# *Supporting Care Transitions for Persons with Dementia and Their Caregivers*

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None of the planners or presenters for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

# LEARNING OBJECTIVES

- Describe what a transition from one setting to another looks like
- Identify ways to ease transitions for the PWD (Person With Dementia)
- Identify ways to help caregivers with the transition
- Look at current research on the subject
- Develop one or two key takeaways that could help influence your practice in terms of easing transitions.
- Look at technology that can help ease transitions (if time)

# BRIEF INTRODUCTION TO MYSELF AND MY ROLE

- 20 years at the Veterans home this Summer
- No one, not one person, has said that this is where they always wanted to be..not once.
- There is a need for care settings, and "till death do us part" is not always a realistic goal.

# BREAK INTO GROUPS

- Go around your group and introduce yourselves
- What type of work do you do and how long have you been in your current position?
- The person in place the longest in group spokesperson for this exercise
- Write down what your group thinks about when they hear the word "transition"
- Come back to large group and present what your group discussed.

# STATE OF RESEARCH ON VITAL ROLE OF TRANSITIONS

During Covid a lot of issues became magnified. Transitions was clearly not a smooth-running part of the health care system and became a glaring issue during Covid.

# TRANSITIONS

- Transitions happen when there is a catalyst
- Transitions can, and often do, involve changes in settings (SNF, ALF, downsizing, living with family, etc.)
- Transitions can also involve changes in abilities-no longer able to leave alone, gets lost in familiar places, no longer recognizes familiar people, etc.)
- New symptoms-hallucinations, exit seeking, bathing, continence
- End of life transitioning

# RESEARCH
# CATALYSTS, BUFFERS, FACILITATORS, AND OBSTACLES

Let's spend a few minutes looking at transitions using the model of existing conflicts, possible buffers, becoming a facilitator and navigating obstacles.

# CATALYSTS

We discussed that catalysts can be many different types of events/changes

# BUFFERS TO HELP WITH TRANSITION

- *If you're able to step back and take steps like getting the powers of attorney, adjusting the household arrangements…you become much more resilient, and that resilience cushions you against… the next part of that transition.*

# FACILITATORS

- Positive relationships with health care providers

# OBSTACLES
# EVERYONE WANTS TO STAY AT HOME

It is vital to recognize that any transition to a facility comes with stigma and layers of preconceived notions(both good and bad)

# A FEW TECHNIQUES TO REDUCE/MINIMIZE OBSTACLES

-Myth of “Summer Camp” model

-Strategies to ease “saying goodbye”

# FAMILIES/CAREGIVERS CAN FEEL PUSHED TO THE SIDE

Caregivers, even medical professionals, can feel pushed to the side and “not heard”.

-Encourage writing down schedules, habits, unique experiences, prior to a transition (home care or a facility)

# *OBSTACLES CONTINUED*

*CONFLICTING GOALS* WERE INDICATED TO HAVE CAUSED PROBLEMS DURING TRANSITIONS WHEN PARTICIPANTS FELT THAT THEIR VIEWS WERE NOT RESPECTED IN THE HEALTH CARE TEAM. SOMETIMES, SYSTEM GOALS DIRECTLY OPPOSED AND "OUTRANKED" THE GOALS OF PERSONS WITH DEMENTIA AND THEIR CAREGIVERS.

*Trying to book these events…[the coordinator's] goals were different than mine. Mine were to make [my husband] happy with the people that came, to try and make it as few new faces as possible… Her goal was to have you be specific about the exact times that you would want those PSWs (personal support workers, a.k.a. nursing aides), and to have it a regular weekly booking(Ashborne, 2021).*

# CLARIFY GOALS AND EMPOWER FAMILIES TO BE CLEAR ABOUT GOALS

# FRACTURED HEALTH CARE SYSTEM IS AN OBSTACLE

# DIFFERING REALITIES AND GOALS: IN CONFLICT AND ALIGNMENT

*CONFLICTING REALITIES* OFTEN LED TO COMMUNICATION DIFFICULTIES DURING TRANSITIONS. ONE CAREGIVER, 57, EXPLAINED HOW HER HUSBAND'S VIEW OF REALITY DID NOT ALIGN WITH HERS IN SAYING: *"…HIS OPINION OF WHAT HE IS CAPABLE OF AND REALITY IS NOT ALWAYS THE SAME."(ASHBORNE, 2021)*

# EDUCATION TO THE CAREGIVER ON DEMENTIA CAN HELP BRING REALITIES INTO ALIGNMENT

-Help families see all distress as a form of communication

-Help friends and families develop empathy versus sympathy

-I have found that strengthening the empathy muscle can greatly develop the "patience" system

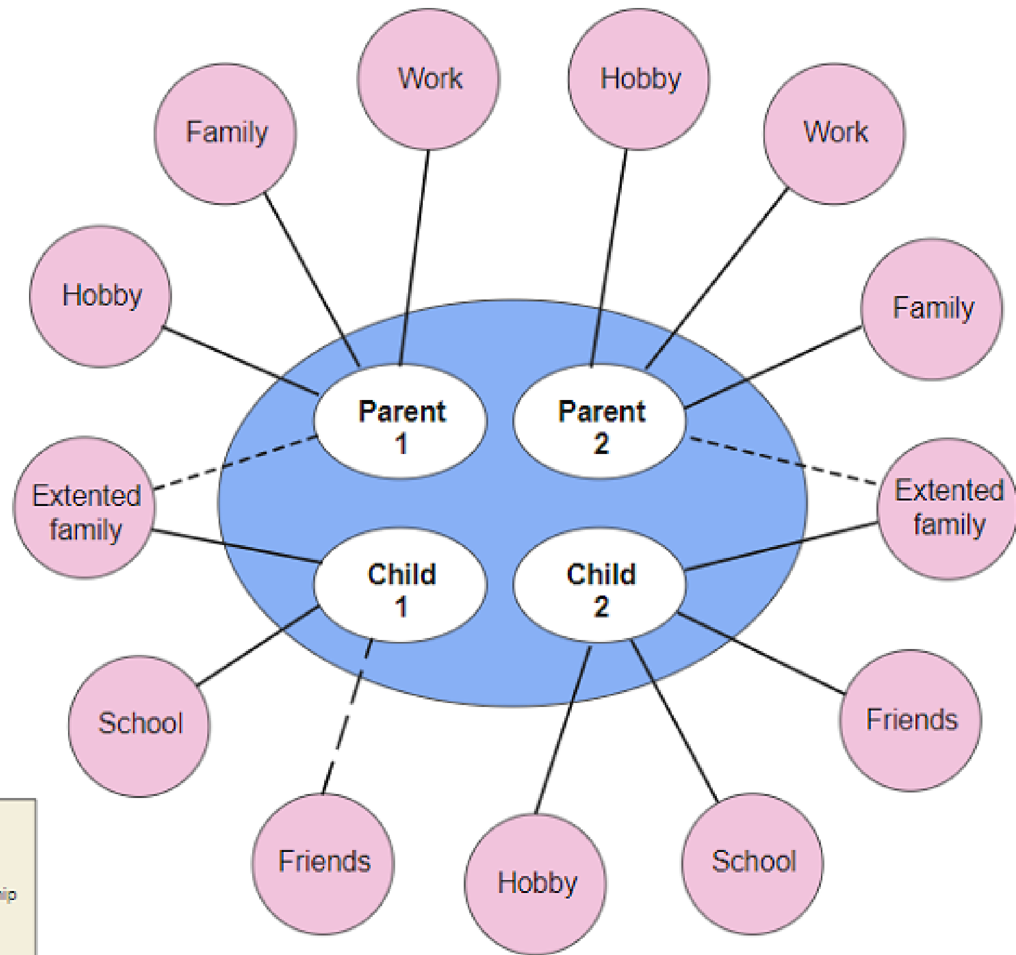
-Educate on where support is.  People do not always see/acknowledge support systems. Use an EcoMap

# EXERCISE TO HELP BUILD EMPATHY AMONG STAFF AROUND TRANSITIONS AND LOSS/ADJUSTMENT

Values Clarification Exercise

# QUICK EXERCISE TO BUILD EMPATHY MUSCLES

- Write down your top ten favorite things…
- Now let's go on a little journey…
- What/who do you have left?


Work
Hobby
Family
Work
Hobby
Family
Parent
1
Parent
2
Extented
family
Extented
family
Child
1
Child
2
School
Friends
Friends
Hobby
School
Positive relationship
Negative or distant relationship
Relationship is needed

# ECOMAPS TO IDENTIFY RESOURCES

- Put the person in the middle
- Draw a picture of where the resources exist and use different types of lines to drawa the strength of that relationship

# PAIR UP

- Brief practice of doing ecomaps-indetifying strengths and resources

# LEARN FROM WHAT WE JUST WENT THROUGH

# EXPERIENCES FROM 25 YEARS OF DEMENTIA CARE ON PINCH POINTS IN TRANSITIONS

- Myth of "Summer Camp" model
- Strategies to ease "saying goodbye". Have a plan!

# KEY POINTS

- Following are tips to help facilitate a smooth transition:
- Be Prepared: Create a “go kit” that includes personal, medical, and daily living items.
- Communication: Alert staff at settings of the person’s medical history (e.g., current medications, allergies, physical limitations, hearing or eyesight problems) and preferences (e.g., food, leisure and daily schedule).
- Documentation: Ensure that the facility has the individual’s health and legal documents (e.g., power of attorney, Do Not Resuscitate) on-file.
- Advocate: Act as an advocate, communicating the person’s known wishes or, if wishes are not known, try to make decisions that are in their best interest.
- Coordination of Care: Get to know each member of the person’s medical team and understand their responsibilities in care planning. To ensure optimal care, it is important that everyone is on the same page.
- Environment: Whether a hospitalization or a long-term care transition, the comforts of home can help. Photos, personal care products and other favorite items can make a new space feel more familiar and personal.
- Observe: A transition can be overwhelming and can affect a person’s overall wellbeing, causing changes in mood and behavior. Lessen these changes by helping with the adjustment by bringing personal items.
- Resources: Familiarize yourself with community support services (e.g., home care, Meals on Wheels) to ensure the person’s safety and immediate needs are met.
- Follow Up: Speak with the medical team throughout the entire transition process.
- Support: Be supportive by remaining calm and attentive. Showing the person love and care can help them adapt to the changes.

Alzheimer's Foundation of America | Care Transitions (alzfdn.org)

# TECHNOLOGY THAT CAN ASSIST WITH TRANSITIONS

- Smart plugs that monitor appliances
- Medical alert devices
- Location trackers
- Voice reminders using Smart Speakers "Alexa"
- In home monitors (Ring type devices)
- Large adaptive clocks
- Talking photo albums
- Music and memory-Playlists and more
- Adapted telephones
- Automated pill dispensers
- ADL support-razers, eating aides, elevated toilets, three sided toothbrush, adaptive clothing
- Futuristic stuff-Telepresent robots, Robotic pets, wearable monitors (B/P., temp. etc), Augmented reality glasses.

# REFERENCES


- Ashbourne, J., Boscart, V., Meyer, S. *et al.* Health care transitions for persons living with dementia and their caregivers. *BMC Geriatr* **21**, 285 (2021). https://doi.org/10.1186/s12877-021-02235-5
- Alzheimer's Foundation of America | Care Transitions (alzfdn.org)-Care Transitions