



State-Approved Curriculum NURSE AIDE I TRAINING PROGRAM

July 2013 Module T



North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Registry Section
Center for Aide Regulation and Education
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Module T – Dementia and Alzheimer’s Disease Teaching Guide

Objectives

- Define the terms, dementia, Alzheimer’s disease, and delirium.
- Describe the nurse aide’s role in the care of the resident with Alzheimer’s.

Instructional Resources/Guest Speakers

- **#1T DVD:** Consider procuring the DVD, *Grace*, a classic program on Alzheimer's disease. The storyline follows seven years in the life of Grace Kirkland and the inspirational care-giving efforts of her husband. It provides a documentation of Alzheimer’s disease from near the time of diagnosis to death. It may be purchased at the following Web site:
www.videopress.umaryland.edu/grace.html
- **#2T Guest Speaker:** employee from a local Alzheimer’s unit; topic: speak about characteristics and care of residents with Alzheimer’s disease

Advance Preparation – In General

- Review curriculum and presentation materials
- Add examples or comments in Notes Section
- Set up computer/projector

Module T – Dementia and Alzheimer’s Disease
Definition List

Activity-based Care – care focused on assisting resident to find meaning in his or her day, rather than doing activities just to keep the person busy

Alzheimer’s disease (AD) – is a progressive disease characterized by a gradual decline in memory, thinking and physical ability, over several years

Behavior – how a person acts

Catastrophic Reactions – out-of-proportion, extreme responses to activities or situations

Cognition – ability to think quickly and logically

Confusion – inability to think clearly, causing disorientation and trouble focusing

Delusion – a false belief

Dementia – usually progressive condition marked by development of multiple cognitive deficits, such as memory impairment, aphasia, and inability to plan and initiate complex behavior

Depression – a loss of interest in usual activities

Dignity – respect and honor

Doing Activities – activities that keep the person busy

Independence – ability to make decisions that are consistent, reasonable and organized; having the ability to perform activities of daily living without assistance

Irreversible – disease or condition that cannot be cured

Meaningful Activities – have value to the resident with dementia

Onset – the time when signs and symptoms of a disease begins

Paranoia – an extreme or unusual fear

Progressive – the way a disease advances

Quality of Life – overall enjoyment of life

Respect – treated with honor, show of appreciation and consideration

Sundowning – increased agitation, confusion and hyperactivity that begins in the late afternoon and builds throughout the evening

Trigger – an event that causes other events

Wandering – moving about the facility with no purpose and is usually unaware of safety

Module T – Dementia and Alzheimer’s Disease	
(S-1) Title Slide (S-2) Objectives <ol style="list-style-type: none"> 1. Define the terms dementia, Alzheimer’s disease, and delirium. 2. Describe the nurse aide’s role in the care of the resident with Alzheimer’s disease. 	
Content	Notes
(S-3) Dementia <ul style="list-style-type: none"> • Usually progressive condition marked by development of multiple cognitive deficits such as memory impairment, aphasia, and inability to plan and initiate complex behavior 	
(S-4) Alzheimer’s Disease (AD) <ul style="list-style-type: none"> • Progressive disease characterized by a gradual decline in memory, thinking and physical ability, over several years • Average life span following the diagnosis of Alzheimer’s disease is eight years, but survival may be anywhere from three to 20 years • Because Alzheimer’s disease is progressive, it is separated into three stages: Early (Mild), Middle (Moderate) and Late (Severe) – each stage is different and will require different actions on the part of the nurse aide 	
(S-5) Early Stage Alzheimer’s Disease <ul style="list-style-type: none"> • Memory loss begins to affect everyday activities • Difficulty remembering names of people, places or objects • Difficulty following directions • Disoriented to time and place • Increased moodiness, agitation or personality changes due to forgetfulness or embarrassment • Has poor judgment and makes bad decisions • Develops difficulty maintaining living spaces, paying bills and managing money 	
(S-6) Middle Stage of Alzheimer’s Disease <ul style="list-style-type: none"> • Longest of three stages • Increased restlessness during evening hours (sundowning) • Increased level of memory loss; starts losing ability to recognize family members • Requires assistance with activities of daily living • Increased problems with communication, ambulation and impulse control • Increased behavioral issues; may become violent at times • Urinary and fecal incontinence • May experience auditory or visual hallucinations and become suspicious of caregivers • Finally requires full-time supervision 	
(S-7) Late Stage of Alzheimer’s Disease	

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<ul style="list-style-type: none"> • Considered terminal stage • Loses ability to verbalize needs; may groan, grunt or scream • Does not recognize self or family members • Becomes bed-bound • Total dependence for activities of daily living • Body function gradually declines • Death 	
(S-8) Delirium <ul style="list-style-type: none"> • State of severe confusion that is reversible and occurs suddenly • Usually triggered by a rapid onset (acute) of illness or change in physical condition that is life threatening, if not recognized and treated • Signs and symptoms of acute delirium – rapid decline in cognitive function, disorientation to place and time, decreased attention span, poor short-term memory and immediate recall, poor judgment, restlessness, altered level of consciousness, suspiciousness, hallucinations and delusions • Notify nurse immediately of any resident that begins to exhibit the above symptoms or behaviors and stay with resident 	
(S-9) Dementia or Delirium? <ul style="list-style-type: none"> • Delirium and dementia are often confused • Delirium is reversible; dementia is progressive and irreversible 	
(S-10) Dementia and Alzheimer’s Disease – Key Terms <ul style="list-style-type: none"> • Cognition – ability to think quickly and logically • Confusion – inability to think clearly, causing disorientation and trouble focusing • Irreversible – disease or condition that cannot be cured • Onset – the time when signs and symptoms of a disease begins • Progressive – the way a disease advances 	
(S-11) Maintenance of Respect, Dignity and Quality of Life <ul style="list-style-type: none"> • Dignity – respect and honor • Independence – ability to make decisions that are consistent, reasonable and organized; having the ability to perform activities of daily living without assistance • Quality of life – overall enjoyment of life • Respect – treated with honor, show of appreciation and consideration 	
(S-12) Maintenance of Respect, Dignity and Quality of Life <ul style="list-style-type: none"> • Every human being is unique and valuable, therefore, each person deserves understanding and respect • Dementia does not eliminate this basic human need • Person-centered care maintains and supports the person regardless 	

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of level of dementia	
(S-13) Maintenance of Respect, Dignity and Quality of Life <ul style="list-style-type: none"> Residents’ abilities, interests, and preferences should be considered when planning activities and care As the disease progresses, adjustments will be required in order to maintain dignity Important for staff to know who the resident was before the dementia started 	
(S-14) Maintenance of Respect, Dignity and Quality of Life <ul style="list-style-type: none"> An individual’s personality is created by his/her background, including <ul style="list-style-type: none"> Ethnic group membership (race, nationality, religion) Cultural or social practices Environmental influences, such as where and how they were raised as children Career choices Family life Hobbies 	
(S-15) Maintenance of Respect, Dignity and Quality of Life <ul style="list-style-type: none"> Encourage residents to participate in activities and daily care, but avoid situations where resident is bound to fail Humiliation is disrespectful, degrading, and can increase likelihood of disruptive behaviors To promote independence, do things with resident rather than for them 	
(S-16) Maintenance of Respect, Dignity and Quality of Life <ul style="list-style-type: none"> Allow time for residents to express feelings and take time to understand what they are feeling Provide emotional support Long-term care facilities must provide care for residents in a manner and an environment that promotes maintenance or enhancement of each resident’s dignity, respect, and quality of life 	
(S-17) Dementia and Alzheimer’s Disease – Communication <ul style="list-style-type: none"> Residents with Alzheimer’s disease often experience problems in making wishes known and in understanding spoken words Communication becomes more difficult as time goes by Changes commonly seen in the resident with Alzheimer’s <ul style="list-style-type: none"> Inability to recognize a word, phrase Inability to name objects Using a general term instead of specific word Getting stuck on ideas or words and repeating them over and 	

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<p>over</p> <ul style="list-style-type: none"> ○ Easily losing a train of thought ○ Using inappropriate, silly, rude, insulting or disrespectful language during conversation ○ Increasingly poor written word comprehension ○ Gradual loss of writing ability ○ Combining languages or return to native language ○ Decreasing level of speech and use of select words, which may also cause the use of nonsense syllables ○ Reliance on gestures rather than speech 	
<p>(S-18) Communicating with Resident with Dementia and Alzheimer’s Disease – Nurse Aide’s Role</p> <ul style="list-style-type: none"> • There are several components when assisting resident with communication <ul style="list-style-type: none"> ○ Patience with resident ○ Show interest in the subject ○ Offer comfort and reassurance ○ Listen for a response ○ Avoid criticizing or correcting ○ Avoid arguments with resident ○ Offer a guess as to what resident wants ○ Focus on the feelings, not on the truth ○ Limit distractions ○ Encourage non-verbal communication 	
<p>(S-19) Dementia and Alzheimer’s Disease – Communication Techniques Used by Nurse Aide</p> <ul style="list-style-type: none"> • Nurse aide’s method of communicating with the resident with Alzheimer’s disease is as critical as the actual communication • Utilizing the following techniques will decrease frustration for both the resident and nurse aide <ul style="list-style-type: none"> ○ Obtain resident’s attention before speaking and maintain attention while speaking ○ Address resident by name, approach slowly from front or side and get on same level or height as resident ○ Set a good tone by using calm, gentle, low-pitched tone of voice ○ If conversation is interrupted or nurse aide or resident leaves room, start over from beginning ○ Slow down, do not act rushed or impatient ○ If information needs to be repeated, do so using same words and phrases as before ○ Speak clearly and distinctly using short, familiar words and short sentences, and avoiding long explanations ○ Emphasize key words, break tasks and instructions into clear and simple steps, offer one step at a time; and provide resident 	

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<p>time and encouragement to process and respond to requests</p> <ul style="list-style-type: none"> ○ Use nonverbal cues, such as touching, pointing or starting the task for resident ○ If the resident’s speech is not understandable, encourage to point out what is wanted or needed 	
<p>(S-20) Dementia and Alzheimer’s Disease – Communication Strategies Used by Nurse Aide</p> <ul style="list-style-type: none"> • Communication strategies to use when communicating with residents that have dementia <ul style="list-style-type: none"> ○ Listen carefully and encourage them; do not talk down to them, nor talk to others about them as if they were not present ○ Minimize distractions and noise ○ Allow enough time for resident to process and respond; if they have difficulty explaining something, ask them to explain in a different way ○ Monitor body language to ensure a non-threatening posture and maintain eye contact ○ Nonverbal communication is very important to dementia residents ○ Choose simple words and short sentences, and use a calm tone of voice ○ Call the person by name and make sure you have their attention before speaking ○ Keep choices to a minimum in order to reduce resident’s frustration and confusion ○ Include residents in conversations with others ○ Do not make flat contradictions to statements that are not true ○ Change the way responses are made to avoid confusion, frustration, embarrassment, and behavioral outbursts ○ Use of communication devices (such as a picture board, books, or pictures) encourages resident’s independence and decreases frustration 	
<p>(S-21) Dementia and Alzheimer’s Disease – Communication Tips by Nurse Aide</p> <ul style="list-style-type: none"> • Communication tips to use when caring for resident with Alzheimer’s disease <ul style="list-style-type: none"> ○ Be calm and supportive ○ Focus on feelings, not facts ○ Pay attention to tone of voice ○ Identify yourself and address the resident by name ○ Speak slowly and clearly ○ Use short, simple and familiar words, and short sentences ○ Ask one question at a time ○ Allow enough time for a response 	

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<ul style="list-style-type: none"> ○ Avoid the use of pronouns (e.g., he, she, they), negative statements and quizzing ○ Use nonverbal communication, such as pointing and touching ○ Offer assistance as needed ○ Have patience, flexibility and understanding 	
(S-22) Dementia and Alzheimer’s Disease – Key Words About Behavior Issues <ul style="list-style-type: none"> • Behavior – how a person acts • Catastrophic reaction – an extreme response • Delusion – a false belief • Depression – a loss of interest in usual activities • Paranoia – an extreme or unusual fear • Sundowning – increased agitation, confusion and hyperactivity that begins in the late afternoon and builds throughout the evening • Trigger – an event that causes other events • Wandering – moving about the facility with no purpose and is usually unaware of safety • Alzheimer’s disease progresses in stages and so does behavior 	
(S-23) Dementia and Alzheimer’s Disease – Key Words About Behavior Issues <ul style="list-style-type: none"> • Behavioral responses that may be associated with each stage of the disease <ul style="list-style-type: none"> ○ Early stage – depression, anxiety, irritability ○ Middle stage – wandering, agitation, sleep disturbances, restlessness, delusions, hallucinations, general emotional distress ○ Late stage – verbal or physical aggression, agitation, gradual behavioral decline as disease progresses to death 	
(S-24) Dementia and Alzheimer’s Disease – Behavior Issues <ul style="list-style-type: none"> • Behavior – an observable, recordable, and measurable physical activity <ul style="list-style-type: none"> ○ People with normal brain function have the ability to control responses ○ People with Alzheimer’s disease and dementia have lost much of this ability 	
(S-25) Dementia and Alzheimer’s Disease – Behavior Issues <ul style="list-style-type: none"> • Behavior is a response to a need <ul style="list-style-type: none"> ○ The resident is frequently unable to express his or her needs because of cognitive losses ○ Nurse aides must be attentive to gestures and clues demonstrated by the resident ○ Every behavior is a response to a need or situation 	

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<ul style="list-style-type: none"> ○ Gestures, sounds, and conversation may reveal trigger to the behavior ○ As verbal skills diminish, behavior becomes the communication method • Before choosing a specific behavioral intervention, trigger of behavior must be identified • Triggers may be environmental, physical, or emotional <ul style="list-style-type: none"> ○ Environmental triggers – rearrangement of furniture, increased number of people in facility, change in daily schedule ○ Physical triggers – new medications, infections, pain ○ Emotional triggers – may include reactions to loss, depression, frustration, self-perception, past life events, personality 	
<p>(S-26) Dementia and Alzheimer’s Disease – Behavior Issues</p> <ul style="list-style-type: none"> • Effective behavior management <ul style="list-style-type: none"> ○ Identifying trigger ○ Understanding trigger ○ Adapting environment to resolve behavior • Changing the environment (such as reducing excessive noise and activity) or providing comfort measures (such as rest or pain medication) may reduce behavior • Intervention must meet needs of resident while maintaining respect, dignity and independence • Successful behavioral interventions <ul style="list-style-type: none"> ○ Preserve resident’s dignity ○ Helps staff gain confidence, improve morale, and increase job satisfaction • Behavior control also assists in reducing use of restraints, decreases abuse and neglect, and increases family satisfaction 	
<p>(S-27) Dementia and Alzheimer’s Disease – Behavior Issues</p> <ul style="list-style-type: none"> • Common behaviors <ul style="list-style-type: none"> ○ Wandering ○ Sundowning ○ Depression ○ Disorientation to person, place, and/or time ○ Inappropriate sexual behavior ○ Emotional outbursts ○ Combativeness (hostility or tendency to fight) ○ Inappropriate toileting (use of inappropriate areas for toileting, such as a plant) ○ Easy frustration ○ Repetitive speech or actions ○ Swearing, insulting, or tactless speech ○ Shadowing (following others) ○ Withdrawal 	

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<ul style="list-style-type: none"> ○ Hoarding (hiding objects or food) ○ Sleep disturbances ○ Paranoia and suspiciousness ○ Delusions and/or hallucinations ○ Decreased awareness of personal safety ○ Catastrophic reactions (extreme emotional responses such as yelling, crying, or striking out that seem out of proportion to the actual event) 	
<p>(S-28) Wandering</p> <ul style="list-style-type: none"> • Wandering is a known and persistent problem behavior that has a high risk factor for resident safety • Safety risk factors may include <ul style="list-style-type: none"> ○ Falls ○ Elopement ○ Risk of physical attack by other residents who may feel threatened or irritated by the activity • Residents wander for several reasons and may include <ul style="list-style-type: none"> ○ Trying to fulfill a past duty, such as going to work ○ Feeling restless ○ Experiencing difficulty locating their room, bathroom or dining room ○ Reacting to a new or changed environment • Preservation of resident safety is the main objective when caring for the wandering resident and interventions include <ul style="list-style-type: none"> ○ Establish a regular route ○ Provide rest areas ○ Accompany the resident ○ Provide food and fluid ○ Redirect attention to other activities or objects ○ Determine if behavior is due to environmental stress 	
<p>(S-29) Sundowning</p> <ul style="list-style-type: none"> • Sundowning is behavioral symptom of dementia that refers to increased agitation, confusion, and hyperactivity that begins in late afternoon and builds throughout the evening • Interventions <ul style="list-style-type: none"> ○ Encourage rest times ○ Plan bulk of activities for the morning hours ○ Perform quieter, less energetic activities during the afternoon 	
<p>(S-30) Sexual Activity</p> <ul style="list-style-type: none"> • Inappropriate sexual activity is another behavior issue. Offensive or inappropriate language, public exposure, offensive and/or misunderstood gestures are the characteristics of this behavior • Interventions 	

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<ul style="list-style-type: none"> ○ Treat the resident with dignity and respect ○ Remove resident from public situation ○ Redirect attention to an appropriate activity ○ Assist the resident to bathroom 	
<p>(S-31) Dementia and Alzheimer’s Disease – Agitation</p> <ul style="list-style-type: none"> • Agitation occurs for a variety of reasons • Nurse aides must ensure safety and dignity of agitated resident while protecting safety and dignity of other residents • Interventions <ul style="list-style-type: none"> ○ Do not crowd the resident; allow them room to move around while still providing for safety ○ Ask permission to approach or touch them ○ Maintain a normal, calm voice • Interventions <ul style="list-style-type: none"> ○ Slow down and do not rush the resident ○ Limit stimulation in the resident’s area ○ Avoid confrontations and force ○ Avoid sudden movements outside of the resident’s field of vision 	
<p>(S-32) Dementia and Alzheimer’s Disease – Disruptive Verbal Outbursts</p> <ul style="list-style-type: none"> • Disruptive verbal outbursts are one of the most persistent behaviors in a long-term care facility. These outbursts may include: <ul style="list-style-type: none"> ○ Screaming ○ Swearing ○ Crying ○ Shouting ○ Loud requests for attention ○ Negative remarks to other residents or staff (including racial slurs) ○ Talking to self • Anger and aggression are often the visible symptoms of anxiety and fear. • Interventions <ul style="list-style-type: none"> ○ Reassure residents that they are safe ○ Redirect their attention to an activity ○ Assist residents with toileting, feeding or fluids ○ Move residents to a quiet area • Notify nurse immediately of aggressive behaviors that may threaten other residents and/or staff and stay with the resident 	
<p>(S-33) Dementia and Alzheimer’s Disease – Catastrophic Reaction</p> <ul style="list-style-type: none"> • Emotional, environmental, or physical triggers may result in a 	

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catastrophic reaction <ul style="list-style-type: none"> • Catastrophic reactions are out-of-proportion responses to activities or situations 	
(S-34) Dementia and Alzheimer’s Disease – Catastrophic Reaction <ul style="list-style-type: none"> • Warning signs of a possible reaction <ul style="list-style-type: none"> ○ Sudden mood changes ○ Sudden, uncontrolled crying ○ Increased agitation ○ Increased restlessness ○ Outburst of anger (physical or verbal) 	
(S-35) Dementia and Alzheimer’s Disease – Catastrophic Reaction <ul style="list-style-type: none"> • Interventions include <ul style="list-style-type: none"> ○ Speak softly and gently in calm voice ○ Protect resident, self, and others as necessary ○ Remove the person from a stressful situation ○ Avoid arguing with the resident ○ Avoid the use of restraints ○ Redirect the resident’s attention ○ Change activities if the activity is causing the reaction 	
(S-36) Dementia and Alzheimer’s Disease – Catastrophic Reaction <ul style="list-style-type: none"> • Interventions that should not be used include <ul style="list-style-type: none"> ○ Arguing with resident or other staff members ○ Speaking loudly to resident or other staff members ○ Treating resident like a child ○ Asking complicated questions ○ Using force or commanding resident to do something 	
(S-37) Dementia and Alzheimer’s Disease – Catastrophic Reaction <ul style="list-style-type: none"> • Caregiver behaviors that should be encouraged and used to decrease or prevent use of restraints <ul style="list-style-type: none"> ○ Maintaining calm and non-controlling attitude ○ Speaking softly and calmly ○ Asking one question at a time and waiting patiently for the answer ○ Using simple, one step commands, and positive phrases ○ Avoiding crowding resident with more people than needed for the task ○ Providing a distraction, such as an activity or music 	
(S-38) Dementia and Alzheimer’s Disease – Activities <ul style="list-style-type: none"> • Goal in the care of residents with Alzheimer’s disease is to give support needed so that they can participate in the world around 	

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<p>them to the best of their ability</p> <ul style="list-style-type: none"> • Nurse aide must focus on the fact that the resident is involved and satisfied, not on the task or activity 	
<p>(S-39) Dementia and Alzheimer’s Disease – Activities</p> <ul style="list-style-type: none"> • Activities fall into two categories <ul style="list-style-type: none"> ○ Doing activities – keep the person busy ○ Meaningful activities – have value to the resident with dementia • Activity-based care is focused on assisting resident to find meaning in his or her day, rather than doing activities just to keep the person busy 	
<p>(S-40) Dementia and Alzheimer’s Disease – Activities</p> <ul style="list-style-type: none"> • Principles of activity-based care <ul style="list-style-type: none"> ○ Focuses on giving caregivers the tools to create chances for residents with dementia to be successful in activities and their relations with other people ○ Uses any daily activity that can be broken down into individual, sequential steps ○ Works within remaining abilities or strengths of the resident with Alzheimer’s disease, helping to shift emphasis away from resident’s disabilities and impairments ○ Adjusts an activity based on resident’s ability level ○ Depends on caregiver’s interest and desire to create opportunities for successful interactions that are planned and guided to encourage resident’s full involvement ○ Rewards the resident’s attempts at participating in activities and provides them with a sense of being capable and alive 	
<p>(S-41) Dementia and Alzheimer’s Disease – Activities</p> <ul style="list-style-type: none"> • Timing of activities is important and individualized <ul style="list-style-type: none"> ○ Attention and focus activities, physical activities and sensory activities provided during each resident’s prime time and on a set, routine basis may increase participation and satisfaction with that activity • Cultural environment refers to values and beliefs of people in an area <ul style="list-style-type: none"> ○ Staff, residents, families, visitors and volunteers determine culture of the facility ○ Promotion of positive environment begins with inclusion of the residents and making them feel important to relationships and activities 	
<p>TEACHING TIP #1T: DVD</p> <p>Show DVD, <i>Grace</i>, if available.</p>	

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<p>TEACHING TIP #2T: Guest Speaker</p> <p>An employee from a local Alzheimer’s unit</p>	
<p>(S-42) Dementia and Alzheimer’s Disease – Nurse Aide Stress and Burnout</p> <ul style="list-style-type: none"> • Providing care on daily basis for resident with Alzheimer’s or dementia extremely stressful • This population of residents may be more prone than others to becoming victims of abuse or neglect • Because of this, nurse aides that deal with Alzheimer’s or dementia residents must take additional precautions to ensure they do not over-react or react negatively to resident behaviors • Regardless of the cause, nurse aides must take necessary steps to ensure that they do not react inappropriately to resident behavior • Frustration can lead to <ul style="list-style-type: none"> ○ Negative, harsh or mean-spirited statements made to staff or residents ○ Physical abuse of residents ○ Emotional abuse of residents ○ Verbal abuse of residents ○ Neglect of residents • Nurse aides must always remember that statements and behaviors of residents suffering from Alzheimer’s or dementia are beyond control of the resident and not personally directed toward nurse aide • Usual profile of employee who is subject to burnout <ul style="list-style-type: none"> ○ Takes work personally and seriously ○ Works over at end of a shift ○ Works extra shifts ○ Takes on extra projects ○ Very high or unrealistic expectations ○ Perfectionist attitude • Signs of staff burnout include <ul style="list-style-type: none"> ○ No longer enjoying work ○ Irritable with residents and co-workers ○ Fear of failure, inadequacy, job loss and obligation to supervisor, co-workers, family ○ Feelings of being overwhelmed ○ Viewing work as a chore ○ Frequent complaints of illness • Strategies to use to assist in preventing burnout include <ul style="list-style-type: none"> ○ Maintain good physical and mental health ○ Get adequate amounts of sleep on off days and before each shift 	

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<ul style="list-style-type: none">○ Remain active within family and community○ Maintain a separation between work and personal relationships○ Maintain a sense of humor	
(S-43) THE END	