

Dementia Care: Tips for ADLs

Instructor Guide



UPDATED JUNE 22, 2011



Care and Compliance Group, Inc • 800.321.1727 • www.careandcompliance.com

INSTRUCTOR GUIDE:
DEMENTIA CARE: TIPS FOR ADLS

Overview	This module addresses that residents should be encouraged to remain as independent as possible. We will discuss when residents require assistance, approaches will be unique to each resident; when continued refusal occurs, staff must solicit help from a supervisor; and why it is important to share information with coworkers about what approaches work best for each resident.
Video(s)	"Dementia Care: Tips for ADLs" (41 minutes)
Special Supplies	Providing assistance with activities of daily living (ADLs) to residents with cognitive impairments can be challenging for your care staff. This training includes a video that addresses important tips and techniques. During your training with your staff you should address individualized care plans and strategies specific to the needs of your residents.
Learning Objectives	<ol style="list-style-type: none">1. Help for caregivers when serving residents with dementia;2. The future of Alzheimer's disease;3. Lewy body dementia;4. Vascular dementia;5. Frontotemporal lobe dementia;6. Creutzfeldt-Jakob disease (CJD);7. Huntington's disease;8. HIV/AIDS related dementia: AIDS dementia complex (ADC);9. Co-morbidity;10. Urinary tract infection and dementia;11. Dysphagia and aspiration;12. Skin breakdown;13. Physical care of residents with dementia;14. Pre-appraisal;15. Fundamentals of ADL care;16. Incontinence care;17. Falls.

QUIZ: DEMENTIA CARE: TIPS FOR ADLS

Name: _____

Date: _____

1. If a resident insists on wearing the same clothes every day, it may be helpful to:
 - a. Remove the soiled clothing at night when the resident is sleeping
 - b. Let the resident continue to wear the clothing, it is their choice
 - c. Do not allow the resident to put on the same clothes in the morning

2. Which of the following may be the cause of a resident becoming aggressive when performing personal care?
 - a. Feeling pain and not being able to communicate it
 - b. Not understanding what is being done to them
 - c. A caregiver invading their personal space
 - d. The resident feeling overwhelmed
 - e. All of the above

3. Encouraging a resident's family to bring items that are familiar and comforting to the resident can help bring a sense of home to the resident.
 - a. True
 - b. False

4. When beginning a shower or bath:
 - a. Set the water temperature so that it is comfortable
 - b. Let the resident feel the water with their hands first, and then adjust the temperature to their wishes
 - c. a & b

5. A very cool room temperature is always the best environment for toileting.
 - a. True
 - b. False

6. When a caregiver is brushing the teeth of a resident, use:
 - a. Quick vigorous brush strokes
 - b. Use gentle short strokes
 - c. Caregivers may never brush a resident's teeth

7. When a resident sits down for a meal:
 - a. Ask them to eat as quickly as possible
 - b. Use an authoritative tone of voice and tell them to "eat now"
 - c. None of the above

8. If a resident wishes to eat when pacing, a banana may be a good food choice.
 - a. True
 - b. False

9. Finger foods are not encouraged as they may make the resident feel like a child.
 - a. True
 - b. False

10. When serving a resident their meal, many times it is easier for the resident if you:
 - a. Place one ready to eat item from the meal on the table before the resident sits down, and then bring the remaining items one at a time
 - b. Have the resident serve themselves from serving bowls at the center of the table

11. Surrounding the resident with 3 or 4 care staff when toileting may:
 - a. Offer a sense of security
 - b. Cause fear and resistance to toileting

12. When a resident is making inappropriate weather related clothing choices:
- a. Tell the resident that they may not wear those clothes and pick something the caregiver feels is more appropriate
 - b. Let the resident wear whatever they want
 - c. As the weather changes throughout the year, pack up in storage boxes the inappropriate clothing so the resident will have appropriate choices in their drawers/closet

13. It is best practice when bathing a resident to make sure they are close to the hot water controls so the resident may adjust temperature as desired.

- a. True
- b. False

14. In some cases, it is more comfortable for a resident to undress in their room, place a robe on, and then enter the bath area.

- a. True
- b. False

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Certificate of Completion

THIS IS TO RECOGNIZE

FOR DEDICATION TO QUALITY RESIDENT CARE
THROUGH EDUCATION AND PROFESSIONAL DEVELOPMENT.

DEMENTIA CARE: TIPS FOR ADLS

Instructor Signature

Date

Dementia Care: Tips for ADLs

Learner Workbook



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HELP FOR CAREGIVERS

Studies funded by several Institutes, including the NIA, NINR, and NIMH, have found that caring for a person with AD is highly stressful and can contribute to negative physical and psychological health outcomes.

Caregiver research is beginning to discover effective ways to ease the burden of caregiving. Researchers have learned that:

1. The needs of caregivers evolve over time as AD progresses.
 - Support programs should be tailored to the needs of the caregiver at various stages of caregiving.
2. Traditions and attitudes about caregiving vary across cultural groups.
 - Programs and services for caregivers must be culturally appropriate and sensitive.
3. Use of multiple types of support over an extended period of time helps caregivers.
 - Caregivers may need help and support for months.
4. Help caregivers become educated about AD, improve flexibility in responding to caregiving demands, and learn a variety of practical strategies can help.

Studies have found it is helpful to teach caregivers:

- How to read the emotional and physical cues of the person with AD
 - How to understand the sequence of events that often leads to inappropriate behaviors
 - How to respond to the needs of the person with AD in a variety of creative ways, such as:
 - Maintaining flexibility in the face of many demands
 - Becoming educated about the disease
 - Learning practical strategies
 - Using available resources
 - Involving other family members and friends, and
 - Balancing the needs of the person with their own needs
5. Help caregivers deal with the complicated issue of whether and when to place a loved one in a nursing home.
- One clinical trial tested the effects of an enhanced counseling and support program on nursing home placement and caregiver health.
 - Participants in the program were able to delay placement of their loved ones in nursing homes by about 18 months.

6. Helping caregivers stay physically active has big benefits.
 - Researchers have found that regular moderate exercise is an important stress reliever for caregivers and helps to:
 - reduce blood pressure increases due to stress
 - improve sleep quality
 - reduces psychological distress and depression

Recent Studies:

An emerging body of findings suggests that chronic stress has a negative impact on the immune system. A study by NIA investigators compared the immune cells of AD caregivers and a control group. They found strong evidence that the chronic stress of caregiving adversely affected the caregivers' immune function. The ultimate goal of AD research is to find ways to reduce stress and burden on caregivers.

Numerous NIA-supported Alzheimer's Disease Centers (ADC) are located around the country conduct research, provide investigator training and patient care, and support the research process by developing innovative strategies to improve participation of diverse populations in AD clinical trials.

For locations of Alzheimer's Disease Centers, go to:
<http://www.nia.nih.gov/Alzheimers/ResearchInformation/ResearchCenters>

THE FUTURE

Several NIA initiatives provide critical venues through which investigators can conduct interdisciplinary and collaborative AD research.

Alzheimer's Disease Centers

The NIA-funded Alzheimer's Disease Centers (ADCs) promote basic research, training and education, and technology transfer (www.nia.nih.gov/Alzheimers).

They also conduct multi-center and collaborative studies of diagnosis and treatment in AD, age-related neurodegenerative diseases, and normal aging.

Alzheimer's Disease Genetics Initiative

The Genetics Initiative collects blood samples and other clinical data from people with AD and their unaffected family members. Data is kept in a unique data repository for the initiative to providing DNA and cell lines to qualified investigators for genetics studies.

Alzheimer's Disease Genetics Consortium

Launched in 2007 to accelerate the application of genetics technologies to late-onset AD through collaborations among most of the leading researchers in AD genetics.

The Cognitive and Emotional Health Project

This initiative will spur advances in understanding changes in cognition and emotion in adulthood and what can be done to preserve and enhance positive outcomes

An important complement to the National Institutes of Health's (NIH) research initiatives in AD are its efforts to educate and inform people with AD, their families, the public, providers, and others interested in the disease. The NIA Alzheimer's Disease Education and Referral (ADEAR) Center (www.alzheimers.org) provides a variety of outstanding resources on AD, including information about caregiving, diagnosis and treatment, and results of research findings.

"The multi-faceted, collaborative AD research efforts [supported by the NIH, NIA, and others] . . . brings us closer to the day when we will be able to successfully manage or even prevent this terrible disease, which robs our older relatives and friends of their most precious possession—their minds."

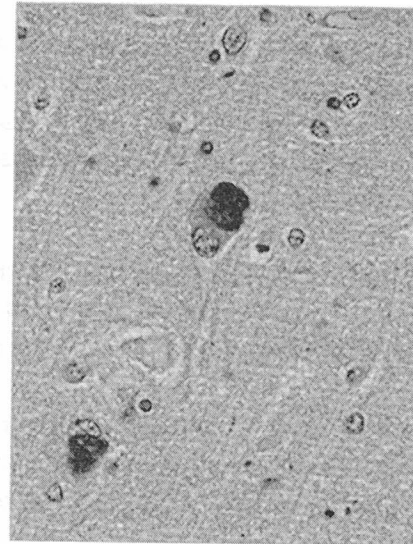
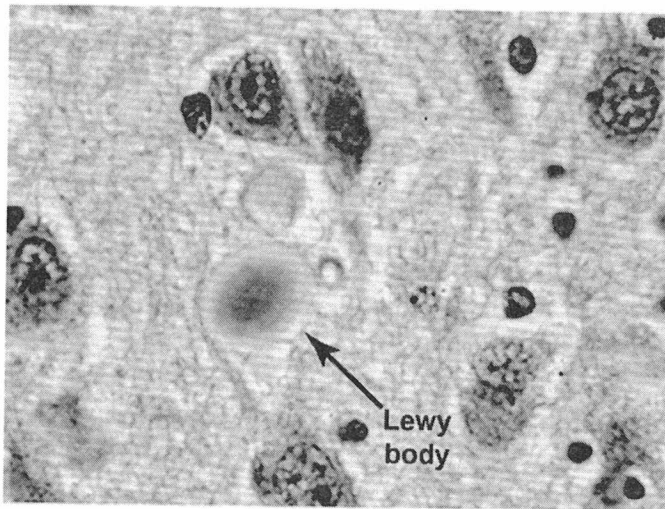
LEWY BODY DEMENTIA

Lewy body dementia (LBD) is a progressive brain disease and the second leading cause of degenerative dementia in the elderly. The clinical name, "dementia with Lewy bodies" (DLB), accounts for up to 20% of all dementia cases in the US. Over 50% of Parkinson's disease patients develop "Parkinson's disease dementia" (PDD). PDD is also a Lewy body dementia.

Other names for the Lewy body dementias are:

- Lewy body disease (LBD)
- Diffuse lewy body disease (DLBD)
- Cortical Lewy body disease (CLBD)
- Lewy body Variant of Alzheimer's (LBV)(LBVA)
- Parkinson's disease with dementia (PDD)

Microscopic view of Lewy bodies



The central feature of LBD is progressive cognitive decline, combined with three additional defining features:

1. Pronounced “fluctuations” in alertness and attention, such as frequent drowsiness, lethargy, lengthy periods of time spent staring into space, or disorganized speech,
2. Recurrent visual hallucinations, and
3. Parkinsonian motor symptoms, such as rigidity and the loss of spontaneous movement.

The earliest signs of LBD are:

- Sleep disturbance (including muscle movement during sleep)
- Loss of smell
- Medication reactions (may become psychotic with some medications)

Later signs of LBD may include:

- Abnormal response to medications (adverse reactions)
- Autonomic instability (such as get up, then fall back)
- High number of falls
- Visuospatial deficits (for example, a black mat may look like a black hole to a LBD resident)

The symptoms of LBD are caused by the build-up of Lewy bodies – accumulated bits of alpha-synuclein protein -- inside the nuclei of neurons in areas of the brain that control particular aspects of memory and motor control. Alpha-synuclein accumulation is also linked to Parkinson's disease, multiple system atrophy, and several other disorders, which are referred to as the "synucleinopathies." The similarity of symptoms between LBD and Parkinson's disease, and between LBD and Alzheimer's disease, can often make it difficult for a doctor to make a definitive diagnosis.

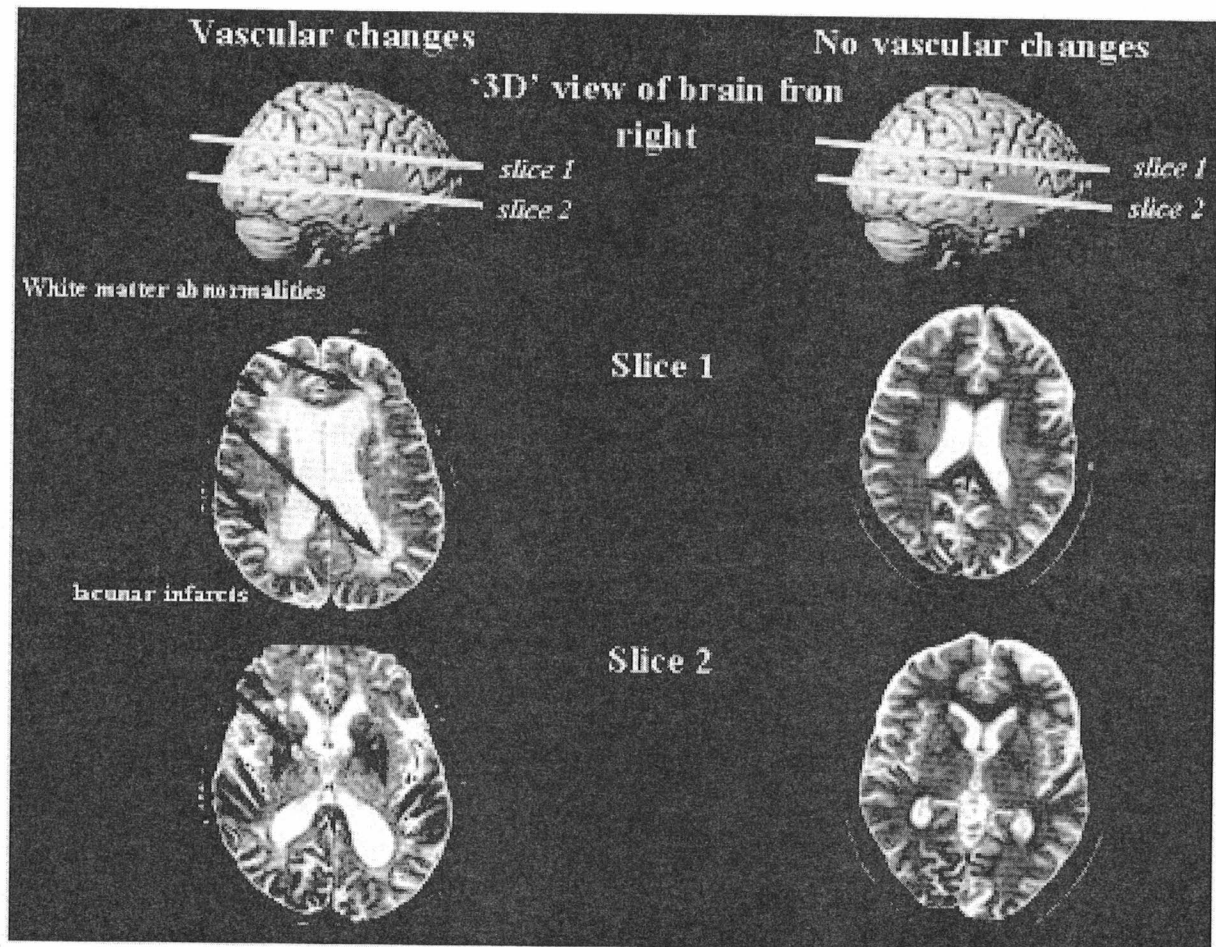
Lewy bodies are often also found in the brains of people with Parkinson's and Alzheimer's diseases. These findings suggest that either LBD is related to these other causes of dementia or that an individual can have both diseases at the same time.

There is no cure for LBD. There are no known therapies to stop or slow the progression of LBD. Treatments are aimed at controlling the cognitive, psychiatric, and motor symptoms of the disorder. Treatment can be difficult since many medications can make symptoms worse.

Like Alzheimer's disease and Parkinson's disease, LBD is a neurodegenerative disorder that results in progressive intellectual and functional deterioration. Average survival after the time of diagnosis is similar to that in Alzheimer's disease, about 8 years, with progressively increasing disability.

VASCULAR DEMENTIA

Multi-infarct dementia (MID), or vascular dementia, is thought to be the third most common cause of dementia in the elderly. MID is caused by multiple, tiny infarcts or strokes in the brain. A stroke is an injury to a blood vessel (either a clot in the vessel or the tearing of the vessel wall) that results in bleeding into brain tissue.



Some of these strokes may occur without noticeable clinical symptoms, but over time, as more areas of the brain are damaged and more small blood vessels are blocked, the symptoms of MID begin to appear.

Symptoms include:

- confusion or problems with short-term memory
- wandering, or getting lost in familiar places
- walking with rapid, shuffling steps

- losing bladder or bowel control
- laughing or crying inappropriately
- having difficulty following instructions
- having problems counting money and making monetary transactions

MID, which typically begins between the ages of 60 and 75, affects men more often than women. MID can be diagnosed by an MRI or CT of the brain, along with a neurological examination. However, the symptoms of MID are so similar to Alzheimer's disease, it can be difficult for a doctor to make a firm diagnosis. Since the diseases often occur together, making a single diagnosis of one or the other is even more problematic.

There is no treatment available to reverse brain damage that has been caused by a stroke. Treatment focuses on preventing future strokes by controlling or avoiding the diseases and medical conditions that put people at high risk for stroke: high blood pressure, diabetes, high cholesterol, and cardiovascular disease. The best treatment for MID is prevention early in life – eating a healthy diet, exercising, not smoking, moderately using alcohol, and maintaining a healthy weight.

The prognosis for individuals with MID is generally poor. The symptoms of the disorder may begin suddenly, often in a step-wise pattern after each small stroke. Some people with MID may even appear to improve for short periods of time, then decline after having more silent strokes. The disorder generally takes a downward course with intermittent periods of rapid deterioration. Death may occur from stroke, heart disease, pneumonia, or other infection.

FRONTOTEMPORAL LOBE DEMENTIA

Frontotemporal dementia (FTD) describes a clinical syndrome associated with shrinking of the frontal and temporal anterior lobes of the brain. The photos on the next two slides vividly show the shrinking of the frontal lobe of the brain in the comparisons.

Usually affects individuals between the ages of 40 and 60, the age of onset may range from 20 to 80.

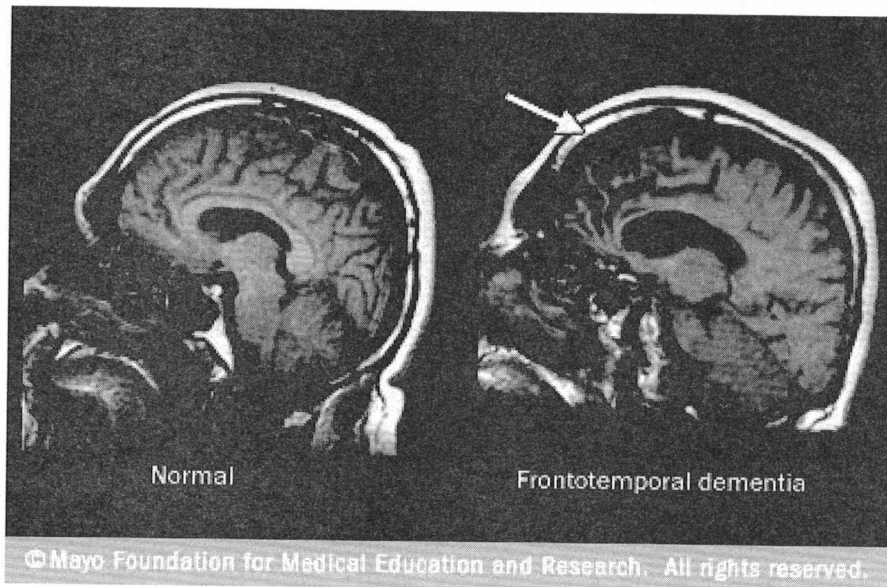
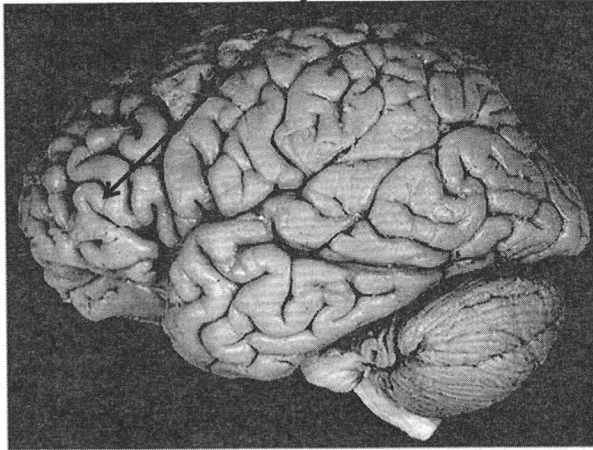
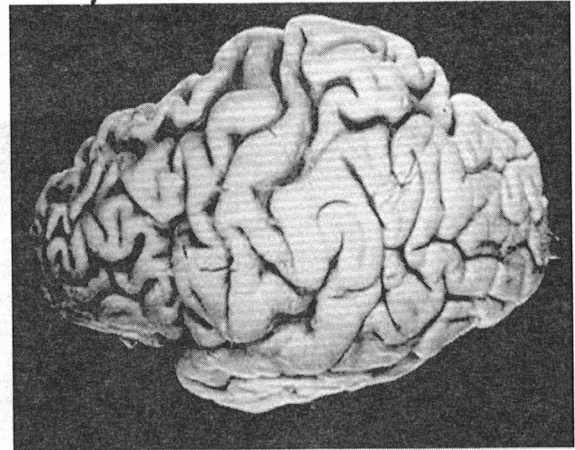


Image obtained from: <http://georgiahealthinfo.gov/cms/node/106167>

Comparison: Frontal Lobe



Normal brain



Brain with frontotemporal lobe atrophy

Frontotemporal dementia (FTD) is also known as:

- Pick's Disease
- Primary Progressive Aphasia
- Semantic Dementia
- Dementia – Semantic

Originally known as Pick's disease, the name and classification of FTD has been a topic of discussion for over a century. The current designation of the syndrome groups together Pick's disease, primary progressive aphasia, and semantic dementia as FTD.

The symptoms of FTD fall into two clinical patterns that involve either:

1. changes in behavior, or
 2. problems with language
-
1. The changes in behavior may include:
 - either impulsive (disinhibited) or bored and listless (apathetic)
 - inappropriate social behavior or lack of social tact
 - lack of empathy

- distractibility
 - loss of insight into the behaviors of oneself and others
 - an increased interest in sex
 - changes in food preferences
 - agitation or, conversely, blunted emotions
 - neglect of personal hygiene
 - repetitive or compulsive behavior
2. The problems with language may include difficulty making or understanding speech, often in conjunction with the previously discussed symptoms associated with the behavioral type of FTD.
- One of the difficulties for families and the physician attempting to make a diagnosis is that spatial skills and memory remain intact.

No treatment has been shown to slow the progression of FTD. Behavior modification may help control unacceptable or dangerous behaviors, such as aggression and/or agitation. There is a strong genetic component to the disease; FTD often runs in families.

The outcome for people with FTD is poor. The disease progresses steadily and often rapidly, ranging from less than 2 years in some individuals to more than 10 years in others. Eventually some individuals with FTD will need 24-hour care and monitoring at home or in an institutionalized care setting.



Learning Exercise:

DEMENTIA SPECIALTY TRAINING: Check for Understanding

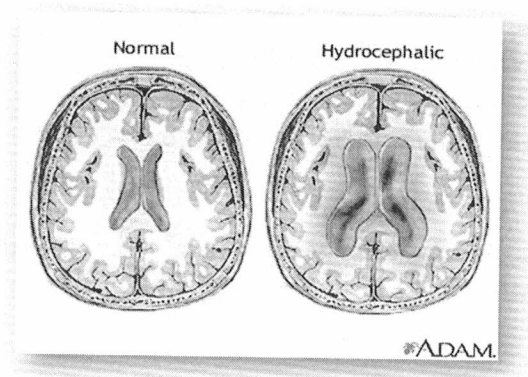
Pick's disease is also called:

- A. Lewy Body Dementia
- B. Alzheimer's disease
- C. Vascular dementia
- D. Frontotemporal lobe dementia

Explain your answer:

NORMAL PRESSURE HYDROCEPHALUS

Normal pressure hydrocephalus (NPH) is an abnormal increase of cerebrospinal fluid (CSF) in the brain's ventricles, or cavities. It occurs if the normal flow of CSF throughout the brain and spinal cord is blocked in some way. This causes the ventricles to enlarge, putting pressure on the brain.



Normal pressure hydrocephalus can occur in people of any age, but it is most common in the elderly population. It may result from a subarachnoid hemorrhage, head trauma, infection, tumor, or complications of surgery, or may occur from an unknown reason.

Symptoms of NPH include:

- progressive mental impairment and dementia
- problems with walking
- impaired bladder control leading to urinary frequency and/or incontinence
- a general slowing of movements or may complain that his or her feet feel "stuck"

Because these symptoms are similar to those of other disorders, the disorder is often misdiagnosed or goes unrecognized and is never properly treated. The symptoms of NPH usually get worse over time if the condition is not treated.

Doctors may use a variety of tests, including brain scans (CT and/or MRI), a spinal tap or lumbar catheter, intracranial pressure monitoring, and neuropsychological tests, to help them diagnose NPH and rule out other conditions.

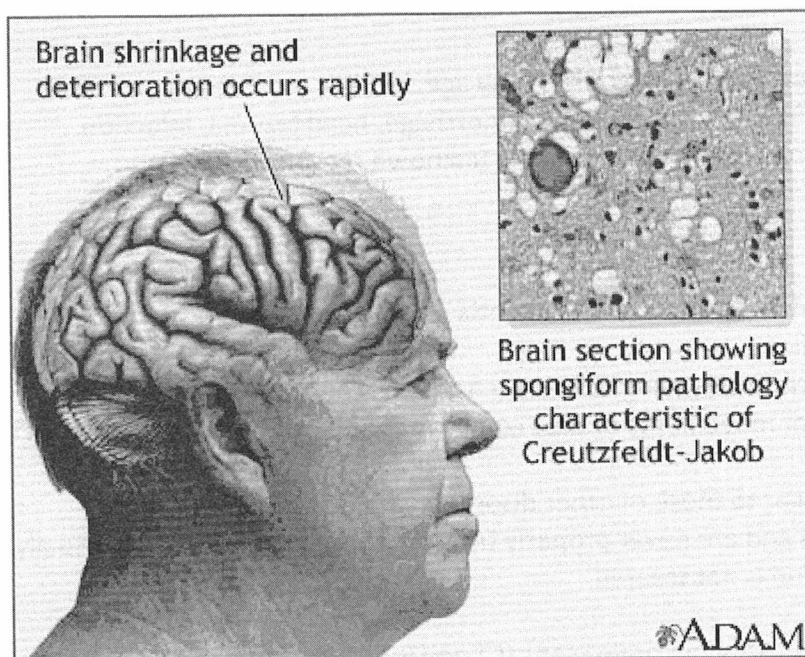
Treatment for NPH involves surgical placement of a shunt in the brain to drain excess CSF into the abdomen where it can be absorbed. This allows the brain ventricles to return to their normal size. Regular follow-up care by a physician is important in order to identify subtle changes that might indicate problems with the shunt. While the success of treatment with shunts varies from person to person, some people recover almost completely after treatment.

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CREUTIZFELDT-JAKOB DISEASE (CJD)

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Animal TSE diseases include scrapie in sheep and goats; chronic wasting disease in deer, elk and moose; bovine spongiform encephalopathy (BSE) in cattle ("Mad Cow disease"); and feline spongiform encephalopathy in cats.



Creutzfeldt-Jakob disease (CJD) is a rare, degenerative, invariably fatal brain disorder. In the United States there are about 200 cases per year. CJD is characterized by rapidly progressive dementia.

Typically, onset of symptoms occurs about age 60, and about 90 percent of patients die within 1 year. In the early stages of disease, patients may have failing memory, behavioral changes, lack of coordination and visual disturbances. As the illness progresses, mental deterioration

becomes pronounced and involuntary movements, blindness, weakness of extremities, and coma may occur. There are several known variants of CJD. These variants differ somewhat in the symptoms and course of the disease.

There are three major categories of CJD:

- In sporadic CJD, the disease appears even though the person has no known risk factors for the disease (most common; 85% of cases).
- In hereditary CJD, the person has a family history of the disease and/or tests positive for a genetic mutation associated with CJD (5 to 10% of cases).
- In acquired CJD, the disease is transmitted by exposure to brain or nervous system tissue, usually through certain medical procedures (1% of cases).

There is no evidence that CJD is contagious through casual contact with a CJD patient.

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There is no treatment that can cure or control CJD. Current treatment for CJD is aimed at alleviating symptoms and making the patient as comfortable as possible.

HUNTINGTON'S DISEASE

Huntington's disease (HD) results from genetically programmed degeneration of brain cells, called neurons, in certain areas of the brain. This degeneration causes uncontrolled movements, loss of intellectual faculties, and emotional disturbance.

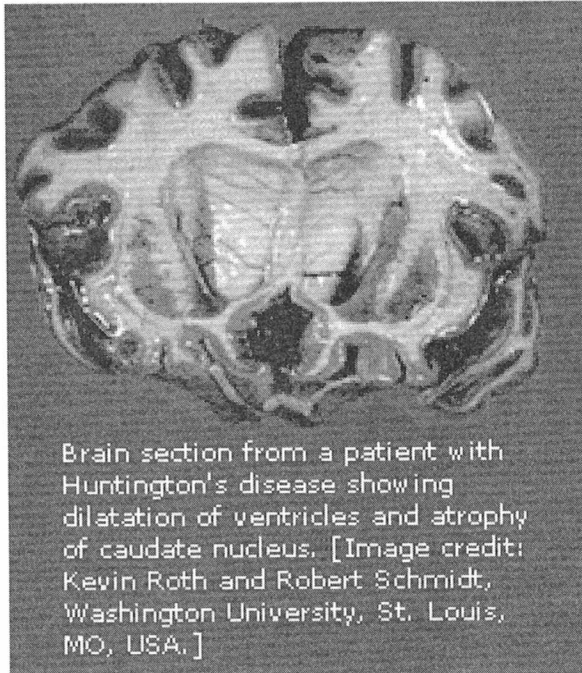


Image from: <http://www.ncbi.nlm.nih.gov/disease/GIFS/HD.gif>

HD is a familial disease, passed from parent to child through a mutation in the normal gene. Each child of an HD parent has a 50-50 chance of inheriting the HD gene. A person who inherits the HD gene will sooner or later develop the disease. A genetic test, coupled with a complete medical history and neurological and laboratory tests, helps physicians diagnose HD. In 1 to 3 percent of individuals with HD, no family history of HD can be found.

Some early symptoms of HD are:

- mood swings, depression, irritability or trouble driving, learning new things, remembering a fact, or making a decision.

As the disease progresses, concentration on intellectual tasks becomes increasingly difficult and the patient may have difficulty feeding himself or herself and swallowing.

The rate of disease progression and the age of onset vary from person to person.

Physicians prescribe a number of medications to help control emotional and movement problems associated with HD. It is extremely important for people with HD to maintain physical fitness as much as possible, as individuals who exercise and keep active tend to do better than those who do not.

At this time, there is no way to stop or reverse the course of HD.

HIV/AIDS RELATED DEMENTIA: AIDS DEMENTIA COMPLEX (ADC)

Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome can cause dementia. Since the development of better anti-HIV therapy fewer cases of AIDS dementia have been reported in America and in Europe.

The type of dementia that people with HIV get can differ from person to person. It is reported that about 15 to 30% of people with HIV infection show mild neuropsychological problems. These symptoms of HIV dementia can be so mild that people suffering from HIV infection resulting in dementia may not be aware of them.

As the symptoms of HIV dementia increase and become evident it may mean that the HIV infection has progressed to AIDS (Acquired Immune Deficiency Syndrome). Severe dementia demonstrating a progression from HIV to AIDS occurs in about 20% of older patients. Cognitive impairment associated with HIV disease is most widely called **AIDS dementia complex (ADC)**. ADC has a varied spectrum of clinical manifestations and severity.

AIDS Dementia Complex (ADC) is also known as:

- HIV dementia
- HIV encephalopathy
- HIV-associated dementia
- HIV-associated neurocognitive disorder

The term, AIDS Dementia Complex (ADC) encompasses cognitive deficits, behavioral changes, and motor involvement. Those affected with ADC may manifest deficits in each of the 3 aspects at varying severity. Some may present primarily with cognitive changes such as slowed processing of information captured by neuropsychological testing. Others may present for behavioral management. Others may be affected by motor symptoms such as unsteady gait, tremor, or weakness.

At one time 15 to 20% of all people with AIDS developed AIDS dementia complex. With the increasing success of retroviral drugs, the numbers of people progressing to AIDS dementia complex has halved. AIDS dementia complex is now more associated with people in the late

stages of AIDS when people affected suffer multiple infections because of their poor immune systems.

Symptoms of AIDS dementia complex include:

- Poor concentration
- Forgetfulness
- Loss of short-or long-term memory
- Social withdrawal
- Slowed thinking
- Short attention span
- Irritability
- Apathy
- Ego centric attitude-lack of caring or concern for oneself or others
- Weakness
- Poor coordination
- Impaired judgment
- Problems with vision
- Personality change

Aggressive treatment is required for AIDS dementia complex as it is associated with higher death rates. Treatment often included antiretroviral drugs. Ritalin (methylphenidate) a psycho stimulant can be helpful for lethargy and slowed thinking.

Antiretroviral drugs can cause temporary problems with cognition (mental activity such as thinking, attention, reasoning, decision making and dealing with concepts) and some people on this type of medication can become confused.

We encourage you to explore some excellent websites for learning about dementia and possible causes.

- <http://www.nia.nih.gov/Alzheimers/AlzheimersInformation/Causes>
- http://www.alz.org/national/documents/brochure_basicsofalz_low.pdf
- http://www.alz.org/alzheimers_disease_causes_risk_factors.asp
- <http://www.nia.nih.gov/alzheimers>
- <http://www.nlm.nih.gov/medlineplus/alzheimersdisease.html>
- <http://www.nia.nih.gov/Alzheimers/AlzheimersInformation/Symptoms>
- <http://www.nia.nih.gov/Alzheimers/AlzheimersInformation/Diagnosis>

CO-MORBIDITY

In the context of this course on dementia, co-morbidity is defined as other medical conditions that are existing simultaneously, but independently, with the resident's diagnosis of dementia. We are going to discuss the following four common medical conditions among elderly residents with dementia:

1. Respiratory infection
2. Urinary tract infection
3. Dysphagia and aspiration
4. Skin breakdown

Respiratory Infection

Residents with dementia should be frequently assessed for respiratory infection. Signs and symptoms include:

- thick green sputum
- cough
- fever
- fatigue
- behavior changes
- malaise

Interventions and Prevention

- Deep breathing exercises
- Frequent ambulation
- Changing of position
- Personnel and family or friends with respiratory infections should not come in contact with the client
- If signs and symptoms of a respiratory infection are noted the physician should be contacted

Urinary Tract Infection

Signs and Symptoms

- Frequent requests to void
- Restlessness
- Painful urination
- Refusal to urinate
- Grasping at “private parts”
- Strong urine odor
- Deeper color of urine
- Blood in urine
- Pus in urine
- Confusion
- Fever
- Malaise
- Crying or moaning, especially when voiding

Interventions include:

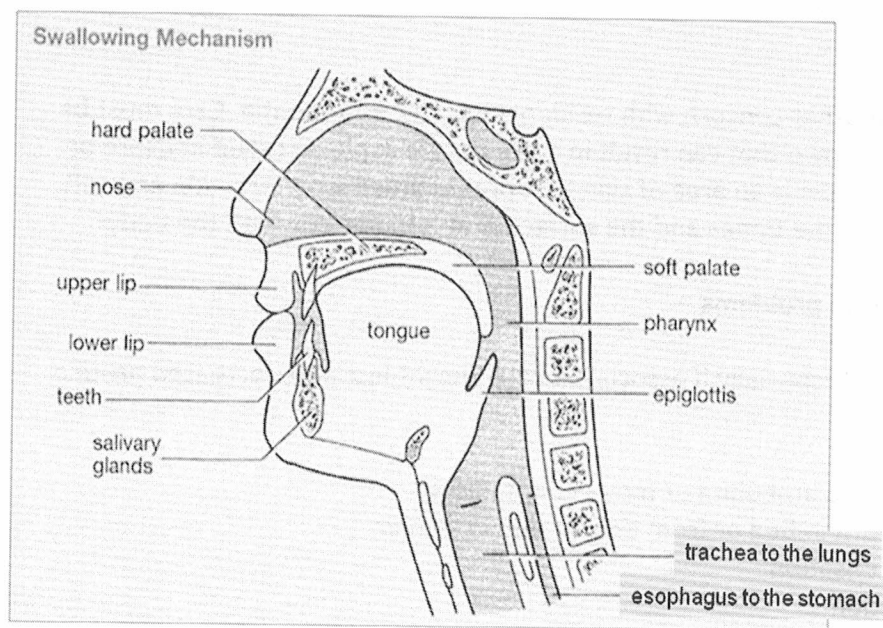
- Always maintain a supply of clean catch supplies in the community
- Develop a relationship with a lab for easy MD analysis ordering
- Don’t wait for a number of symptoms to test—test early
- Encourage fluids
- Meticulous perineal care
- Wipe front to back
- Head of penis down to scrotum

Dysphagia and Aspiration

Dysphagia refers to a difficulty swallowing. Aspiration refers to inhaling food or liquids into the lungs. The resident with dysphagia is more at risk for choking and aspiration. Dysphagia and aspiration may easily occur to residents who have a history of strokes, Parkinson's disease, and other neuromuscular disorders. Careful interventions must be followed to ensure the safety of the resident with dysphagia.

Swallowing mechanism: Take a look at the diagram on the next page that shows the swallowing mechanism.

Note the close proximity of the trachea that takes air to the lungs and the esophagus that takes food to the stomach. You can see how easy it would be for a resident to aspirate food or choke on food.



Signs and Symptoms

- Coughing and choking while eating
- Drooling or spilling food out of the mouth
- Pocketing food in the cheek
- Some residents may aspirate without any obvious symptoms (also known as “a silent aspirator”)
- Watch for signs and symptoms of a respiratory infection in residents at risk for dysphagia (e.g., cough, fever, chills, etc.)

Interventions to minimize aspiration include:

- Maintain a relaxed pace. Hurrying increases the likelihood of choking and aspiration.
- Instruct the resident not to talk for a few seconds after swallowing.
- Cut food into small bite-sized pieces.
- If the resident is weak or paralyzed on one side of the body place food into the mouth on the unaffected side of the mouth.
- Instruct the resident to swallow twice after every bite.
- Look in the cheek for food that may have been “pocketed.”
- Do not “wash down” food with liquids.
- Allow the resident to sit up or stand for 15 minutes after completing a meal or snack.

Skin Breakdown

Maintaining skin health is another concern with residents who have dementia. Care must be taken to minimize skin breakdown that can result in a pressure ulcer (also called bedsore or decubitus ulcer). A pressure ulcer is an area of skin that breaks down when the skin and soft tissues are squeezed between the bones and the surface that is in contact with the body.

Factors that contribute to skin problems

- Poor nutrition, especially if associated with weight loss and decreased protein intake
- Dehydration
- Lack of ability to ambulate or move about easily
- Inability to turn in bed or from side to side in a chair
- Decreased sensation
- Poor circulation
- Poor cognitive function
- Sliding down in a chair or bed when skin is tugged opposite of muscle and bone (shearing)
- Loss of bladder and/or bowel control
- Decreased activity

Areas most prone to skin breakdown:

- Bony prominences of the body
(sacral area, scapula, elbow, spinous process)
- Parts of the body where skin is in contact with skin
(under arms, under breasts, etc.)
- Body parts with poor circulation
(heels)

The three most common causes of pressure sores are:

1. Pressure

- Pressure from body weight on tissues as they become squeezed between bones and a surface restricts blood flow

2. Friction

- Frequent shifts in position are the key to preventing pressure sores.
- But, the friction that occurs when a resident simply turns from side to side can damage the skin, making it more susceptible to pressure sores.

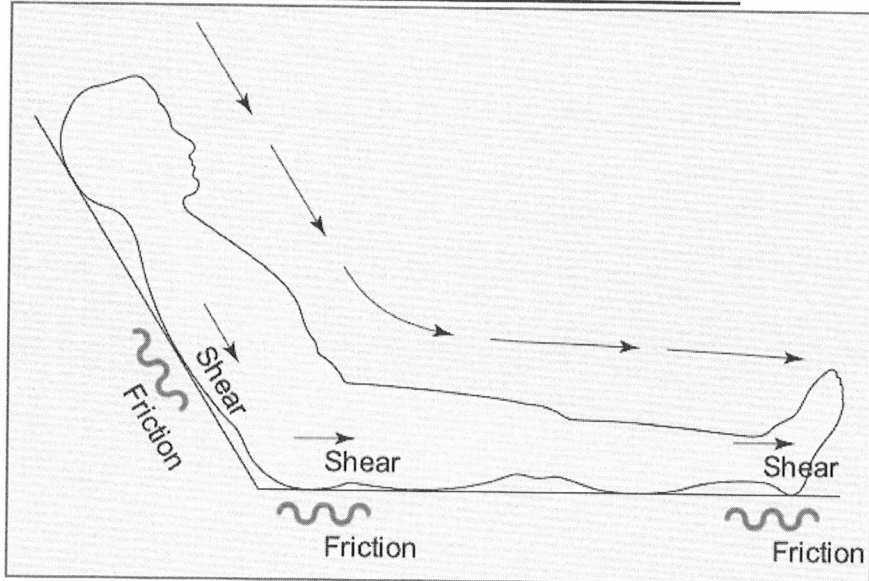
Most common causes of pressure sores, cont.:

3. Shear

- This occurs when the skin moves in one direction, and the underlying bone moves in another.
- Sliding down in a bed or chair or raising the head of your bed more than 30 degrees is especially likely to cause shearing, which stretches and tears cell walls and tiny blood vessels.
- Especially affected are areas such as the tailbone where skin is already thin and fragile.

The graph on the next page shows the areas prone to pressure sores due to pressure, friction, and shear.

Skin Areas Prone to Pressure, Friction, and Shear



Interventions include:

- Inspection
- Keep skin clean
- Keep skin properly moisturized
- Prevent chaffing and excessive wetness
- Encourage mobility and movement
- Provide incontinent care
- Report and document skin problems



Learning Exercise:

DEMENTIA SPECIALTY TRAINING: Check for Understanding

One way to help residents minimize the aspiration of food while eating is:

- A. Cut food in big pieces
- B. If a resident is chewing on a big piece, have them wash it down with water
- C. Instruct the resident to swallow twice after each bite
- D. If the resident is weak or paralyzed on one side of the body, place food into the mouth on the weak side of the mouth

Explain your answer:

PHYSICAL CARE OF RESIDENTS WITH DEMENTIA

Caring for all residents, especially those with dementia, must include a physical care assessment. A physical care assessment is an important way we learn to know about the needs of our residents. This helps us to:

- Determine the needs of this specific individual
- Determine if my facility is the best environment for care
- Verify there are no prohibited health conditions
- Consider risk management
- Develop a plan for appropriate care

Now that you understand the disease of dementia, let's look at how the disease impacts planning for the physical care needs of dementia residents.

Each individual will have different needs. We are going to discuss some of the physical care needs for persons with dementia for each of the following ADLs:

1. Bathing and hygiene
2. Dressing
3. Toileting and continence
4. Transferring/ambulation
5. Feeding

1. Bathing and hygiene

- The resident:
 - may not be aware of his or her needs
 - may be unaware of odors
 - may perceive self as able to perform
 - may resist care

2. Dressing

- The resident:
 - May not pick out appropriate clothing
 - May tend to wear the same clothing over and over
 - May feel violated if someone is assisting him to dress

3. Toileting and continence

- The resident:
 - May be aware of incontinence issues and attempt to hide it
 - May be unaware
 - May resist the use of briefs

- May be continent now, but experience functional incontinence once admitted
- May have skin breakdown issues

4. Transferring/Ambulation

- The resident:
 - May have increasing problems with mobility
 - May have medication induced problems
 - May have a gait disturbance related to degeneration
 - May not remember to use assistive devices
 - May be chair or bed bound
 - May be a significant fall risk

5. Feeding

- The resident:
 - May have difficulty maintaining weight
 - May require prompting and cueing
 - May have hydration issues because unaware of thirst
 - May have problems focusing on a meal

PRE-APPRAISAL

When you are responsible for pre-appraising a resident, make sure you gather accurate information. One of the ways you can enhance accuracy is to set a proper environment to obtain the information.

Setting the environment for the pre-appraisal

1. Provide adequate space, particularly if the person uses a mobility device
2. Meet with the family and responsible party—typically you will meet together and then separately
 - Rationale: Family often answer “for” the resident. Additionally, some discussion may be demeaning for the potential resident to overhear.
3. Minimize noise and distraction, such as turn off the radio, etc.
4. Plan the appraisal for a time of day the person will not be exhausted
5. Make sure your tone of voice and body language convey you are unhurried
6. Use good listening skills
7. Allow for silence--this gives the person time to collect his or her thoughts

It is essential to include an appraisal of activities of daily living (ADL). Here are some things you will want to be asking:

1. Location--Where does the resident usually perform the ADL?
2. Timing—When, how often?
3. How much assistance--prompt, cue, standby, total assist, 2 person?
4. Special equipment or tools needed?
5. Previous daily routine and schedule?
6. History of techniques for refusal or challenging behaviors?

The physical care assessment and the ADL appraisal, and other information, will help you create your Service Plan for your resident.

Appropriate service plans are important for persons with dementia. A good service plan unites care staff with common goals and methods of care delivery. Persons with dementia always do better with consistency in care. Consider the following when creating a service plan for a resident with dementia.

1. Poor assessments = poor service plans
2. CCL mandates a yearly update of the service plan
3. Use the name of the resident in the service plan to promote the personhood of this resident
4. Involve responsible party
5. Seek medical advice

FUNDAMENTALS OF ADL CARE

Now that you have pre-appraised the resident and created a service plan for the resident, there are some fundamental concepts associated with care delivery.

- Rely on information from pre-appraisal
- Be organized--gather equipment and supplies you will need
- Know thy resident--some want advance warning for care, for others it is a hindrance
- Utilize task breakdown as needed
- Utilize prompting and cueing
- Do not overreact to behaviors or refusal
- Make sure the environment is ready, such as privacy, bath temperature, etc.

Now, we are going to take a look at the fundamentals of ADL care in each of the following categories:

- Dressing
- Grooming
- Bathing
- Nutrition and eating

Dressing

1. Request ample supply of clothing from the family.
2. Clothing must fit well—always monitor for proper fit as a resident may have significant discomfort without complaining
3. Lay clothes out in the order to be put on
4. If impaired, put clothes on the weak side first and remove from strong side first
5. Roll up clothing to facilitate dressing, open zippers, etc. to avoid tugging and struggling
6. Remove soiled clothing from the room once off the resident to avoid redressing with soiled clothing.
7. Allow residents to wear favorites often--this can be a comforting factor.
8. Some residents dress many times a day. This cannot always be considered a problem.

Grooming

1. Request electric razor, unless safe with safety razor
2. Remove make-up once applied in the morning to prevent over-use
3. Baby tooth brushes are often easier when assisting—they may create less gag response
4. Keep hair styles to what the resident is used to having --avoid cutting hair or resorting to braids, etc.

5. Allow accessorizing if it was the resident's pattern—if he or she feels handsome or beautiful it makes an attitude difference
6. Watch details the resident may now overlook—dirty nails, poor hygiene in “crevices,” dry skin which needs lotion, etc.

Bathing

1. Have all supplies handy so the resident is not left unattended
2. Check the temperature of water
3. Allow the resident to put his or her hand in water to become accustomed to it
4. Provide a hand towel to protect the resident's face as needed
5. Use hand held showers to prevent the splashing that occurs with overhead showers
6. Pour water from a container when any shower device is unacceptable; some residents do not like any kind of spray
7. Use a grab bar to hold on to if standing for rinsing or perineal care
8. Distract the resident with pleasant conversation
9. Give the resident something to hold on to if resisting or slapping out

Nutrition and eating

The last fundamental of ADL care that we are going to discuss is nutrition and eating. This is a very important topic and is fairly long. We will be discussing nutritional concerns, dining fundamentals, and 8 factors that can cause problems with making sure our dementia residents get proper nutrition.

There are some nutritional concerns you may have.

- Is my resident getting enough to eat?
- Is my resident well nourished through good food choices?
- Is my resident safely consuming foods?
- Is my resident getting as much pleasure as possible from the dining experience?

Dining fundamentals

1. Don't overwhelm with food selections, but still promote choice
2. Have easy to consume foods available
3. Get the greatest “bang” from nutritionally sound food choices
4. Never rush a dementia resident when eating
5. Think safety--monitor food temperatures and size of bites
6. Have the resident clean his/her hands well before meals
7. Provide protective clothing as desired
8. Emotionally support the resident with sincere praise and reassurance
9. Provide good after meal hygiene (face wiped, hands and clothing clean, oral care, nail care)

It is important to make sure that our dementia residents get adequate nutrition. Inadequate nutrition can result in:

- Anemia
- Impaired activity
- Reduced healing capability
- Potential for skin breakdown

Let's look at 8 common factors which can lead to problems with ensuring good nutrition for our residents:

1. Communication issues
2. Lack of cues
3. Noise
4. Stress
5. Medication
6. Visual impairment
7. Oral problems
8. Mealtime issues

1. Communication Issues

- Our resident may not understand it is meal time
- Our residents often communicate to us through behaviors—refusal behaviors may be the resident's way of communicating anger, lack of control or powerlessness
- Interventions for communication problems

Communicate meal time using words your resident knows. Allow simple choice—maybe he is not ready to eat now, but will be in 10 minutes. Allow simple choices with foods as appropriate.

2. Lack of cues

- Interventions to assist with cueing
 - Provide pleasant aromas (open the door to the kitchen, use bread machines or crock pots, etc.)
 - Use visual clues (show off the foods)
 - Make sure the food is attractively plated
- Touch can be a cue as well
 - Allow the residents to participate in food preparation (always consider safety)
 - Place the napkin in his lap and allow him to feel the napkin

- Hearing can cue eating
 - The “noise” from pots and pans or a spoon stirring in a pot can be an audio cue
 - Ice clinking in a glass can cue drinking
 - Hearing a mixer running can evoke positive thoughts about food

3. Noise

- Interventions to prevent noise distractions
 - Avoid the use of nonfood preparation equipment at meal times (vacuums, etc.)
 - Staff should not use loud voices
 - Soft background music is positive for some residents

4. Stress

- Interventions to reduce stress
 - Allow the resident quiet time before the meal-don’t rush straight from an exhausting activity
 - Allow some residents to “eat on the run” –coercing them to sit is stressful
 - Some residents may do better if allowed to eat alone, rather than with table mates
 - Gentle soothing touch throughout the meal can be comforting for some (pat his hand, rub his shoulder)

5. Medications

- Medications can inhibit adequate nutrition
 - Simply passing the meds during mealtime can be an unpleasant interruption
 - The taste of the medication can remove the desire to eat
 - Side effects of drugs can affect appetite
- Interventions to reduce medication related problems with nutrition
 - Give meds without interrupting the meal
 - Keep the MD informed of appetite changes, especially when meds are changing
 - Work with the MD and pharmacist to give meds in a manner that minimizes bad taste (e.g., ask for flavored elixirs, giving meds with certain foods to reduce after-taste, etc.)
 - When necessary ask about retiming medication administration

6. Visual impairment

- Vision impairments can have an effect on food consumption
- It is normal for anyone to refuse to eat when he cannot discern what he is consuming
- Interventions for visual impairments
 - Provide adequate lighting
 - Use contrast when serving food (corn in a yellow bowl may be hard to consume)
 - Plates with a different colored border can help residents distinguish food placement
 - Explain food location for severe impairments, such as “Your peas are at 6:00 o’clock, your potatoes are at 10:00 o’clock, etc.”

7. Oral problems

- Oral problems can make mealtime miserable.
 - Poor dentition (missing or decayed teeth)
 - Ill fitting dentures
 - Sores in the mouth
 - Dry mouth
 - Chapped lips
- Interventions when residents have oral problems
 - Always seek regular dental care—suspect dental pain if sudden decrease in eating. Monitor for grimacing or other pain cues
 - Use mouth rinses as ordered
 - Get denture “re-lines” as often as necessary
 - Apply lip balm before meals
 - Have adequate fluids available

8. Mealtime issues

- Interventions to provide support during meal time
 - Staff should not take breaks off the floor during or close to resident meals
 - Bring in other facility staff as needed (e.g., maintenance, business office, volunteers, etc.)
 - Provide assistive devices (heavy mugs, curved silverware, plate guards) as necessary
- When residents require feeding:
 - Be seated with the residents.
 - Be relaxed and appropriately conversational
 - Serve appropriate sized bites

- Allow the resident to control the pace
- When residents have swallowing problems:
 - Seek a medical evaluation and follow physician recommendations stringently
 - Use thickeners as appropriate
 - Make sure the food comes from the kitchen appropriately prepared – serving the wrong foods can be deadly
 - Make sure the resident is sitting up straight
 - Never leave a resident alone during mealtime with swallowing problems
 - Prompt the resident to swallow as necessary
 - Watch for cheeking and food build up
- When the resident prefers to “eat on the run” select foods that are easy to manage when walking:
 - Place foods in an easy to carry container (a plastic cup with raisins)
 - Avoid foods that fall apart (e.g., burritos)
- Examples of easy to carry foods:
 - ½ sandwich-not overloaded
 - Chicken fingers
 - Pieces of fruit
 - Pureed soup with a no spill (sippy-cup) lid
 - Cooled pizza
- When the resident finds it easier to eat with his hands, serve food in “easy to pick up” containers such as small bowls or finger food such as:
 - Fruits and vegetables: apple slices, orange wedges, peeled bananas, squash spears, green beans, carrot strips
 - Meats: chicken strips, strips of beef, pork medallions, fish sticks
 - Dairy products: Cheese sticks, chunks of cheese, ice cream bars
 - Breads/Starches: bread sticks, crackers, potato wedges, large penne pasta, rolled tortillas
- Feeding towards the end of life:
 - Some residents will require an extraordinary amount of time and may need meals at “off times” as to not affect other resident care
 - Holding a resident while small “sips” of food are consumed can be very comforting
 - Be cautious not only of swallowing concerns, but irritating foods as well
- Keeping the resident hydrated is very important.
- Causative factors for dehydration include:
 - Excessive pacing
 - Unaware of thirst
 - Medications
 - Does not remember to drink
 - Can’t figure out how to get a beverage
- Methods to improve fluid intake include:
 - Offer favorites—offer often

- Use containers a resident likes and is used to using—favorite cups from home, etc.
- Cue for beverages “Whew—I am thirsty,” tinkling ice, smell of lemonade
- Offer “hidden fluids”—popsicles, watermelon, oranges, cucumbers, soups
- Menu Planning for the resident includes:
 - Obtain an accurate food preference history (family, resident, picture book)
 - Keep track of current food preferences
 - Track dietary orders (list in kitchen, pictorial reminders)
 - Use nutritionally sound snacks
 - Offer small frequent feedings--these may work better for some residents
 - Keep late night food available—this is a must
- Bowel health is also related to nutrition
- Dehydration, lack of fiber, slowing motility, medications can cause problems
- Monitor and encourage fluid intake
- Consider fiber rich, easy to consume foods
 - Bran added to current recipes
 - Whole grain foods
 - Fresh fruits and vegetables
 - Whole juicing
 - Always consult with the resident’s physician

INCONTINENCE CARE

Bowel health is also related to nutrition. Dehydration, lack of fiber, slowing motility, medications can cause problems. Monitor and encourage fluid intake. Consider fiber rich, easy to consume foods.

- Bran added to current recipes
- Whole grain foods
- Fresh fruits and vegetables
- Whole juicing
- Always consult with the resident's physician

The following are some fundamentals of incontinence care:

1. Get as much information about voiding patterns, etc. before admission
2. Set up the environment to promote continence—clear view of toilet, easy access, grab bars, etc.
3. Never accept a change in continency as normal; always get a medical evaluation
4. Assist with toileting as long as possible—diapering is a last resort
5. Provide meticulous skin care

One of the major causes of restlessness is a desire to use the toilet. If the resident does not have the ability to connect the desire to meaningful action, behavior issues can arise. Episodes of incontinence are upsetting to residents and incontinence can lead to other complications.

Good care begins with a good appraisal. Here are some questions to answer during an appraisal:

- Does incontinence exist?
- If yes, is it bladder, bowel or both?
- Is this a new or long existing problem?
- How does the resident respond to the problem?
- Does the resident have any resistance to care?
- Has there been a medical evaluation?
- What has already been attempted or how is it avoided?
- Is incontinence limited to a time of day?
- Does the resident pass urine or feces in inappropriate places?

Let's look at some factors that can lead to incontinence:

- Impaired mobility—the resident just cannot make it to the toilet

- Cognitive impairment--the resident can't figure out how to remove clothing or can't figure out where the bathroom is located
- Poor fluid intake
- Embarrassment--the resident does not want to toilet in an unfamiliar place
- Lack of control--sphincter problems or a neurogenic or overactive bladder
- Medications—for example, diuretics or anti-hypertensives

Incontinence may be from different causes. Let's look at 4 different types of urinary incontinence:

1. Stress incontinence

- Stress incontinence is related to weak pelvic floor muscles and/or ineffective urethral sphincter.
- It is characterized by leakage of small amounts of urine after coughing, sneezing, laughing.
- Stress incontinence is not limited to only female residents.

2. Urge Incontinence

- Urge incontinence causes leakage of urine after a feeling of need to void—there is no time to wait.
- Causes of urge incontinence include cystitis due to UTI or brain pathology preventing the ability to send a nerve message to the bladder to wait to empty.
- Other causes include caffeine, medications, atrophic changes to the bladder, anxiety, and constipation.

3. Overflow Incontinence

- Overflow incontinence causes an involuntary loss of urine associated with over stretching the bladder because of urine retention.
- The resident may hesitate to void, dribble, void frequently. This resident is at risk for UTIs (urinary tract infections).
- Causes of overflow incontinence include: obstruction related to enlarged prostate, urethral obstruction, nerve damage, or a bladder that does not empty well.

4. Functional Incontinence

- A resident with functional incontinence has a functioning urinary tract, but simply cannot get to the toilet.
- Functional incontinence may be due to immobility, memory impairment, cognitive decline, or other reasons.

The goal with residents is to maintain continence for as long as possible. Admittedly it can be "easier" for care staff to put a brief on a resident. But, keeping a resident continent is important for his/her physical well being and the resident's self esteem.

Here are some suggestions on how to help keep a resident continent for as long as possible:

- Toilet regularly-at least every two hours-allow the resident to completely empty the bladder-use methods of distraction (radio, something to read, pictures)
- Provide signage to the toilet
- Use assistive devices when needed (bedside commodes, urinal)
- Use "easy to remove" clothing
- Provide adequate fluids-dehydration can cause the bladder to spasm and spill urine

REMEMBER: Protect the resident's dignity!

The resident may not be able to verbalize his embarrassment, but it does not mean he does not have uncomfortable feelings.

Here are some suggestions to help a resident maintain his or her dignity:

1. Always provide privacy.
2. Be very matter of fact about "accidents."
3. Refer to diapers as briefs or pants.
4. Do not use negative body language or sounds (e.g., holding nose, making faces etc.).
5. Have all supplies ready so the resident is not left standing partially clothed.
6. Have something for the resident to hold so he does not place his hands in urine or feces.
7. Engage the resident in pleasant conversation.
8. Do not talk about the incontinency in front of the resident.
9. Invite him to "go for a walk" or "freshen up," rather than "let's change your brief."

It is very important to make sure an incontinent resident receives careful skin care. Here are some suggestions for caring for the skin of the incontinent resident:

1. Remove as much urine and fecal matter as possible when removing the brief.
2. Cleanse the skin with wipes or washcloth.
3. Ensure entire perineal area is cleansed--clean with gentle stream of water if necessary
4. Rinse thoroughly if not using a rinse free product
5. Pat dry, especially in folds of skin
6. Apply barrier creams or ointments as ordered by the resident's physician
7. Report any redness, rashes, or peeling to the resident's physician

Careful perineal care is very important. Inadequate perineal care can be very uncomfortable for a resident and can result in any of the following:

- redness
- excoriation
- vaginal infections
- extreme discomfort

One of the difficulties a caregiver can face is when a resident who is incontinent refuses care. Here are some suggestions for dealing with the resident:

1. Do not argue
2. Re-attempt later
3. Use a "change of face" by having a different caregiver try to provide the care
4. Use distraction
5. Verify you are following established pattern and preference
6. Consider pain as a cause of refusal

How you approach each resident when providing incontinent care is important. Consider situations you have had with your residents who are incontinent. Below, explain two situations when a resident resisted care. What could you have done differently that might have resulted in success?

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper appears to be a standard notebook page, possibly from a composition book. The edges of the paper are slightly irregular, suggesting it might be a scan of a physical document. There is no handwriting or other markings on the page.

FALLS

When caring for persons with dementia, falls are a significant concern. On the following screen, you can review risk factors and implications for falls. When planning care for your residents, consider the results from studies regarding fall prevention. The next several pages provide information on fall risk, medical conditions and falls, and how falls can be prevented.

DEMENTIA AND FALL RISK

Factors associated with dementia	Implications for falls
Memory loss	Impairs ability to learn and maintain safety measures (for example, forgetting to use walking frame).
Dyspraxia	Disturbance in perception of body in space, and perception of depth and distance.
Language impairment	Inability to express desires or understand verbal and written cues (for example, signs or directions).
Impaired executive function (planning and organizational capacity, and mental flexibility)	Diminished ability to initiate, monitor, and stop certain actions (for example, wandering or repetitive behavior).
Diminished insight into ability	Poor monitoring of safety issues and performance of unsafe actions.

Other Medical Conditions and Falls

Health condition	Balance systems affected	Issues to consider
Stroke	motor, sensory, central integration	Physical abilities can deteriorate, especially if relatively inactive; can benefit from physiotherapy, walking, or exercise.
Parkinson's disease	motor, and motor planning	Should have regular medical review; might require medication review; might benefit from physiotherapy, walking, or exercise.
Meniere's disease, vestibular neuritis, benign paroxysmal positional vertigo	vestibular system	Dizziness requires medical assessment; some causes of dizziness are treatable by simple measures.
Musculo-skeletal problems (arthritis, joint pain, muscle weakness)	motor, skeletal systems	Medical review for any change in joint pain or function; might benefit from physiotherapy, walking, or exercise; consideration of aids to reduce pain.
Glaucoma, cataracts, macular degeneration	somato-sensory system	Diminishes ability to feel feet; causes weakness in muscles that clear foot from floor when walking.

HOW CAN FALLS BE PREVENTED?

Fall prevention requires a combination of medical treatment, rehabilitation, and environmental modification. Several studies have shown that effective fall prevention strategies include:

- Assessment after a fall to identify and address risk factors and treat underlying medical conditions.
- Physical conditioning and/or rehabilitation using prescribed exercises to improve strength and endurance; physical therapy; gait training; and walking programs.

- Environmental assessments and modifications to improve mobility and safety such as installing grab bars, adding raised toilet seats, lowering bed heights, and installing handrails in the hallways.
- Review of prescribed medications to assess their potential risks and benefits and minimize use.
- Providing patients with hip pads that can effectively prevent most hip fractures if a fall occurs.
- Technological devices such as alarm systems that are activated when patients try to get out of bed or move unassisted may be useful.

Studies have been conducted to determine if physical restraints help prevent falls. Below is a summary of findings from several studies:

- Routine use of restraints does not reduce the risk of falls or fall injuries.
- Restraints can actually contribute to fall-related injuries and deaths.
- Limiting a patient's freedom of movements leads to muscle weakness and reduces physical function.

EXERCISE

A safe physical environment plays a role in decreasing falls. Our residents often do not anticipate or are not aware of environmental risks. Tour your facility, noting any possible risks (e.g. extension cords, furniture in pathways, damaged flooring, poor lighting, etc.). Develop an action plan to remedy each risk.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper appears slightly aged or off-white. There is no handwriting or other markings on the page.