good working order. Power point safety plugs. • Consider removal of portable electrical appliances and set up in an adjoining room to allow safe use and access • Consider installation of ceiling heating/fan.
• Accidental misuse/poisoning from pharmaceuticals/toiletry items	• Remove non-essential items if identified as a risk, items that can cause injury such as shaving blades, scissors. • Consider safe storage options such as magnetic locks.

Grooming

Definition: Caring for hair, teeth and nails as well as shaving and application of cosmetic products as part of overall personal hygiene and creation of a person's preferred presentation[72]. Activities may include shaving of hair on the face, brushing and styling of head hair, cleaning and caring for teeth or dentures and application of make-up and/or religious or cultural body art[72].

Strategies for grooming

Table 8 Strategies for grooming

Strategies for grooming	
Challenge:	**Strategies:**
• Difficulty brushing and styling head hair • Neglecting to attend or difficulty accessing hairdresser/barber at required intervals	• Break tasks down into simple, manageable steps. Gently prompt each step. • Encourage the person to complete as many steps as possible independently. • Use simple, clear directions such as "brush hair at back". • Hand needed items one at a time. • Allow the person to complete tasks their own way, if effective, even if method is unorthodox. • Place laminated (with matte finish) prompt cards appropriately to assist with sequencing. • Position items required for the task in easy reach and in line of sight where possible. • Consider optimal position, sitting for task ensures for stability and to reduce the physical demand of the task. • Demonstrate actions or use hand over hand techniques.

Strategies for grooming	
Challenge:	**Strategies:**
	• Consider modified brushes and combs if traditionally used items become difficult to manipulate. • If looking after the hair has become difficult, consider more frequent visits to the hairdresser / barber to maintain hair according to personal preference such as hair to be coloured, set or styled in a particular way. • Encourage easy care hairstyle. • Consider hairdressing services which visit at home if transport to regular appointments at a salon becomes a barrier, or if the person becomes overwhelmed by the business of a hair salon.
• Difficulty shaving facial hair • Neglecting to shave facial hair regularly	• Consider type of razor/shaving technique and device used. Can the steps be simplified to enable independence and safety? Is use of a safety razor or an electric shaver for a razor the safest option? • Allow the person to complete tasks their own way, if effective, even if method is unorthodox. • Use laminated (matte finish) prompt cards to assist with sequencing and position in an appropriate place. • Position items required for the task in easy reach. • Hand items one at a time. • Demonstrate actions or use hand over hand techniques.

Strategies for grooming	
Challenge:	**Strategies:**
	• If person has more complex facial hair grooming preferences such as beard and moustache trimming, consider regular barber appointments to address this maintenance.
• Difficulty cleaning and caring for teeth or dentures • Neglecting to maintain dental hygiene	• Reinforce teeth and denture care activities in the daily routine. Ensure dentures are worn. • Ensure items are in easy reach. • Use set up assistance and/or adapted brushes and cleaning solutions as appropriate to facilitate independence. • Attend regular dental reviews and seek more individualised advice from dentist for dental management. • Consider using an electric toothbrush if assisted brushing is needed.
• Difficulty applying cosmetics, make-up or cultural body art such as use of the Bindi or henna tattooing	• Simplify products used and application method. For example, tinted moisturiser instead of foundation, mascara with a large brush handle. Consider tattooed makeup if appropriate to the person. • Ensure mirror access and lighting is adequate. • Consider assistance needed to apply Bindi or other culturally specific body art.

Strategies for grooming	
Challenge:	**Strategies:**
• Difficulty completing nail care • Neglecting to maintain nail care	• Ensure nail care is a consistent part of the weekly personal care routine so it is less likely to be neglected. • Ensure nail grooming tools are in easy reach such as nail brushes by the sink, emery boards near sitting areas. Be mindful of leaving scissors or clippers accessible if safety concerns exist. Purchase several replacements of tools at a time so that items remain familiar. • Combine nail care assistance with another pleasurable activity if resistance to nail care exists. For example, hand or foot massage, listening to music, reminiscing or watching a TV program or film. • Utilise regular visits to nail salons. • Attend regular podiatry reviews particularly if the person has other medical conditions which can impact on overall foot and nail health.

Dressing

Definition: The organised and sequential process of putting on and removing clothing and footwear in a manner which meets current social modesty, safety and weather requirements. Examples include the manipulation of dresses, shirts, skirts, underwear, trousers, coats, hats, socks/stockings, gloves, saris, kimonos, turbans and other forms of cultural or religious garments[7].

Strategies for dressing

Table 9 Strategies for dressing activities

Strategies for dressing	
Challenge:	**Strategies:**
• Forgetting how to dress (consider dressing dyspraxia as a cause)	• Be patient and allow time to orient and apply clothing. • Encourage client to complete aspects of task as able, use simple and concise prompts. • Break down tasks into manageable steps. • Use tags to identify back of clothes and aid orientation. • Support ability by laying out clothing items in order of getting dressed to promote sequencing. • Hand items one at a time so that the person does not have to seek out individual items. • Use simple instructions such as "Pull up your pants". • Compliment appearance as well as effort expended. • Ignore mistakes of little consequence such as clashing colours. • Consider cultural values – facilitate continued wearing of turban, hijab,

Strategies for dressing	
Challenge:	**Strategies:**
	burka if desired, rather than suggest western cultural dress.
• Recognition of the item of clothing but forgetting which body part goes into the clothing item	• Demonstrate aspects of getting dressed and then allow time for their attempt. Progress to hand over hand methods if needed. • Use cue cards/prompts for reference. • Consider mirror use for visual feedback. Be mindful that mirrors can be counterproductive for some people if they find they can't recognise themselves. • Utilise clothing with simple design – avoid complex patterns or ambiguous styles which may exacerbate confusion.
• Physical difficulty manipulating clothing	• Modify fastenings or style of preferred clothing items. Consider larger-sized loose fitting clothes, elastic waist bands, larger buttons or Velcro™ closures. • Consider footwear options that promote independence, such as slip-ons and Velcro™ closures.
• Dressing inappropriately for temperature	• Pack away seasonally unnecessary items to minimise chance of over dressing. • Review heating/cooling in environment. • Purchase lighter weight clothing items with greater warmth properties to manage underdressing.

Strategies for dressing	
Challenge:	**Strategies:**
• Forgetting to change clothes	• Encourage the person to change regularly. Tactfully remove soiled clothes at the end of each day and substitute with clean ones. • Purchase multiples of similar preferred clothing items to minimise repeated wearing of the same garment due to limited other preferences. • Select clothing that is easy care (no ironing/dry cleaning). • Be mindful of lifelong habits and values. May not have changed clothes as regularly throughout life. • If the person is resistant, suggest changing clothes for outings or events such as to go shopping. • Changing clothes can be done while toileting, as the person is already partially undressed.
• Undressing frequently	• Evaluate reason for this – is the person too hot, needing to toilet, wanting to rest in bed, clothes uncomfortable etc. • Consider clothing with back zippers or fastenings to prevent removal of clothes.
• Enhanced sensitivity to textures limiting preference in clothing options.	• Observe with different textures to determine comfort and distress. • Remove items with textures now deemed as unpleasant.

Environmental strategies related to dressing

Table 10 Environmental strategies related to dressing

Environmental strategies related to dressing	
Challenge:	**Strategies:**
• Difficulty selecting clothes	• Arrange wardrobes and drawers so that like items are stored together. • Use photographs/labels on individual drawers/doors to identify contents. • Consider clear panels on doors to allow viewing of items inside. • Install a counter top or shelf to arrange items for dressing. • Remove unnecessary clutter and minimise distractions. • Remove clothes that are no longer appropriate or no longer fit. • Ensure adequate light and temperature, consider sensor lighting in the wardrobe. • Rotate seasonal items through appropriately. Rearrange the cupboard with the change of season. • Utilise colour contrast for visual problems (such as placing light items on a dark bedspread). • Consider privacy needs, closing door or use of window treatments and be aware of preferences of LGBTI individuals and cultural and religious groups.

Toileting and Continence

Definition: The sequential actions of responding to needs and executing urination and defaecation. This includes choosing and mobilising to an appropriate location to void, assuming accurate positioning, adjusting clothing and/or devices and cleaning self accurately. May involve the use of various styles of toilet, commode, catheter, continence aids, buckets or bidets[7].

Strategies related to toileting and continence

Table 11 Strategies related to toileting and continence

Strategies related to toileting and continence	
Challenge:	**Strategies:**
• Difficulty transferring from toilet	• Toilet is usually the lowest seat in the house, consider height needed for independent transfer. • Ensure toilet seat is securely fastened, loose seat may cause fear of falling.
• Difficulty locating or reaching toilet paper	• Use contrasting colour for the toilet paper to the wall. • Consider optimal placement of toilet paper and / or dispenser.
• Difficulty manipulating clothing, impaired sequencing of steps to toilet	• Simplify clothing. Use Velcro™ tape instead of buttons and zippers. Try hook and loop fasteners or elastic waistbands for trousers and skirts. Select clothing that is easily washable. • Use simple step by step instructions such as "take down your pants". Only give the next instruction once the first instruction has been completed.

Strategies related to toileting and continence	
Challenge:	**Strategies:**
	• Use same prompts to promote routine via repetition.
• Urinating in places other than the toilet	• If in time guide to the toilet and verbally prompt about using the toilet. • Look for non-verbal clues that person is about to go to urinate and prompt to go to the toilet.
• Difficulty with urinary retention	• Refer to Continence Service for assessment. • Consider keeping a voiding diary (frequency and amount) which can assist in establishing a toileting routine. Once routine is established, try to avoid unnecessary changes. • Monitor fluid and food intake and output.
• Difficulty sitting still for long enough to use the toilet	• If the person is restless and will not sit on the toilet allow them to get up and down a few times. Try distraction techniques on the toilet or calming music. • Consider running a tap or provide a drink of water.
• Impaired awareness of full bladder/bowel impacting on appropriate time to visit the toilet	• Watch for non-verbal clues such as pulling on clothes or agitation, then suggest with short simple words to go to the toilet. • Observe toileting pattern and suggest a routine schedule, such as 2 hourly toileting. • Utilise protective garments or disposable pads.

Strategies related to toileting and continence	
Challenge:	**Strategies:**
	• Reduce caffeine intake.
• Frequent mobilising to the toilet as has forgotten they have only recently been	• Reassure that they have recently been to the toilet. • Distract or divert to other tasks. • Consider medical review to check for bladder retention or infection.
• Incontinence at night	• Encourage the person to go to the toilet just before bedtime. • Decrease fluid intake after dinner and avoid caffeine to decrease nocturia. • Use continence pads / pull ups and / or Kylie™ sheets at night. • Electric blanket can be dangerous if person is incontinent.
• Constipation or diarrhoea (possibly overflow)	• High fibre diet • Adequate fluids • Regular exercise • Bowel routine • Medical review/specialist review

Environmental strategies related to toileting and continence

Table 12 Environmental strategies related to toileting and continence

Environmental strategies related to toileting and continence	
Challenge:	**Strategies:**
• Difficulty locating toilet and/or recognising toilet	• Set up bedroom layout so there is direct line of sight to the toilet if possible. • Use visual cues to assist with locating the toilet. Place a sign or label on the toilet door such as a picture or photograph of the toilet in a prominent position. • Close doors to all other rooms that may be easily confused and leave toilet door open. • Paint toilet area a contrasting colour to set it apart from hallway. Use arrows or cues to direct path. • Consider sensor light or night lights. Glow in the dark strips placed around light switches highlight location. • Remove clutter and extraneous objects from passageways or stairways on way to the toilet to minimise confusion and distraction. • Use colour contrasting door knobs. • Replace usual white toilet seat with a coloured (blue or red) toilet seat so it is distinguishable from bowl and floor. • Install bells or alarms on doors, cabinets or drawers to alert the caregiver when person is opening them.

Environmental strategies related to toileting and continence	
Challenge:	**Strategies:**
• Toilet seat height is too low	• Use modifications best suited, options include grab rails, toilet raise, over toilet frame.
• Urinating in places other than toilet	• Remove any confusing objects from on or around the toilet or commode such as wash cloths, reading material or objects which may confuse the purpose of the room. • Utilise appropriate signage and facilitate line of sight to the toilet where possible. • Install safety gates at stairways.
• Distance to toilet too far	• Ensure appropriate light, which may include automatic or sensor lighting to illuminate path to toilet and minimise risk of falls and lost time due to disorientation. • If assistance is required with toileting, have a sensor alarm mat next to the bed to alert care partner when getting up for night toileting. • Consider commode/urinal bottle use at bedside or in the bedroom for night toileting. • Ensure hallway is clutter free and any cords are secured along the path between the toilet and the bedroom. • Leave toilet light on as a prompt to locating it.

Eating and Drinking

Definition: The organised and sequential actions of consuming food and drink for nutrition. Generally involves upper limb movements to accurately bring food and drink to the mouth in culturally appropriate ways and the use of utensils or implements to prepare food portions into sizes for safe and enjoyable consumption[7].

Strategies related to eating and drinking

Table 13 Strategies related to eating and drinking

Strategies related to eating and drinking	
Challenge:	**Strategies:**
• Loss of appetite • Dehydration or inadequate nutrition • Develops an insatiable craving for sweets • Decreased variety of food preferences which could lead to vitamin deficiency further impacting cognition	• Try to prepare familiar foods in familiar ways that are culturally appropriate. • Consider size of the meal, if appetite is low, presenting a large meal may be overwhelming. • Colourful food will stimulate interest. • Prepare strongly flavoured and aromatic foods to stimulate appetite. Or use food scented oils (such as cinnamon and orange). Eliminate noxious odours. • Check medications for side effects which could lead to loss of appetite or a sweet craving e.g. antidepressants. • Allow the person to eat if they are hungry. Have healthy snacks available. • Try to facilitate ongoing participation in personally meaningful religious and cultural traditions such as Ramadan.

Strategies related to eating and drinking	
Challenge:	**Strategies:**
• Forgetting to eat or drink (amnesia) or when next meal is due • Eating too often due to memory loss • Consuming excess caffeine or alcohol as they forget they have already had a drink • Eating and drinking non-food product or substances • Refusing to eat or sit at a table for meals	• Involve the person living with dementia in the meal preparation wherever possible. • Keep meal times routine, simple, relaxed and calm. • Try frequent small meals, 5-6 per day. • Ensure adequate fluid intake, can use popsicles, soups, smoothies to ensure it's adequate. • Finger foods allow for increased independence and limits spillage. • Have low calorie snacks available. • Limit alcohol or caffeine to agreed amounts. • Use reminders or alarms (such as phone calls) to prompt meal times. • Maximise food intake when cognition is at its best. • Limit distractions during mealtime, such as TV, noise.
• Socially inappropriate mealtime behaviour such a cramming food into their mouth, eating rapidly	• Provide prompting of appropriate behaviour in a calm and concise manner. • Provide a small spoon or fork to limit amount of food being put in the mouth at once. • Cut food into small pieces if over eating is an issue. • Eat together so that the person can model on the care partner / family member.
• Forgetting how to chew and swallow	• Speech pathologist review. Consult regarding need for thickened fluids or vitamised food.

Strategies related to eating and drinking	
Challenge:	**Strategies:**
• Dysphagia which can result from changes to oral, oropharyngeal or oesophageal function • Dry mouth or oral discomfort due to ill-fitting dentures for example • Difficulty performing voluntary actions such as opening mouth to a utensil	• Utilise feeding techniques such as allowing time to chew or swallow, not overloading the person's mouth. • For chewing problems try light pressure on the lips or under the chin, tell the person when to chew, demonstrate chewing offer small bites. • For swallowing problems remind the person to swallow, stroke the throat gently, check mouth to see if food has been swallowed. Avoid foods that are hard to swallow, moisten foods. • Provide a smaller spoon to decrease mouthful size. • Monitor food temperatures.
• Difficulty maintaining food hygiene practices	• Have a sign above the sink encouraging hand washing. • Prompt to wash hands before handing food, also to wash ingredients if appropriate. • Hand over hand guidance with hand washing can be a task providing tactile stimulation. • Avoid bibs. Use a shirt or apron preferably something the client would normally wear.

Environmental strategies related to eating and drinking

Table 14 Environmental strategies related to eating and drinking

Environmental strategies related to eating and drinking	
Challenge:	**Strategies:**
• Inability to locate food, cutlery and crockery • Difficulty using cutlery (apraxia)	• Leave unperishable appropriate snacks in a place that is easily seen. • Label meals or snacks in the fridge. • Bright coloured plates and cups are easier to see on a table and may increase food and liquid intake. • Add colour contrasting to edge of table to increase awareness and visibility. • Use placemats with solid, bold colours on the table top, so cups plates and utensils are seen due to the colour contrast. • Arrange utensils and crockery in a consistent manner and keep setting as simple as possible. • Avoid patterned plates as they may cause confusion or misinterpretation of foods. • With liquids, if spillage is problematic utilise a travel mug with lid. • Straws with one-way valves may assist drinking. • If grasp is a problem, built-up handles on cutlery may benefit. • If family live separate or overseas, consider the social experience through virtual dining. Use a video link camera to eat with others. • Reduce clutter and distractions on the dining table.

Sleep

Definition: A state of reduced consciousness and inactivity to enable body systems to rest and restore. Typically lasts for hours at a time. Involves positioning oneself in a comfortable and safe environment to enable effective rest to occur such as bed, chair [72].

Strategies related to sleep

Table 15 Strategies related to sleep

Strategies related to sleep	
Challenge:	**Strategy:**
• Disturbance to the person's sleep cycles – regularly awakes during the night and sleeps during the day • Difficulty distinguishing between day and night • Going to bed too early or sleeping too much during the day	• Establish a sleep routine that is familiar and predictable with set times. • Decrease caffeine intake late in the day. • Encourage activity during the day as a means of engagement and discouraging sleep. • Limit TV especially if the person tends to fall asleep in front of the TV during the day. • Use a prominent clock and encourage looking at it to orient to time.
• Overtiredness impacting on a person's ability to fall asleep • Reduced need for sleep due to reduced activity • Refusing to go to sleep	• Maintain firm activity schedules and structure. • Establish a consistent and individualised settling routine to facilitate relaxation and interest in sleep. • Use relaxing strategies, such as simple breathing activity or soothing music.
• Continence issues	(See section on Continence).

Strategies related to sleep	
Challenge:	**Strategy:**
• Medical conditions such as Angina, Congestive Heart Failure, Diabetes, UTI, Depression, Sleep Apnoea • Side effects of medications such as diuretics • Environmental changes causing disorientation	• Discuss optimal management of medical conditions in relation to sleep with a doctor. • Try to keep environmental factors consistent, such as temperature, lighting, textures of bedding, nightwear and furniture in same place.
• Agitation following upsetting events/situations • Disturbing dreams	• Minimise discussions of or triggers from distressing events/situations so not to relive it. • Calmness and reassurance assist to settle back to sleep. • Discuss concerns with a doctor if becoming frequent and distressing.
• Hunger and / or thirst during the night	• Ensure adequate oral intake as part of evening routine. • Provide non-caffeinated drink, water is best, and encourage resettling.

Environmental strategies related to sleep

Table 16 Environmental strategies related to sleep

Environmental strategies related to sleep	
Challenge:	**Strategies:**
• Physical limitations impacting on being able to move in bed and to transfer in/out of bed. • Risk of falls from the bed or in the bedroom.	• Bed sensors can activate lighting or alert family/care givers of the person attempting to get out of bed. • Bed rails are not recommended for use with people with dementia due to risk of entrapment. Bed rails may be interpreted as a barrier resulting in attempts to climb over the rails. • Consider the use of bolsters at the bed edge to act as physical cue to minimise risk of rolling from bed. • Supportive positioning in lying for management of pain or postural discomfort. • Bed height needs to allow both getting in and getting out of bed. Too high it results in increased effort to lift legs into bed, too low means getting up from bed edge is too difficult. Raising the bed needs to consider both situations. • If there is a risk of falling out of bed, a low bed will assist to minimise injury, an adjustable electric bed may be needed. Smart wiring throughout the house could be used. • Lighting in bedroom at night needs to be adequate when getting up to the toilet, bedside light or light with movement sensor to be considered.

Environmental strategies related to sleep	
Challenge:	**Strategies:**
	• Provide contrasting day/night lighting to aid circadian rhythm. Consider Bright Light Therapy for increased daytime wakefulness and a quiet room to signal night sleep routine. • Use bold colours on bed linen, different colour for fitted and flat sheets makes it easier to distinguish the two. Patterned bed linen should be avoided as it can be disturbing perceptually to the person living with dementia. • Consider the sleeping preferences of indigenous and cultural groups and tailor adaptions appropriately. Some people may prefer to sleep on the floor, some may have special bedding.

Sexuality and intimacy

Definition: Engaging in activities that result in sexual satisfaction and /or meet relationship needs[8]. Sexuality involves how a person feels about themselves, relating to others of the same or opposite gender, it involves establishing and maintaining relationships and expressing oneself in a relationship[73].

Strategies relating to sexuality and intimacy

Table 17 Strategies related to sexuality and intimacy

Strategies relating to sexuality and intimacy	
Challenge:	**Strategies:**
• Requests for intimacy become demands • Requests may be considered unreasonable and more frequent	• Important to remember that such behaviours are a result of decline in cognition. Care partner or family must be assisted to learn that the demands made are intrinsic to the person, and not planned or personal toward them. Counselling from a medical or health professional may be beneficial. • Family / care partner to consider their own boundaries. • Attempt to determine person's need for touch / closeness versus sexual activities. Discussion with medical practitioner or psychologist may be needed.
• Lack of attention and sensitivity to intimacy needs of the person's partner • Lack of interest in intimacy and sexual activity	• Assist to identify opportunities for touch and intimacy throughout the day such as hand holding/stroking, embracing. • Partner needs to be encouraged to discuss feelings that may range from guilt, rejection, distaste.

Strategies relating to sexuality and intimacy	
Challenge:	**Strategies:**
• Lack of inhibition such as undressing or masturbation • Making advances to others they have mistaken for their partner	• Try distraction. • Gently, calmly, and concisely state the behaviour is inappropriate, and redirect the person. • If uncomfortable, family member or care partner should leave the situation, for their emotional protection. The person may no longer know when to appropriately express their sexual desire, and also may lack awareness of the impact on others.
• Confusion regarding consent	• Consent can be fluid. Consent should be established before each activity not just implied from the previous time.

Instrumental activities of daily living

These activities require significant organisation, planning and problem solving to competently be able to attend to nutritional needs and maintaining a household. Cognitive demands of these activities are greater than the basic activities of daily living.

Responsibility for own medications and maintaining one's health

Definition: Accessing, storing and administering own medications, including knowing what needs to be taken and when, refilling prescriptions to ensure ongoing supply. Also includes awareness of one's health, accessing health care when needed and doing what is needed in case of emergency[7].

Strategies to support responsibility for own medications and maintenance of health

Table 18 Strategies to support responsibility for own medications and maintenance of health

Strategies to support responsibility for own medications and maintenance of health	
Challenge:	**Strategies:**
• Not aware of medications prescribed and what they are for.	• Have a medication list with dosage and reason for medication written down. Have several copies of the list, one for home and one for wallet or purse. • Encourage medications reviewed by the General practitioner (GP)0 regularly, with discussion around medications taken and consolidating medication administration times. • Encourage the person to become familiar with own medications, and significant side effects such as impact of diuretics, anti-coagulants etc.

Strategies to support responsibility for own medications and maintenance of health	
Challenge:	**Strategies:**
	• Transgender or gender variant people will have need for ongoing hormone medication or injections, cessation may have detrimental risks. • Consider prescription renewal and the process involved, use of a Webster-pak® pack gives this responsibility to the pharmacist.
• Forgetting to take medications • Forgetting having already taken medication and taking it again	• Assist to establish daily routines that incorporate medication taking. Link the taking of medication to routine activities such as meal times. • Consider use of a Webster-pak®/blister pack, a weekly calendar pack with all regular medication sealed within blister compartments. This allows both the person and care partner to monitor consistent taking of medication. • Use of a dosette type plastic box with compartments for seven days may assist, they come in various sizes allowing for 1, 2, 3 or 4 doses per day. Slide out or flip up lids for each dose compartment. Weekly set up of the box needs to be considered and possibly practised, or a care partner may need to assist in the process. • Medication reminders, such as a medical watch or a pill box with timers, both with auditory prompts.

Strategies to support responsibility for own medications and maintenance of health	
Challenge:	**Strategies:**
	• Engage support services to provide medication prompts or consider alarm on mobile phone to prompt medications. • If needed, use of a locked box may be necessary to be opened by family / care partner / support worker only to administer medication, so to avoid overdose.
• Taking medications no longer prescribed or out of date	• Medication review by either the GP or pharmacist. Either take all medications to the next visit to GP or arrange for a home visit from the pharmacist to review medications. • Note doses missed in Webster-pak® pack per week. • Return Webster-pak® packs that still have remaining medication doses to the pharmacist to prevent overdosing, and also to inform regarding consistency if self-medicating.
• Difficulty accessing medication due to difficulty opening medication packaging	• Discuss with the pharmacist alternative containers available. • Explore if blister packs are easier. • Place a bowl under the blister pack to catch tablets as they fall out.
• Difficulty cutting / crushing medications	• Access a pill cutter / crusher available from most pharmacies and on the web.
• Unaware of strategies in case of illness, injury or emergency	• Discussion on ways to raise the alarm in case of illness, accident or other emergency. This discussion

Strategies to support responsibility for own medications and maintenance of health	
Challenge:	**Strategies:**
	may need to be repeated and practiced in part. • Ensure nominated family member's phone number is prominent near the phone or via label on the phone. • Discuss the "000" phone number and locate it near or on the phone. • Consider personal emergency alarm pendant or simple mobile phone. • Person to carry in the wallet / purse an identification card with name, address and emergency contact phone number. • Consider a medical alert bracelet to tell others important information in case of emergency, such as memory loss. • If living alone, a locked box externally provides a method of gaining access to the home in case of emergency.

Environmental strategies to support responsibility for own medications and maintenance of health

Table 19 Environmental strategies to support responsibility for own medications and maintenance of health

Environmental strategies to support responsibility for own medications and maintenance of health	
Challenge:	**Strategies:**
• Forgetting to take medications	• Set medications in a visible location, such as where breakfast making occurs for morning tablets.
• Taking medications inappropriately, such as taking medications at incorrect intervals or repeating a dose due to forgetting that it has already been taken	• If needed, use of a locked box to be opened by family / care partner / support worker to administer medication. • Install magnetic locks on drawers and cupboards.

Meal preparation

Definition: Meal preparation is preparing food for eating. This generally requires planning, organising, cooking and serving a meal for oneself and if needed also for others. Elements of the task include deciding what is to be prepared, selecting, measuring and combination of ingredients in an ordered procedure so as to achieve desired results. Meal preparation often includes heating ingredients or a pre-prepared meal[7].

Strategies related to meal preparation

Table 20 Strategies related to meal preparation

Strategies related to meal preparation	
Challenge:	**Strategies:**
• Difficulty planning or initiating meal preparation	• Encourage regular daily routine including meal time. • Be aware of cultural differences to meal times and when special religious practices need to be considered. • Shared meal ensures it occurs and also provides social interaction. • Develop timetable for weekly meals. • Have simple recipes written out to prompt what to do and when. • Limited meal options decrease the demand on decision making. • Consider stocking up on simple snack type meals. • Source delivered hot or frozen meals, or purchase pre-prepared meals from meal services or supermarket. • Access support services with meal preparation, serving and prompting to eat. • If possible encourage the person to participate in meal preparation or

Strategies related to meal preparation	
Challenge:	**Strategies:**
	sit with the care partner to observe meal preparation. • Harness family support by providing meals for reheating or sharing a meal. • Consider take away home delivery services or dining out. Encourage healthier options.
• Decreased judgement in knowing which are unsafe foods and drinks. Examples include: out of date foods, concentrated foods such as pickles, hot sauce, cleaning fluids	• Encourage care partner / family to assist in monitoring and checking food for being out of date or inappropriate (e.g. diabetic diet). • Hazardous products should be stored safely and out of sight. • Ensure cleaning products are stored separately from food.
• Unsafe use of sharp utensils including knives	• Have foods pre-cut e.g. pre-cut fresh foods or frozen vegetables. • Limit sharps in utensil drawer.
• A need to continue to be involved in kitchen activities but safety concerns exist	• Provide opportunity to participate in food preparation and kitchen tasks, e.g. peeling / chopping vegetables, making sandwiches, washing dishes. • Provide picture prompts or concise written information to prompt a task or the sequence of a task.
• Kitchen accidents / injury risks	• Keep emergency “000” or poison information phone number by the phone. Also have card with own phone number and address to assist in providing personal information when stressed.

Environmental strategies related to meal preparation

Table 21 Environmental strategies related to meal preparation

Environmental strategies related to meal preparation	
Challenge:	**Strategies:**
• Difficulties finding ingredients / utensils / crockery /cookware	• Ensure adequate light, use daylight where possible, if kitchen is dark, is a skylight an option? • Reduce clutter in cupboards / drawers and on bench tops. Reduce the number of utensils, pots etc., the fewer decisions the person living with dementia needs to make the easier it is to find what is needed. • Use colour contrast in storage areas to assist with searching skill. • Store frequently used items in prominent consistent locations that are within line of sight. • Label cupboards and drawers, such as cutlery, cups and plates, pantry and so on. Labels need to be big, bold, contrasting, eye level, and age / culture appropriate. Use pictures rather than words if reading is difficult. • Use clearly labelled and transparent storage containers for ingredients.
• Forgetting how to adjust the temperature of hotplates / the oven.	• Use colour marking to indicate most common temperature setting. • Contrast backing on light switches. • Have diagram mounted prominently near controls with prompts of which knob to turn and by how much.

Environmental strategies related to meal preparation	
Challenge:	**Strategies:**
	• Dials and knobs on stoves, ovens etc., may be easier to recognise and understand than pressure sensitive pads.
• Difficulty turning on/off taps, forgetting which tap is hot or cold, leaving tap running possibly risk of overflowing sink.	• Clearly label taps to indicate hot / cold. • Have lever style taps. • Install flood prevention and detection devices such as water overflow prevention devices for sinks, pressure release plugs, tap caps.
• Burning self by touching hot plates or unsafe practices with cookware. • Putting inappropriate dishes / utensils on a hot plate or in the oven.	• Induction hot plates use a magnetic field to heat saucepan and content but cook top takes time to heat up and to cool down. • Use oven guards to minimise contact burns. • Label area where oven proof and stove top cookware is located, to prompt use of appropriate item.
• Forgetting to turn off the stove hot plates leaving gas or electricity on after cooking. • Unsafe in use of stove, burning food or the pot / saucepan.	• Use written reminders (“turn off stove”) and place in location where it will be seen when using stove. Use low glare laminate or don’t laminate as it increases glare. • Use a timer either on the oven or a simple food timer to assist in knowing and being alerted to cooking times. • Install a device (usually an electrician needed) to gas or electric stove that is a stove isolation system that will turn off

Environmental strategies related to meal preparation	
Challenge:	**Strategies:**
	stove when left unattended for a period of time. • Gas alarms plugged into a power point detect escaping gas including unignited gas. • Ensure installation of circuit breaker / isolation switch.
• Forgetting how and when to turn off / on appliances such as electric kettle, toaster	• Simplify appliances: microwave with simple controls, kettle with safety cut-off (also prevents it boiling dry) and cordless appliances that beep when left on. • Use colour marking to indicate on / off switches. • Use simple written instructions of process to use appliance. • Give away / sell / discard appliances rarely used. • Replace long cords on appliances with coiled or retractable ones.
• Misjudging edges of bench tops, shelves resulting in dropping utensils / crockery, spilling foods, bumping into things	• Ensure adequate lighting in the kitchen, at the bench and table. Maximise natural light. Have light on whenever preparing food. Recommendation for globes which most closely resemble daylight. Globes should aim to provide light equivalent to daylight and minimise shadows. • Contrast in colour between bench tops, seating and floors will highlight edges and assist judgement of depth and size.
• Kitchen accidents / injury risks	• If kitchen is an unsafe place for the person, may need to use furniture

Environmental strategies related to meal preparation	
Challenge:	**Strategies:**
	to redirect mobility through kitchen or lock the kitchen door to prevent access to the kitchen. • Disconnect stove or oven, or remove appliances that are not able to be used in a safe manner. • Minimise falls by considering non-slip flooring, removing mats, removing floor clutter. • If necessary, use child proof type lock systems on some cupboards to prevent access. Also need to provide access to cupboards with safe content to allow kitchen activity.
• Fire risks	• Ensure smoke detector in place, battery changed every 6 months, decrease dust build up by vacuuming regularly. • Have fire extinguisher in good working order.

Shopping

Definition: Accessing shops to buy needed items for everyday activities, this includes selecting and gathering needed items and paying for items using cash or bank / credit card. Items selected may be food, drink, personal items, cleaning materials, or household items. It may involve instructing care partners about shopping needed and providing a shopping list and needed funds[7].

Strategies to support shopping

Table 22 Strategies to support shopping

Strategies to support shopping	
Challenge:	**Strategies:**
• Difficulty organising self to go shopping	• Have a label by the front door as a reminder of important things to take, e.g., wallet / purse, glasses, keys and mobile phone. • Have a regular shopping day and a similar time, so it is part of the weekly routine.
• Used to visiting various shopping centres, but difficulty finding way around the centre	• Choose one that is easy to get to, easy to find your way around and use it all the time. • Encourage going in the same entrance and taking note of landmarks.
• Difficulty getting to the shops and home again	• Encourage use of local council shopping bus services if available. • Using taxi to/from shops requires some planning and forethought. May require learning or relearning a process. Consider applying for the taxi subsidy scheme to access vouchers for subsidised taxi fares. • Utilise support service, for care partner to accompany the person

Strategies to support shopping	
Challenge:	**Strategies:**
	shopping or do the shopping on behalf of the person. • Try internet shopping with family / care partner assist if needed.
• Difficulty navigating around the shop and finding needed items	• Develop a picture shopping list to allow for recognition of items by matching product labels.
• Unable to remember what needs to be purchased. Also buying duplicate items from week to week	• Write and take a shopping list. Have a standard list, where items needed can be ticked off. • When writing a list check the pantry and fridge to ensure not buying items already stocked. • Develop a shopping list that is grouped according to the area of the shop such as dairy, meats and vegetables. • If shopping for the person, ensure they are involved in making the shopping list.
• Difficulty handling money / using a bank card	• Have a purse / wallet that is easily opened and accessed. • Make sure you are wearing prescribed glasses to help in identifying the coins. • Encourage going when shops are not at their busiest so there is not the pressure of people. • Discourage carrying large amounts of cash. • Encourage care partner to provide amount of money needed for the purchase with the person living with dementia still able to have the autonomy of making the purchase.

Strategies to support shopping	
Challenge:	**Strategies:**
	• Practise at home counting coins and making change to maintain money handling skills.
• Physical limitations impacting on shopping • Limited endurance and mobility • Visual deficits impacting on mobility and shopping tasks	• Encourage use of usual walking aid, or use of shopping trolley for support. • Consider accessible parking permit application to allow for near access to entrance of shops. • Plan timing of shopping to ensure optimal energy reserves. • Consider need to be accompanied to shops by family / care partner / friends to ensure safety. Assistance may be needed due to cognitive and visual deficits. • Consider local council shopping bus. • Can loan/hire mobility equipment from larger shopping centres.

Environmental strategies to support shopping

Table 23 Environmental strategies to support shopping

Environmental strategies to support shopping	
Challenge:	**Strategies:**
• Forgetting to take keys and locking self out of home	• Install a locked box for the house keys. • Install code locking system for front door. • If living alone, ensure family and maybe a trusted neighbour have keys to the home.
• Unable to remember what needs to be purchased	• White board mounted near fridge / pantry to write down groceries needed, to then later transfer these to a paper list. • Place shopping list with keys and wallet / purse by home exit (front door).
• Difficulty unpacking / putting away groceries	• Label shelves in pantry and fridge to assist in putting groceries away, ensure usual location for items. • Consider an upside-down refrigerator, with the more frequently used fridge compartment at easy reach level.
• Physical limitations impacting on shopping	• Having a small shopping trolley to transport items from shop, rather than having to carry may assist. • Home delivery of groceries eliminates the need to carry heavy bags of groceries.

Using the telephone

Definition: Using a landline telephone or mobile phone or similar device to communicate with family or friends includes initiating and receiving communications[7].

Strategies to support use of the telephone

Table 24 Strategies to support use of the telephone

Strategies to support use of the telephone	
Challenge:	**Strategies:**
• Decrease use of the telephone, rare attempts to make phone calls and answer them • Forgetting reason for the phone call	• Establish a routine to make a regular phone call (weekly) to a family member or friend to maintain phone skills. • Avoid buying a complicated phone requiring learning of new processes, if it's too hard to use, person may avoid using it. • Background noise can be very distracting during a phone call. Encourage turning off radio, television.
• Difficulty managing the mobile phone	• Repetition is needed to learn new phone skills, involves new processes and possibly greater dexterity. • Family need to learn that a mobile phone requires more steps than a landline. This should be considered in context with the person living with dementia's capacity. • Purchase a model of phone that has basic features and functions. • If prepaid phone credit is used, ensure the person knows there is an expiration date and write this on a calendar or in a diary.

Strategies to support use of the telephone	
Challenge:	**Strategies:**
• Misplacing the mobile phone	• Encourage the person to retrace their steps. • Use another phone to call or text the mobile phone. • If phone has GPS, service provider may have GPS location service or may at least be able to cut off service to the phone. • If phone has 'find my phone' function access a computer to locate the phone.

Environmental strategies to support use of the telephone

Table 25 Environmental strategies to support use of the telephone

Environmental strategies to support use of the telephone	
Challenge:	**Strategies:**
• Decreased use of the telephone both to make phone calls and answer them • Forgetting reason for the phone call	• Place phone in a prominent place to prompt use and allow for easy access to answer it. • Place a notebook or diary and pen beside the phone to allow writing down phone messages.
• Difficulty remembering important phone numbers	• Display commonly used telephone numbers near the phone. Place the emergency contact phone number on the telephone using a label. • Program important phone numbers into home phone memory (speed dial facility) and provide simple written prompts for use. • Trial special needs phones such as those with picture dialling. • Have a card or personal phonebook by the phone listing phone numbers of family / friends / care partners.
• Leaving phone off the hook • Losing cordless phone	• Consider wall phone versus table phone, it is more evident when phone is off the hook. • Encourage routine checking phone that is in working order each day.

Managing finances

Definition: Able to access money in cash or via bank / credit card, able to budget, pay bills and keep track of income[7].

Strategies to support managing finances

Table 26 Strategies to support managing finances

Strategies to support managing finances	
Challenge:	**Strategies:**
• Difficulty recalling PIN on bank / credit card	• Encourage changing Personal Identification Number (PIN) at the bank to a number relevant to the person. • Encourage use of paypass™ where possible. • When cards are too challenging, use of cash for small purchases may still allow some autonomy with shopping.
• Unsafe management of finances resulting in being financially vulnerable • Carrying large sums of money • Uncharacteristic spending of large sums of money	• From discussion with the person, family and the bank, instigate an account that has a limited amount of funds to control over spending. • Where possible plan ahead and obtain legal advice while the person living with dementia is able to participate. • Consider Enduring Power of Attorney (EPA) and Enduring Power of Guardianship (EPG) early to ensure the person living with dementia can express his/ her wishes.
• Forgetting to pay bills	• Make emptying the mail box and going through the mail a regular joint activity with family to allow

Strategies to support managing finances	
Challenge:	**Strategies:**
	activity but provide assistance as needed. • Encourage a routine of paying bills as soon as they arrive. • A diary or calendar can be used to keep track of when bills are due. • Use document tray or similar for unpaid bills in a prominent place to provide a visual prompt. • Use of direct debit for regular bills decreases cognitive demands. • Deciding to allow family to take over the management of bills will avoid late payments and stress of having to remember.
• Unable to determine important mail from unimportant mail, including email and online advertising	• Assist the person to establish a simple filing system. • Develop a sheet with visual prompts and bill / document titles to help identify regular mail and documents that need to be kept. • Cancel any subscriptions that are no longer relevant. • Regularly throw out unnecessary mail / advertising. • Set filters on email with family assistance. • Encourage care partner or EPA to provide support in reviewing mail and identifying which mail needs attention. • As capacity declines, have mail redirected to family member or whoever has EPA, including access to email and electronic billing.

Environmental strategies to support managing finances

Table 27 Environmental strategies to support managing finances

Environmental strategies to support managing finances	
Challenge:	**Strategies:**
• Unsafe storage of financial information	• Determine one place for all important documents, a designated drawer or folder. • Depending on documents, consider installing a lock box to store valuable documents.
• Unable to decide important mail from unimportant mail	• Add a 'no junk mail' sticker to the mail box to limit unimportant mail, hence decreasing decision making. • Assist to sort mail on regular basis to decrease disorganisation and clutter.

Doing laundry

Definition: Washing clothes and other items such as towels, sheets, using a washing machine or hand washing, hanging the washing out to dry then collecting it, folding it, ironing and putting it away[7].

Strategies to support doing laundry

Table 28 Strategies to support doing laundry

Strategies to support doing laundry	
Challenge:	**Strategies:**
• Difficulty knowing that washing needs to be done	• Establish a routine day to attend to laundry. May need family / care partner prompting to initially instigate routine. • Ensure laundry basket near where clothing is changed. • Link washing with cleaner coming, which will then serve as a prompt.
• Forgetting to turn off iron	• Purchase iron with automatic cut off switch for iron left unattended. • Determine usual storage place for iron remembering that it takes up to 30 minutes for iron to cool.
• Difficulty with ironing board	• Leave iron set up if set up is difficult and if space permits. Also this may encourage activity. • Ensure orientation of the board for safe set up, avoiding cord draping over ironing board.

Environmental strategies to support doing laundry

Table 29 Environmental strategies to support doing laundry

Environmental strategies to support doing laundry	
Challenge:	**Strategies:**
• Difficulty turning on and programming washing machine / dryer • Flooding risk if washing machine drainage hose is in sink	• Provide signage with brief outline of steps to start appliance. Include photos to provide visual prompt. Include emptying lint filter to minimise fire risk. • Consider removing washing machine water flow taps to prevent accidental turning off. • Use colour contrast markings to indicate most common setting. • Flood prevention and detection device if washing machine drainage hose is in sink. Overflow prevention devices such as pressure release plugs. • If needing to replace the washing machine, consider similar model so controls are similar. • Use of a combined washer and dryer may simplify laundry process.
• Injury risk	• Ensure adequate lighting, to resemble day light. • To prevent scalding from hot water in washing task, thermostatic mixing valve on hot water tap. • Ensure laundry floor is non-slip. Any mats should be rubber-backed. Ventilation needed to prevent moisture building up on floors. • Ensure paths to access extended clotheslines are level, well maintained and free of clutter.

Environmental strategies to support doing laundry	
Challenge:	**Strategies:**
	• Use trolley instead of carrying a basket of laundry. • Lower the height of the clothesline to decrease reach. • Use clothes airer rack rather than clothesline. • Use dryer rather than hanging clothes.
• Difficulty locating appropriate laundry products, such as laundry powder / liquid, prewash spray	• Label storage space with label that is big, bold, contrasting, words or pictures depending on person's ability. • Only have needed laundry items to choose from. • Consider colour contrast between shelving and laundry products to make things easier to see. Open shelving so items are easily seen. • Ensure other hazardous cleaning products are stored separately and securely to avoid confusion. • Magnetic locks on cupboards if access needs to be limited.

Doing housework

Definition: Maintaining a house by cleaning and tidying of the house, including heavy cleaning such as cleaning bathroom and toilet, sweeping / mopping / vacuuming floor, changing bed linen, and lighter chores including washing dishes, tidying rooms, disposing of rubbish[7].

Strategies to support doing housework

Table 30 Strategies to support doing housework

Strategies to support doing housework	
Challenge:	**Strategies:**
• Lack of initiative	• Facilitate writing a "to do" list of chores. • Encourage and work alongside person living with dementia to complete chores, to allow participation, achievement and success. • Provide positive feedback when tidying and cleaning achieved. • Consider family or support service assistance with cleaning chores weekly or fortnightly to decrease demands of cleaning chores. • Draw up a timetable for weekly chores, thus developing routines.
• Difficulty recalling chores that need to be done or how to do them • Difficulty using the vacuum cleaner	• Establish priorities of chores to be done. • Encourage the person to complete parts of the tasks that can be done safely. • Simplify task and equipment used. If vacuum cleaner is too difficult attempt use of a manual carpet cleaner.

Environmental strategies to support doing housework

Table 31 Strategies to support doing housework

Environmental strategies to support doing housework	
Challenge:	**Strategies:**
• Change in vision; older person has diminished ability to focus quickly and adapt to changes in light conditions, they need 3 to 5 times more light for tasks. Hence reduced ability to notice dust, grime and dirt that need cleaning up	• Natural light is best. • Sheer curtains on windows block out daytime glare and night time reflections but also allow light in. • Change globes to resemble daylight.
• Misusing cleaning products	• Hazardous products should be stored out of sight and in safe places. • In purchasing cleaning products consider non-poisonous ones, then label clearly.
• Injury risks	• Minimise falls by considering non-slip flooring, removing mats, removing clutter. • Leave light on during the day where there is insufficient day light. Have lighting throughout transition areas to help eliminate shadows. • Consider a person's ability to judge risk of task. Remove items such as ladders and footstools.

Using transport

Definition: Traveling to needed and chosen destinations as a passenger either by private car, taxi, or using public transport[7].

Strategies to support use of transport

Table 32 Strategies to support use of transport

Strategies to support use of transport	
Challenge:	**Strategies:**
• Unable to drive self, due to declining cognitive function • Physical limitations in using public transport due to decreased ability to ambulate	• Investigate transport options available through the local council. • Consider use of taxis and applying for Taxi Subsidy Scheme for discount taxi fares. • Investigate transport provided through Commonwealth Home Support Program • Can transport be provided by family / care partner / friend? • Consider application for accessible parking permit.
• Difficulty providing personal details in case of emergency.	• Person to carry in the wallet / purse an identification card with name, address and emergency contact number. • Consider a medical alert bracelet to tell others important information in case of emergency.
• Difficulty with recalling planned destination or transport arrangements	• Have planned transport arrangements written in diary or on the calendar • Have the address of the destination written down and within easy reach. • Have family or care partner be responsible for knowing destination information.

Driving

Definition: Being in control of a motor vehicle and travelling under one's own direction. Able to operate all aspects of the vehicle, able to obey road rules and able to find way to chosen destination and home again[7].

Strategies to support driving

Table 33 Strategies to support driving

Strategies to support driving	
Challenge:	**Strategies:**
• Concern regarding safety to drive due to cognitive decline / diagnosis of dementia • Getting lost while driving • Evidence of dents and scratches on the motor vehicle • Motor vehicle accidents	• GPs have to complete a "Fitness to Drive certificate" for drivers over 80 years, and in this are able to identify if there is concern regarding a person's driving ability. • Assessing Fitness to Drive – Commercial and Private Vehicle Drivers is a joint publication of Austroads and the National Transport Commission (NTC)[74]. It contains nationally agreed medical standards for the purposes of driver licensing. • Mandatory reporting of a medical condition (such as dementia) and/or if taking any medication that may affect your ability to drive, must be directed to the relevant state government department of transport by the person or their medical practitioner. • Usual practice if there is doubt of driving ability is to refer for an occupational therapy driving assessment. Referral can be made by any health professional.

Gardening and outdoor chores

Definition: Activities outside the house and involving tending to and cultivating plants in a garden space. Tasks may include planting, pruning, weeding, watering, mulching, harvesting and raking leaves[72].

Strategies to support gardening and outdoor chores

Table 34 Strategies to support gardening and outdoor chores

Strategies to support gardening and outdoor chores	
Challenge:	**Strategies:**
• Injury risks	• Consider the risk versus the sensory experience and benefit of being outdoors in the garden, especially if it has been a lifelong interest. • Consider bringing elements of the garden indoors such as potted plants, vase of leaves/flowers from the garden.
• Falls risks	• Practice walking on different surfaces, paving versus lawn to vary challenge to balance and improve safety. • Ensure using an appropriate walking aid.
• Remembering moving rubbish bin to road side for collection	• Contact the local council to ask for assistance from rubbish collectors. • Consider asking family or a trusted neighbour to assist.

Environmental strategies to support gardening and outdoor chores

Table 35 Environmental strategies to support gardening and outdoor chores

Environmental strategies to support gardening and outdoor chores	
Challenge:	**Strategies:**
• Injury risks	• Declutter garden areas to ensure clear walkways. • Ensure there is a shaded place to sit and relax and look at the garden. • Consider raised garden beds to grow vegetables or herbs, allow for easier access and ensure it is more within line of sight. • Only have needed and low risk garden tools available such as rake, broom, etc. • Clear pathways in the garden by removing overhanging branches, remove moss, remove plants with thorns.
• Falls risks	• Uneven surfaces are trip hazards, repair may be needed. • Install a retractable hose to reduce trip hazard from hose. • Improve safety on backyard steps have handrails for support, and highlight edges of steps with contrast paint or contrast non-slip strips. • Remove ladders and other items that may prompt unsafe behaviour. • Ensure adequate lighting such as a sensor light at night time if there is a need to go outside or if the person is prone to wandering.
• Poisoning	• Ensure plants are non-toxic.

Environmental strategies to support gardening and outdoor chores	
Challenge:	**Strategies:**
	• If concerned about inappropriate use or ingestion, lock away garden chemicals and fertilisers.
• Wandering away from home	• Create barriers that disguise entrances and exits, such as furniture barriers, tarpaulin draped over a gate. • Doorknob covers can prevent a person from opening a door. • Add a latch to a gate (at the top or bottom of the gate) or a digital locking system. • Install pathways to encourage walking around the garden / backyard. • Fences remove the visual cue to go outside and also can be camouflaged by shrubs and bushes.
• Physical limitation impacting on ability to garden	• Consider raised garden beds. • Ensure adequate seating with appropriate seat height and armrests, where possible. Have seating in shaded areas.

Pet Care

Definition: Managing the daily needs of a pet, this includes providing food and water, have appropriate shelter if necessary, provide for the ability to urinate and defecate, and exercise. Also attend to the pet's health / medical needs[72].

Table 36 Strategies to support pet care

Strategies to support pet care	
Challenge:	**Strategies:**
• Choosing the appropriate pet	• Consider benefits of having a pet, companionship, comfort and a caring role. • Discuss preferences, space available, care needs and financial cost. • If a dog is wanted, discuss suitable breeds with the vet or other appropriate resource. • Consider animal assisted therapy.
• Difficulty tidying up after a pet such as cleaning up dog faeces, changing kitty litter	• Consider need for assistance from family / care partner. • Trial using a long-handled shovel and brush.
• Difficulty walking the dog	• Walk with family / care partner / friends if there is a risk of getting lost. • If able should have opportunity to manage the dog on a leash. • Employ a dog walker if unable to walk the dog.

Environmental strategies to support pet care

Table 37 Environmental strategies to support pet care

Environmental strategies to support pet care	
Challenge:	**Strategies:**
• Remembering to feed the pet • Under feeding / overfeeding	• Use signage in bold writing and with simple text to prompt feeding. • Have a feeding chart where the person ticks off having fed the dog / cat to avoid over feeding. • Pet food dispensers can regulate food available over the course of a few days.
• Knowing what pet food is and what is not • Knowing amount to feed	• Have pet food clearly labelled and stored appropriately. • Have pet bowls the size that the meal size should be.
• Difficulty tidying up after a pet such as cleaning up dog faeces, changing kitty litter	• Have designated pet toileting area or if walking, have bag for dog faeces attached to lead. • Establish a regular routine to attend to cleaning up after a pet. If physical difficulty bending and reaching to pick up, use a designated long handled dustpan and brush. • May need to ask family / care partner for assist with kitty litter, cleaning a bird cage etc.

Leisure or free time

Definition: Time spent for enjoyment. Free time is time spent away from business, work, job hunting, domestic chores, and education, as well as necessary activities such as eating and sleeping[72].

Strategies to support leisure or free time

Table 38 Strategies to support leisure or free time

Strategies to support leisure or free time	
Challenge:	**Strategies:**
• Difficulty participating in long standing leisure interests • Reduced motivation to initiate/ participate in long standing leisure interests	• Plan the leisure activity as part of the daily and weekly routine. • Grade the complexity of the activity to ensure success and satisfaction. For example if the person enjoys golf, reduce the number of holes played, choose a familiar but appropriate golf course and schedule play at less busy times to allow for rest breaks and increased time to complete the activity. Modify golf set to reduce choice of clubs and weight of bag and equipment. Relax the rules and omit competitive element to activity. As dementia progresses, consider visits to the driving range as an alternative to rounds of golf, or encourage walking the course while others play or if able caddy. • Offer regular encouragement and positive feedback relating to participation. • Focus on supplementary benefits to any leisure activity tried, such as socialisation or exercise.

Strategies to support leisure or free time	
Challenge:	**Strategies:**
	• Create opportunities to participate in activities at home if less able to participate in activity in the community. Make opportunities available to watch sports or special events on television, or on the internet.
• Reduced interest in participating in any type of leisure	• Choose activities which are familiar, repetitive and simple to engage in, such as board games which encourage social skills and often number skills. • Choose activities which elicit success regardless of the length of participation such as word and number puzzles, jigsaw puzzles of appropriate level of challenge, computer games. • Utilise reminiscence as way to engage or create interest in participating in a secondary activity such as use of photo albums may lead to writing a card to a family member. Reading a book/listening to an audio book on a certain topic. Visiting a place of significance to the person, these outings allow for a walk or simple exercise. • Enable access to music and movies which link to a person's interests and era. • Any outing/appointment also provides opportunity for incidental engagement in leisure e.g. stop to enjoy a garden following an

Strategies to support leisure or free time	
Challenge:	**Strategies:**
	appointment, or spend time at a café during a shopping outing. • Consider local seniors activity programmes, cultural clubs and church activity programs for attendance.

Environmental strategies to support leisure and free time

Table 39 Environmental strategies to support leisure and free time

Environmental strategies to support leisure and free time	
Challenge:	**Strategies:**
• Difficulty accessing activities in the home environment	• Create areas for activities that remain set up and are in line of sight for increased participation, such as puzzles or chess set out on a table so can be accessed any time. Consider appropriate seating for reading and leafing through books of interest, books can be left out on the coffee table and rotated regularly to encourage activity. • Ensure lighting for the activity areas and consider colour contrast of table top set up. Make use of natural lighting and participating in activity outdoors as weather permits.
• Difficulty using traditional leisure activity equipment or materials	• Consider use of assistive technology such as computer based or digital devices such as smartphone, tablet, e-reader or gaming console if the person is interested in using technology. • Apps are available which are specifically designed for use by people living with dementia for leisure and cognitive activities on a tablet. These only require simple swiping and tapping hand movements to participate so may suit someone with a reduced capacity for new learning. • Tablet can be set up with easy access to a music library (playlists), movies and internet access.

Environmental strategies to support leisure and free time	
Challenge:	**Strategies:**
	• Tablet can be used with a stylus to enable ongoing writing if traditional pen and paper based tasks are difficult. • E-Reader use may be of benefit if holding and turning the pages of a book is affecting participation in reading. Could also consider use of audio books or podcasts. • Consider gaming consoles which can be used for both leisure and exercise based activities.
• Difficulty accessing community-based leisure activities	• Consider transport needs, parking, noise and crowds as factors which may impact on a person's enjoyment of the activity. • If limited transport options restrict participation consider options via Commonwealth Home Support Program, Home Care Package and cultural and religious groups. • Consider need for informal or formal support person to physically guide and prompt participation in chosen activity. • Consider application for a companion card to allow the person be accompanied to concerts, movies etc. without added costs.

Further Reading

1. Nutrition and Dementia. A review of available research. 2014; https://www.alz.co.uk/sites/default/files/pdfs/nutrition-and-dementia.pdf

2. Dementia Enabling Environments. 2017; www.enablingenvironments.com.au

3. Dementia friendly environments. 2017; https://www2.health.vic.gov.au/ageing-and-aged-care/dementia-friendly-environments

4. Help Sheets 2017; www.fightdementia.org.au/about-dementia/resources/help-sheets

5. Bringolf J. Helpful Handbook for Memory Loss. NSW: Column Inch Communications; 2007.

6. Centre DSD. Good Practice in Design for Dementia and Sight Loss. 2017; www.dementia.stir.ac.uk

7. Design CfEiU. Universal Design Guidelines: Dementia Friendly Dwellings for People with Dementia, their Families and Care partners. In: Ireland NDA, ed. Ireland2015.

8. Garrido-Pedrosa J, Sala I, Obradors N. Effectiveness of cognition-focused interventions in activities of daily living performance in people with dementia: A systematic review. BJOT. 2017;80(7):397-408.

9. Jensen L, Padilla R. Effectiveness of Environment-Based Interventions That Address Behavior, Perception, and Falls in People with Alzheimer's Disease and Related Major Neurocognitive Disorders: A Systematic Review. Am J Occup Ther. 2017;71(5):7105180030p7105180031-7105180030p7105180010.

10. NSW AsA. At Home with Dementia In. 2nd ed. Sydney, NSW: Ageing, Disability and Home Care, Department of Family and Community Services NSW; 2008.

11. Siebert C, Schwartz J. Occupational Therapy's Role in Medication Management. AJOT. 2017;71(Supplement 2).

References

1. Greenwood N, Smith R. The experiences of people with young-onset dementia: A meta-ethnographic review of the qualitative literature. *Maturitas.* 2016;92:102-109.

2. World Health Organization. *Global action plan on the public health response to dementia 2017 - 2025.* Geneva2017.

3. Duong S, Patel T, Chang F. Dementia: What pharmacists need to know. *Canadian Pharmacists Journal.* 2017;150(2):118-129.

4. World Health Organization. *The Global Dementia Observatory reference guide.* Geneva2018.

5. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. Arlington, VA: American Psychiatric Publishing; 2013.

6. World Health Organization. *Towards a dementia plan: A WHO guide.* Geneva2018.

7. Cornelis E, Gorus E, Beyer I, Bautmans I, De Vriendt P. Early diagnosis of mild cognitive impairment and mild dementia through basic and instrumental activities of daily living: Development of a new evaluation tool. *PLoS Medicine.* 2017;14(3):e1002250.

8. Hattjar B. Addressing Sexual Activity. *OT Practice.* 2017;22(19):8-12.

9. Brown L, Hansnata E, Anh La H. *Economic cost of dementia in Australia, 2016-2056.* Canberra, ACT National Centre for Social and Economic Modelling 2016.

10. Dementia Australia. Dementia Prevalence Data 2018-2058, commissioned research undertaken by the National Centre for Social and Economic Modelling (NATSEM), University of Canberra. 2018

11. Alzheimer's Australia. *Living with dementia in the community: Challenges and opportunities.* Australia2014.

12. Alzheimer's Australia. *Caring for LGBTI people with dementia. A guide for health and aged care professionals.* Alzheimer's Australia 2014.

13. Prince M, Ali GC, Guerchet M, Prina AM, Albanese E, Wu YT. Recent global trends in the prevalence and incidence of dementia, and survival with dementia. *Alzheimer's Research Therapy.* 2016;8(1):23.

14. Papastavrou E, Kalokerinou A, Papacostas SS, Tsangari H, Sourtzi P. Caring for a relative with dementia: family caregiver burden. *J Adv Nurs.* 2007;58(5):446-457.

15. Alzheimer's Australia NSW. *Addressing the stigma associated with dementia.* North Ryde, NSW2010.

16. World Health Organization. *Dementia: A public health priority.* Geneva: World Health Organization; 2012.

17. Reppermund S, Brodaty H, Crawford JD, et al. Impairment in instrumental activities of daily living with high cognitive demand is an early marker of mild cognitive impairment: The Sydney memory and ageing study. *Psychological Medicine.* 2013;43(11):2437-2445.

18. Laver K, Cumming RG, Dyer SM, et al. Clinical practice guidelines for dementia in Australia. *Medical Journal of Australia.* 2016;204(5):191-193.

19. Australian Commission on Safety and Quality in Health Care. *A better way to care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital - actions for clinicians.* Sydney, NSW: ACSQHC; 2014.

20. Jackson T, MacLullich A, Gladman J, Lord J, Sheehan B. Undiagnosed long-term cognitive impairment in acutely hospitalised older medical patients with delirium: a prospective cohort study *Age and Ageing.* 2016;45(4):493–499.

21. Maher S. Triaging delirium in older people. *Medical WA Forum*. Perth, WA: Medical Forum; 2014:29

22. Dementia Australia. Help sheets for about dementia: Changed behaviours and dementia. 2017; www.dementia.org.au/about-dementia/resources/help-sheets#Changed-behaviours-and-dementia.

23. Laver K, Clemson L, Bennett S, Lannin N, Brodaty H. Unpacking the Evidence: Interventions for Reducing Behavioral and Psychological Symptoms in People with Dementia. *Physical and Occupational Therapy in Geriatrics.* 2014;32(4):294-309.

24. Laver K, Cumming R, Dyer S, et al. Evidence-based occupational therapy for people with dementia and their families: What clinical practice guidelines tell us and implications for practice. *Australian Occupupational Therapy Journal.* 2017;64(1):3-10.

25. Smallfield S, Heckenlaible C. Effectiveness of occupational therapy interventions to enhance occupational performance for adults with Alzheimer's disease and related major neurocognitive disorders: A systematic review. *American Journal of Occupational Therapy.* 2017;71(5):7105180010p7105180011-7105180010p7105180019.

26. Gitlin L, Corcoran M. *Occupational Therapy and Dementia Care: The Home Environmental Skill - Building Program for Individuals and Families.* Bethesda, MD: AOTA Press 2005.

27. Piersol CV, Canton K, Connor SE, Giller I, Lipman S, Sager S. Effectiveness of interventions for caregivers of people with Alzheimer's disease and related major neurocognitive disorders: A systematic review. *American Journal of Occupational Therapy.* 2017;71(5):7105180020p7105180021-7105180020p7105180010.

28. Guideline Adaptation Committee. *Clinical practice guidelines and principles of care for people with dementia.* Sydney: NHMRC; 2016.

29. Schaber P, Liederman D. *Occupational Therapy Practice Guidelines for Adults with Alzheimer's Disease and Related Disorders.* Bethesda MD: AOTA Press; 2010.

30. Fisher A, Jones K. *Assessment of motor and process skills: Development, standardization, and administration manual.* Vol 1. 7th Revised ed. Fort Collins, Co: Three Star Press; 2012.

31. Ranka J, Chapparo C. *The perceive recall plan perform assessment course manual.* Australia 2015.

32. Hartman-Maeir A, Armon N, Katz N. *The Kettle Test: A cognitive functional screening test* Mount Scopus, Jerusalem: The Hebrew University of Jerusalem & Hadassah; 2005.

33. Hartman-Maeir A, Harel H, Katz N. The Kettle Test: A brief measure of cognitive functional performance. Reliability and valdity in stroke rehabilitation. *American Journal of Occupational Therapy.* 2009;63(5):592-599.

34. The Functional Independence Measure (FIM) system clinical guide, version 5.2. 2009; www.udsmr.org/WebModules/FIM/Fim_About.aspx.

35. *Guide for the uniform data system for medical rehabilitation (adult FIM) version 4.0.* Buffalo, USA: State University of New York at Buffalo; 1993

36. Wales K, Clemson L, Lannin N, Cameron I. Functional Assessments Used by Occupational Therapists with Older Adults at Risk of Activity and Participation Limitations: A Systematic Review. *PLoS One.* 2016;11(2):e0147980.

37. Folstein MF, Folstein SE, McHugh PR. "Mini-Mental State". A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research.* 1975;12:189-198.

38. Mini-Mental State Examination 2017; www.strokengine.ca/indepth/mmse_indepth/.

39. Rowland J, Basic D, Storey J, Conforti D. The Rowland Universal Dementia Assessment Scale (RUDAS) and the Folstein MMSE in a multicultural cohort of elderly persons. *International Psychogeriatrics.* 2006;18(1):111-120.

40. Nasreddine ZS, Phillips NA, Bédirian V, et al. The Montreal Cognitive Assessment, MoCA: A brief screening tool for mild cognitive impairment. *Journal of the American Geriatrics Society.* 2005;53(4):695-699.

41. Koskas P, Henry-Feugeas MC, Feugeas JP, et al. The Lawton Instrumental Activities Daily Living/Activities Daily Living Scales: A sensitive test to Alzheimer's disease in community-dwelling elderly people? *Journal of Geriatric Psychiatry and Neurolology.* 2014;27(2):85-93.

42. Rowland Universal Dementia Assessment Scale. 2017; www.dementia.org.au/resources/rowland-universal-dementia-assessment-scale-rudas

43. Brown J, Pengas G, Dawson K, Brown LA, Clatworthy P. Self administered cognitive screening test (TYM) for detection of Alzheimer's disease: Cross sectional study. *BMJ.* 2009;338.

44. The Test Your Memory Test. 2017; www.tymtest.com.

45. Mueller J, Kiernan R, Langston JW. *Cognistat Manual.* Fairfax, CA: The Northern California Neurobehavioral Group; 2015.

46. Cognistat. 2017; www.cognistat.com.

47. LoGiudice D, Smith K, Thomas J, et al. Kimberley Indigenous Cognitive Assessment tool (KICA): Development of a cognitive assessment tool for older indigenous Australians. *International Psychogeriatrics.* 2006;18(2):269-280.

48. Smith K, Flicker L, Dwyer A, et al. Assessing cognitive impairment in Indigenous Australians: Re-evaluation of the Kimberley Indigenous Cognitive Assessment in Western Australia and the Northern Territory. *Australian Psychologist.* 2009;44(1):54-61.

49. The Montreal Cognitive Assessment. 2017; www.mocatest.org.

50. Manos PJ, Wu R. The Ten Point Clock Test: A quick screen and grading method for cognitive impairment in medical and surgical patients. *The International Journal of Psychiatry in Medicine.* 1994;24(3):229-244.

51. The Clock Drawing Test. 2017; http://seniorfriendlyhospitals.ca/files/Clock%20Drawing%20Scoresheet_0.pdf.

52. Brodaty H, Moore CM. The Clock Drawing Test for dementia of the Alzheimer's type: A comparison of three scoring methods in a memory disorders clinic. *International Journal of Geriatric Psychiatry.* 1997;12(6):619-627.

53. Dubois B, Slachevsky A, Litvan I, Pillon B. The FAB: a Frontal Assessment Battery at bedside. *Neurology.* 2000;55(11):1621-1626.

54. Noone P. Addenbrooke's Cognitive Examination-III. *Occupational Medicine.* 2015;65(5):418-420.

55. Brain and Mind Centre. *The Addenbrooke's Cognitive Examination-III - Frequently asked Questions* The Univerity of Sydney;2017.

56. Rosen WG, Mohs RC, Davis KL. A new rating scale for Alzheimer's disease. *American Journal of Psychiatry.* 1984;141(11):1356 - 1364.

57. Rosen W, Mohs RC, Davis K. A new rating scale for Alzheimer's disease: Alzheimer's Disease Assessment Scale-Cognitive Subscale (ADAS-COG). *American Journal of Psychiatry.* 1984;141 (11):1356-1364.

58. Weyer G, Erzigkeit H, Kanowski S, Ihl R, Hadler D. Alzheimer's Disease Assessment Scale: Reliability and validity in a multicenter clinical trial. *International Psychogeriatrics.* 1997;9(2):123-138.

59. Reitan RM. *Trail Making Test: Manual for Administration and Scoring.* Arizona, USA: Reitan Neuropsychology Laboratory; 1992.

60. Tombaugh TN. Trail Making Test A and B: normative data stratified by age and education. *Archives of Clinical Neuropsychology.* 2004;19(2):203-214.

61. Marshall GA, Amariglio RE, Sperling RA, Rentz DM. Activities of daily living: Where do they fit in the diagnosis of Alzheimer's disease? *Neurodegenerative Disease Management.* 2012;2(5):483-491.

62. Australian Modified Lawton's IADL Scale. 2017; https://ahsri.uow.edu.au/aroc/lawtonsscale/index.html.

63. Johnson N, Barion A, Rademaker A, Rehkemper G, Weintraub S. The Activities of Daily Living Questionnaire: A validation study in patients with dementia. *Alzheimer's Disease & Associated Disorders.* 2004;18(4):223-230.

64. Quinn TJ, Fearon P, Noel-Storr AH, Young C, McShane R, Stott DJ. Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) for the diagnosis of dementia within community dwelling populations. *Cochrane Database of Systematic Reviews.* 2014;4:CD010079.

65. Jorm AF. A short form of the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE): Development and validation. *Psychological Medicine.* 1994;1(24):145-153.

66. Sikkes SA, de Lange-de Klerk ES, Pijnenburg YA, Scheltens P, Uitdehaag BM. A systematic review of Instrumental Activities of Daily Living scales in dementia: room for improvement. *Journal of Neurology, Neurosurgery, and Psychiatry.* 2009;80(1):7-12.

67. Gelinas I, Gauthier L, McIntyre M, Gauthier S. Development of a functional measure for persons with Alzheimer's disease: The disability assessment for dementia. *American Journal of Occupational Therapy.* 1999;53:471-481.

68. Gélinas I, Gauthier L. Disability Assessment For Dementia (DAD)1994.

69. Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale. *Journal of Psychiatry.* 1983;17:37-49.

70. Piersol CV, Earland TV, Herge EA. Caregivers of persons with dementia. *OT Practice*. Bethesda, MD: AOTA Press; 2012 www.AOTA.org.

71. Alzheimer's Australia NSW. At home with dementiaL A manual for people with dementia and their carers. 3rd ed. Sydney, NSW: Ageing, Disability and Home Care, Department of Family and Community Services NSW; 2011 http://www.adhc.nsw.gov.au/publications/documents/documents_a-z.

72. World Health Organisation. International classification of functioning, disability, and health : ICF. Version 1.0. Geneva : World Health Organization, [2001] ©2001; 2001 https://search.library.wisc.edu/catalog/999977181002121.

73. Mohammed A. Addressing sexuality in occupational therapy. *OT Practice.* 2017;22(9):CE1-CE8.

74. Austroads, National Transport Commision Australia. Assessing fitness to drive for commercial and private vehicle drivers: Medical standards for licensing and clinical management guidelines. 2016. https://www.onlinepublications.austroads.com.au/items/AP-G56-16.


Dementia
Training
Australia