

## **Understanding Stages: Dementia Decline by Levels- Handout**

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### **What is Dementia?**

“Dementia is not a disease itself, but rather a set of symptoms that may accompany certain other diseases.”

<http://www.cchs.net/health/healthinfo/docs/2300/2340.asp?index=9170>

**Symptoms** may include:

Memory (short-term first and then long-term),

Problem solving

Judgment

Ability to sequence events

**Diseases** Associated with Dementia include:

Dementia with Lewy bodies

Parkinson's Disease

Huntington's chorea

Vascular Disease (multi-infarct dementia)

Pick's Disease (fronto-temporal dementia)

But the most common disease is :

**Alzheimer's Disease:**

-Estimated over 5 million people in United States suffer from AD

-Accounts for 60 to 80 percent of dementia cases

### **Global Deterioration Scale (GDS)**

The Global Deterioration Scale (GDS) is one of the primary tools for staging dementia based on observation. Developed by Barry Reisberg, MD.

GDS is based on the theory that primary degenerative dementia (AD) can be broken down into 7 stages and takes place over approximately 8 to 20 years.

- Stage 1: No Cognitive Decline
- Stage 2: Very Mild Cognitive Decline
- Stage 3: Mild Cognitive Decline
- Stage 4: Moderate Cognitive Decline
- Stage 5: Moderately Severe Cognitive Decline
- Stage 6: Severe Cognitive Decline
- Stage 7: Very Severe Cognitive Decline

### **Review of the Stages:**

*GDS Stage 1: No Cognitive Decline*

### ***GDS Stage 2: Very Mild Cognitive Decline***

Referred to as “benign forgetfulness”

Subjective complaints of memory deficits

Deficits would not be identified in a very intense testing situation

Might be any one of us if we are having a bad day

### ***GDS Stage 3: Mild Cognitive Decline***

May be referred to as Mild Cognitive Impairment (MCI)

Earliest clear-cut deficits with intensive interview

Forgetfulness often noticeable to others who are intimate (spouse).

May be able to mask deficits from those who are not intimate (neighbors)

Poor work performance in cognitively demanding jobs.

May” show poor performance on concentration and calculation tests (MMSE)

May misplace objects of value such as financial documents

May be at risk for cons (schemes) directed towards the elderly

Forgets important appointments

Slower to learn new information

### ***GDS Stage 4: Moderate Cognitive Decline***

#### Behavior

Denial: you are the problem

Flattened expression

Withdrawal from challenging situations/or activity in general

Very focused

Anxious, angry, wants autonomy

Depression

Desires Autonomy

Tends to refuse things that are new or not their own idea

It is important to establish a relationship or rapport.

#### Physical Mobility

May walk more slowly or be more tentative in “new situations”

Spouse or close friend may note that gait has become slower

#### ADL's

Able to complete self care

Goal directed, understands beginning, middle and end of activity

May require structure and set up

Four to five steps of task when familiar.

Difficulties with Instrumental ADL's (IADLs)

Rigid with daily routine

Person is no longer a safe driver.

Vision Abilities according to ACL  
 4.6 scans the environment  
 4.4 see 3 to 4' and person on left & right  
 4.2 can see 24" & person on right side

### COMMUNICATION

Very functional and socially appropriate  
 Communication may be self centered  
 Able to make needs known  
 Able to participate in conversation  
 Difficulty naming objects, people, places  
 Limited reading comprehension  
 May need cues for word finding deficits  
 May take as long as 2 hours in conversation for the patient to demonstrate overt symptoms

### Caregiver approaches

May need to think of creative ways to encourage the patient to participate.  
 Spend time to develop a relationship.  
 When attempting to encourage task participation: Be reassuring. Be sure that the patient knows you will be there for assistance if needed.  
 Use way finding material

## ***GDS Stage 5: Moderately Severe Cognitive Decline***

### Behaviors

Not oriented to reality  
 Delusion is their perception of reality  
 Not goal directed  
 Perceive that he/she is 20 to 40 years old  
 Wandering with an agenda, on a mission  
 Upset if you are not part of his/her reality  
 Impatient, paranoid, suspicious  
 Sexual acting out  
 Depression

### Physical abilities

May physically feel cold, take longer for body temperature to adjust  
 Uses hands to manipulate objects  
 Uses different grasps for different objects  
 Sustains actions for a least a minute  
 Tunnel vision, 14" in front

### ADL'S

Begin to decline slightly

Benefits from verbal prompts, modeling, manual  
 Independent in toileting and eating  
 Losing ability to choose clothing  
 Senses completion of an activity when materials are used up.  
 Make activities failure proof

### Communication

Difficulty being understood, often repeats self  
 Complex language is hard to understand; does better with use of nouns versus pronouns, concrete words versus abstract words, simple statements versus complex stories  
 Not able to answer detailed questions  
 Able to name familiar objects

### Caregiver Approaches

24 hour care  
 Additional time to perform tasks (2-3 times)  
 Provide functional/rote activities  
 Engage and communicate with the patient  
 Adapt communication style to meet the needs of the patient

## ***GDS Stage 6: Severe Cognitive Decline***

### Behaviors

Wandering pattern: self-stimulation (Without verbalized agenda)  
 Delusions, suspiciousness, anxiety  
 Tearfulness, agitation/aggression  
 May begin “talking to themselves”  
 Visual hallucinations - 20 - 50% have delusions and hallucinations  
 May become paranoid or formally delusional  
 Obsessive symptoms: gets involved in repetitive tasks from the past  
 Environmental stimuli prompts behaviors  
 Much resistance to caregiver with unfamiliar person  
 Nurtures stage 7 and follows stage 5  
 May fear being alone  
 May go along with sex d/t loss of inhibitions. Often diminished sex drive  
 Act on what they think, feel, hear, sense, taste.  
 Loss of will power  
 Diminished sense of self  
 Rummages, no boundaries, everything is mine  
 Being cold or experiencing discomfort can facilitate hostility  
 Increase in negative behaviors/catastrophic events

### Physical Mobility

Loss of trunk rotation  
 Loss of righting reactions  
 Loss of peripheral vision

Downward gaze

ADL's

Unable to recognize everyday objects

Unable to sequence dressing or do fine manipulation, needs assistance both cognitively and physically with self care, except possibly self feeding

Motor Apraxia - Unable to sequence

Agnosia- Inability to recognize was is seen Unable to recognize everyday objects.

Late Loss ADL's effected by end of stage

May become incontinent, first nighttime then daytime fecal incontinence

Performs mechanics of toileting with structure

Days and nights mixed up

Hard time sitting for meals

Communication

May be no longer capable of speaking in sentences

Responses limited to 1 or a few words

May revert to using words from languages acquired earlier in life

Decreased communication of wants/needs

Connects with others through touching, shadowing

Body language and tone of voice are key

Responds only to those directly in front

Aphasic (word salad)

May be able to respond to simple yes no questions with regards to comfort

Sings with sense of Intonation

Caregiver Approach

Provide consistency in CNA/Staff assignments

Anticipate needs such as toileting, pain, and eating.

Simplify ADL tasks such as grooming, dressing, and bathing.

Don't convey frustration/negative emotion to the patient through non verbal communication or tone of voice.

Use manual, visual, tactile cues

Use modeling, mirroring or bridging techniques

***GDS Stage 7: Late Dementia***

ADL's

Unable to manage physical needs.

Dependent on others for survival.

Incontinent

Dependent for all ADL's including self feeding.

End of Life Dysphagia issues/Weight Loss

Malabsorption

Physical mobility

Lost basic psychomotor skills, dependent in functional mobility

Will lose ability to walk, sit up, hold up head

May have some trunk movement in bed (rolling)

May be able to raise body parts against gravity

Risk for skin breakdown, contractures, and loss of swallowing function

Communication

Basic verbal abilities lost

May respond with facial change, oral motor change, some repetitive words

May express self with yelling or grunting

May respond to stimulus of high contrast with increased tone, may turn head to track, may pinch or hit

May respond to touch

Difficulty establishing eye contact

Caregiver Approaches

Total Care, with comfort as focus

Provide sensory stimulation (OT referral?)

Diligent about falls prevention, skin management, positioning, contractures (PT/OT referral?)

Monitor swallowing function and weight/hydration (ST referral?)

## **NOW WE NEED TO UTILIZE RESIDUAL STRENGTHS TO DEVELOP INTERVENTIONS**

“As the disease progresses, there is little or no hope of recovery of memory, but people do not exist of memory alone. People have feelings, imagination, desires, drives, will and moral being. It is in these realms that there are ways to touch our residents and let them touch us.”

(Cohen & Eisdorfer 1986, 22)

### **Retained Strengths**

Emotional awareness

Sensory appreciation

Primary Motor function

Sociability and social skills

Procedural memory/habitual skills

Long-term memory

Sense of humor

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