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Patients With Dementia Are Easy Victims to Predators

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Abstract

Patients with dementia, especially Alzheimer's disease and particularly those in early stages, are susceptible to become victims of predators: Their agnosia (see Case 1) prevents them from detecting and accurately interpreting subtle signals that otherwise would have alerted them that they are about to fall for a scam. Furthermore, their judgment is impaired very early in the disease process, often before other symptoms manifest themselves and usually before a diagnosis is made. Patients with early stages of dementia are therefore prime targets for unscrupulous predators, and it behooves caregivers and health care professionals to ensure the integrity of these patients. In this case study, we discuss how a man with mild Alzheimer's disease was about to fall for a scam were it not for his vigilant wife. We discuss what went wrong in the patient/caregiver interaction and how the catastrophic ending could have been avoided or averted.

Keywords

predators, agnosia, impaired judgment, power of attorney

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Objectives

At the end of this case presentation, readers will appreciate the following:

1. In the early stages of dementia, patients may appear to have normal cognitive functions and therefore may be vulnerable to unscrupulous predators in society.
2. Judgment is impaired very early in the disease process, often well before the memory impairment becomes obvious.
3. As much as possible, patients with dementia should not be contradicted; instead, caregivers should offer alternatives and attempt to distract and redirect them.
4. Legal steps should be taken to protect the patient's assets without handicapping the patient. Expert legal advice may be needed.

Case Presentation

Characters

- Bill, 69 years old, has been diagnosed with mild Alzheimer's disease (Functional Assessment Staging Test [FAST] scale, Stage 3) about a year ago. He lives with Elizabeth, his wife of 47 years. He is content and is involved in a number of activities at home and in the community. Bill retired from his work in an accountancy firm about 3 years ago when the firm's computer system was changed: He found it very difficult to adjust to the new system.
- Elizabeth, Bill's wife, keeps a benevolent, yet nonobtrusive eye on her husband. She ensures he remains safe and physically and mentally active.
- Predator/conman.

Scenario

Bill is sitting in his rocking chair on the front porch when a truck pulls up and a well-dressed gentleman approaches him. He first compliments Bill on his house: "A most beautiful house, Sir . . . an absolute jewel!" He then brings to Bill's attention that the driveway needs to be resurfaced because it "interferes with the aesthetics of the house and diminishes its value."

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Bill shakes his head in agreement. The man smiles and states that the usual cost of resurfacing the drive is at least US$2,500, but he can do it for only US$595 because he is working in the neighborhood and would be doing the work on his personal time. Bill is tempted. The man presses on: The work will be completed the following day, it will increase the value of the property, and it is something Bill will be proud of. "You could even surprise your wife. Don't tell her anything right now and tomorrow afternoon: voila! All done, drive completely resurfaced. What a pleasant surprise!" It doesn't take more to convince Bill.

The man then seems to hesitate; he says, "Sir, . . . I'm embarrassed to bring this up and really would like to apologize, but I know you being a man of the world would understand." Bill smiles and shakes his head in agreement. The man then says that he needs to be paid today, either in cash or by check made payable to cash. He explains that as the banks will be closing soon, he will not be able to cash a regular check. He plans to pick up the materials later today and get started very early tomorrow so that all the work is completed by late morning or early afternoon. Bill is convinced. He walks inside the house and rummages through the drawer where his checkbook should be.

Elizabeth spots him and asks what is going on. Bill tells her he is planning a pleasant surprise for her: "You won't believe your eyes!" She becomes suspicious and wants to find out what is that surprise. Bill tries to deflect her questions, but she persists. Eventually he tells her that he just hired the man outside to resurface the drive. It will be done tomorrow. He, however, needs to be paid now.

Elizabeth is furious and rapidly fires many questions. She does not even wait for Bill to answer. How does he know the man outside? Has he seen the quality of his work? How much will it cost? Why does he want to be paid before even starting the work?

Bill is annoyed, irritated, and confused. Too many competing stimuli are bombarding his mind: The drive needs paving, the workman is waiting outside. Bill has to write him a check. He wanted to surprise his wife, but this is backfiring. Elizabeth is angry and continues to fire questions at him.

Bill cannot cope. He tries to avoid answering the barrage of questions. But Elizabeth persists and eventually establishes that the man outside is a predator/conman and that Bill fell for his seduction. She criticizes Bill for his lack of judgment. Bill is upset, becomes verbally abusive to his wife, and writes the check. Elizabeth picks the check from Bill's hands, tears it, and pockets the checkbook.

Bill is now furious. He can't believe that Elizabeth tore up the check he's written and confiscated the checkbook. He becomes paranoid and accuses Elizabeth of eavesdropping, having him under surveillance, recording his conversations, and also of being unfaithful to him: "I know what you've been up to."

Elizabeth tries to reassure him, but he gets more and more agitated and eventually hits Elizabeth. She falls to the floor and cannot get up. She is in pain: a catastrophic ending.

Case Analysis

It first must be acknowledged that Elizabeth has done a tremendous job keeping her husband living independently and safely at home for about a year (when her husband's diagnosis was first made). It is indeed a tribute to her that she identified the potential predator/conman in time and prevented her husband from completing the transaction he intended to. She immediately noticed her husband's activity and took decisive action. Unfortunately, unlike several episodes in the past year, this time, while trying to stop her husband from a rash, potentially financially expensive action, she upset her husband and this particular episode had a negative outcome.

While caring for patients with dementia, the caregiver is expected to spot and stop each and every potentially aberrant behavior without upsetting the patient. These expectations are not realistic. Hence, it is very important to ensure the health of the caregiver especially if the caregiver is the patient's spouse, living with the patient 24 hr a day, 7 days a week, 52 weeks a year. The unpredictability of the patient necessitates constant vigilance. This is psychologically draining and not sustainable: The caregiver finds herself sucked in, with all her energy, activities, and indeed life centered around the patient with no end in sight.

Arrangements therefore must be made to ensure the caregiver has some free time to herself. This must be done on a regular basis, preferably at least once a week: The caregiver must know that in only a few days' time, she will have some free time to relax and live her own life away from the patient, albeit for a relatively short period of time. If this is not done, sooner or later the caregiver will experience burnout or will develop some illness that will prevent her from continuing caring for her husband.

Health care professionals providing care for the patient therefore must be cognizant of the plight on caregivers, especially nonprofessional caregivers, and should ensure the caregiver has some time to herself when she is not providing care to the patient. Similarly, they must recognize the plight of caregiving by relatives and whenever possible reassure and compliment caregivers on the quality of work they are doing keeping the patient at home. Most caregivers yearn for some recognition that they rarely receive. Worse still, they are often criticized by other relatives (especially those living far away, who have little regular contact with the patient) or health care professionals who often seem oblivious of the demands involved in caring for patient with dementia.

Turning Points/Triggers That Led to This Aberrant Behavior

Bill's easy acceptance of the predator's sales pitch. Bill readily accepted the predator's sales pitch, the trigger for Bill's subsequent aberrant behavior. Bill's impaired judgment, a result of his Alzheimer's disease, made him a prime target for predators. He was happy to hand money to a total stranger with no guarantee other than a verbal agreement. Given the impaired judgment, which is an integral part of the dementing process, a situation such as the one described should have been anticipated.

Could it have been avoided?. Luckily, Bill's vigilant wife was present and tried to stop him from completing the transaction. A suspicious caregiver such as Elizabeth is a safeguard against predators. It is, however, also imperative that legal steps be taken to preserve various financial and other assets of the patient and family. These include that checks be countersigned, credit cards and ATM cards invalidated, and no significant amount of cash readily available in the house. A trusted person also should have power of attorney (POA) for financial matters. This is further discussed below.

Elizabeth immediately disagreeing with Bill. Elizabeth's first reaction was to question Bill's decision to have the drive resurfaced and pay for the work before it is completed. She openly disagreed with Bill. From the very beginning of this interaction, she therefore set herself up for a confrontation with Bill: She questioned his judgment and hence integrity. He was planning a pleasant surprise for her, but instead of being thanked and complimented, he is reprimanded. He cannot understand why she is so upset. He believes he is the one to be upset.

Could it have been avoided?. This situation could have had a better ending had Elizabeth not directly and aggressively confronted Bill. Although often difficult, sometimes virtually impossible, direct confrontation should be avoided with patients who have dementia, especially Alzheimer's disease, because of their paranoid tendencies. Besides, confrontation is rarely necessary, often escalates, easily transgresses from the verbal to physical, and may have a catastrophic ending: In the above-mentioned case, Elizabeth fractured her hip, had to be hospitalized, and then sent to a nursing home. Bill had to stay with his son and family about 200 miles away.

Furthermore, once physical altercations occur, they can be the prelude to physical abuse. Confrontations therefore should be avoided. If this is not possible, the caregiver should just walk away, provided the patient is safe, and return later, with a friendlier, more relaxed mind-set.

When it is necessary to disagree and confront a patient with Alzheimer's disease, it is preferable not to openly disagree, especially at the beginning of the interaction. Excuses or alternative actions can be offered, and attempts should be made to distract the patient and redirect him. This is usually not too difficult given the patient's short-term memory impairment and short attention span. Some approaches Elizabeth could have adopted include the following:

- First agreeing with her husband and even praising his initiative and action, but then telling him it cannot be done and giving him the reasons, which should be plausible. For example, after affirming it is a very good idea, Elizabeth could have said: "Oh Dear, I'm so sorry . . . This is so embarrassing. Please don't write the check; there isn't enough money in our checking account. I withdrew money yesterday to pay the electricity and gas bills and some groceries and didn't have an opportunity of telling you. Will you please forgive me? It would be so embarrassing if the check bounced." Chances are high Bill would have agreed to postpone handing over the check to the man outside.
- Rather than antagonizing Bill, try to find out more about the situation:

Elizabeth could have said, "That's wonderful, what a good idea! I'm so excited! Please introduce me to the man outside. I would like to see how you deal with people like this". She could then have questioned the man outside, asked for references, . . . Chances are very high the predator/conman would have made a quick exit!

- After agreeing with the idea of resurfacing the drive, Elizabeth could have come up with an alternative, for instance, saying something to the effect that the neighbors too are planning to get their drive resurfaced and Bill may be interested in considering that the same Firm or person resurface both drives at the same time. In fact, maybe the man outside would like to pave both drives. "Let's go ask him."
- Elizabeth could try to distract her husband. She could say "Why don't we go to the kitchen? I've just prepared lunch. It's your favorite pasta and it's getting cold. I'll tell the man outside to come back later. After lunch, if you want, we could walk to see the house he is working on. We could have a look at the driveway this man has just finished to check the quality of his work."

In these examples, Elizabeth does not contradict or confront Bill. She merely distracts him and offers another activity after having praised his initiative and therefore dissipating any anxiety he may have about doing the "right thing." In other words, she first disarms Bill before confronting him.

- Elizabeth also could ask Bill for his advice regarding a totally unrelated issue, and Bill may

have forgotten the initial issue at hand. "Bill, I'm so glad you're here, I desperately need your help. Please come and have a look at this . . . "

In all the above options, Bill does not feel threatened. He has not been attacked. His integrity is intact. In fact, his wife appears pleased with his action, condones it, and praises him. This reassures Bill.

His wife also could have taken a further positive step by showing him some sign of love and affection. Patients with dementia need constant reassurance that they are loved. Elizabeth therefore could have patted him on the back, given him a hug him, or gently squeezed his arm as she commends his decision to have the drive resurfaced. Now Bill is relaxed and is not anxious, and it should not be too difficult to move to the next issue: not to hand over the check before the work is completed. At this stage, distracting the patient is also relatively easy: Bill's paranoid delusions have not been triggered and his judgment has not been questioned. In fact, it has just been endorsed. He is open to suggestions and is more likely to accept alternatives his wife is offering or to get distracted. He is reassured Elizabeth is on his side.

It is important to reiterate that in all the above listed options, Elizabeth first agrees with her husband and makes sure he is not on the defensive: She in fact first disarms and reassures Bill and then distracts and redirects him. This is the most important initial step in these interactions. Elizabeth not only agrees with her husband, but reassures and also flatters him by asking his opinion about, for instance, joining with the neighbors to pave both driveways or to introduce her to the predator/conman. By asking Bill for advice and guidance rather than opposing his decision, a confrontation with a potentially catastrophic ending can be avoided, but Bill must be prepared for this distraction. Elizabeth could have achieved this by first agreeing with him, flattering him, showing him some sign of love and affection, and then offering alternatives.

Elizabeth's relentless questioning without giving Bill time to respond. Patients with Alzheimer's disease are not able to cope with multiple stimuli. This has been discussed in Case 1 (Too many choices confuse patients with dementia). Elizabeth also was obviously upset. She did not try to camouflage her true feelings which she therefore readily transmitted to Bill who also became anxious, agitated, and upset. They both inadvertently entered a vicious cycle resulting in a gradually increasing verbal then physical confrontation.

Her relentless and pressing questioning unsettled and confused Bill: too many questions rapidly fired without giving him time to respond. Bill became frustrated, confused, and agitated. Furthermore, given his paranoid tendencies, he assumed Elizabeth was against him and accused her of all sorts of nefarious activities.

Could it have been avoided?. Elizabeth could have made enquiries in a less threatening, friendlier manner, ideally after first agreeing with Bill's initiative. She also could have asked to meet with the person offering to resurface the drive: "I'm so excited! What a good idea! Please introduce me to the man outside. I know virtually all our neighbors, I'm curious to know who is having the driveway resurfaced." Elizabeth then could have asked the man outside for more details and references to establish his credentials.

Elizabeth tried to argue with Bill. It is just not possible to argue with patients who have Alzheimer's disease. Given their impaired short-term memory and short attention span, they are not able to maintain a logical flow of arguments, especially if they are upset, irritated, agitated, or anxious.

Could it have been avoided?. Arguments are major pitfalls that should be avoided. Elizabeth should not try to argue with Bill. As mentioned above, she first should agree with him and then very quickly try to distract and redirect him.

Tearing up the check and confiscating the checkbook. By taking that physical action, Elizabeth crossed the line between verbal and physical interaction and now unwittingly is exposing herself to physical retaliation from Bill. He indeed does retaliate and pushes her; she falls and hurts herself: She's fractured her hip.

Could it have been avoided?. By tearing up the check Bill has just written and confiscating the checkbook, Elizabeth sets herself as judge and executioner, thus fanning Bill's flames of paranoia: Bill feels victimized.

Case Discussion

Power Of Attorney

Many patients with Alzheimer's disease cannot manage their own financial affairs. Unfortunately, it is not "whether" but rather "when" they will lose this ability. Given the unpredictable course of Alzheimer's disease, it cannot be assumed that there will be any advance notice. Furthermore, patients who appear to have good judgmental capacity often make irrational decisions concerning their assets. It therefore behooves the patient's family to take appropriate action to maintain the patient's and family's financial assets. As much as possible, therefore legal action should be taken as soon as possible after a diagnosis is made.

Legal incompetence is not determined by physicians but by a Court and is not just based on the diagnosis, but rather on the patient's mental capacity. Impaired memory on its own is not ground enough for mental incompetence. POA is used to grant another person the authority of making decisions on behalf of the patient. It can have very specific and limited parameters or be all encompassing.

There are essentially two types of POA.

- The "durable POA" gets activated when the patient is no longer cognitively able to handle his financial, health, and other affairs. Durable POA is difficult to reverse. It is therefore important that the person selected to have durable POA be a trusted person who knows the patient well. If no such person is available, the Court may designate a "Guardian at large" who can assume these responsibilities and be answerable to the Court.

As the durable POA does not take effect until the patient is mentally incapacitated, it is suggested that it be done as soon as possible after the diagnosis of dementia is made and that the patient plays a very active role selecting that person while the patient still has enough insight and still able to make a decision based on relatively sound judgment capacity. The longer this decision is postponed, the less likely will the patient be able to make a rational selection, and at that time, a number of other irrelevant, possibly capricious and potentially distracting factors may influence the decision.

- The nondurable or ordinary POA can be tailored to specific purposes such as POA for financial affairs or for health care or POA to buy or sell property. Unlike the durable POA which gets activated when the person becomes mentally disabled, other types of POA become invalid when the person is mentally impaired.

Here too, as for durable POA, the sooner the person is selected, the more input is the patient likely to have.

Establishing a "Trust" is another way of authorizing a person or group of people to manage the patient's financial assets. Patients with Alzheimer's disease also should be encouraged to make a will while they are still able to make rational decisions. Consultation with an experienced attorney is recommended to preserve the patient's and family's financial assets. This also could be an opportunity to discuss end-of-life issues. The Alzheimer's Association and Area Agency on Aging are usually able to provide a list of attorneys with experience in these issues in different parts of the United States.

The Clinical Diagnosis of Alzheimer's Dementia

The criteria for a clinical diagnosis of Alzheimer's dementia include the following:

- A decline of cognitive functions from a previously higher level of functioning.
- Evidence of cognitive impairment in more than one cognitive domain. In Alzheimer's disease, the cognitive impairment occurs in the following spheres:
    - Cortical impairment (the four As):
        - **A**mnesia, or memory impairment, especially for recent events.
        - **A**nomia, an inability to name objects or the name of acquaintances.
        - **A**gnosia, or an inability to recognize objects or persons.
        - **A**praxia, an inability to carry on voluntary activities in the absence of any localized muscle weakness. Common examples include inability to button or unbutton one's shirt or tying one's shoe laces.
    - Subcortical impairment (the four Ds):
        - **D**ysmnesia, or difficulties with memory, mostly forgetfulness.
        - **D**elayed completion of various tasks, the patient needs more time to complete various activities.
        - **D**ysexecutive, or impaired decision making ability and judgmental capacity.
        - **D**epletion, or reduced complexity of thought and vocabulary.
- The cognitive impairment is such that it interferes with the patient's daily activities including social functioning, behavior and in late stages self-care.
- All the above occurring on a background of a lucid, alert level of consciousness, that is, in the absence of delirium or confusional states.

Minimal Cognitive Impairment (MCI) and Alzheimer's Disease

The main difference between mild cognitive impairment and mild Alzheimer's disease is that whereas the former does not interfere with the patient's daily activities, the latter does. Patients with MCI are cognizant of their impaired memory and are able to use memory aids such as making lists and other reminders to cope with their professional and daily activities. Although patients with mild Alzheimer's disease may also use memory aids, they often forget to access them when needed, such as the patient who writes a shopping list but forgets to take it with him while shopping or the patient who is given a shopping before he goes to the store but forgets to check it while selecting the items to be purchased. MCI is discussed in another case study.

The Stages of Alzheimer's Disease

Several staging classifications are available including the following:

a. The FAST scale takes into account the patient's Mini Mental Status Examination (MMSE) and classifies patients into seven main categories and 16 subcategories. It is particularly useful in moderate and severe stages of Alzheimer's disease and other dementias as it also includes the patient's physical capabilities, ability to carry on daily activities, personal hygiene, and control over bodily functions. The FAST staging system is therefore useful to evaluate and quantify the type of care the patient needs and is often used in nursing homes, assisted living accommodations, and other institutions.

The FAST scale also can be used to monitor the patient's rate of deterioration and alert health care providers that the patient's condition has unexpectedly deteriorated and that therefore they may be some other pathology worsening the patient's condition. Conversely, clinicians may observe that the patient's condition has not deteriorated as anticipated as may occur when the patient receives some treatment for dementia. The FAST staging will be discussed in detail in a later case study.

b. The three-stage classification: mild, moderate, and severe/late stages.

For patients with early Alzheimer's disease, the three-stage classification is often used: mild, moderate, and severe/late stages. This stratification is easier to use (only three categories, no subcategories) and has management implications. It must be emphasized, however, that there are no clear well-defined demarcation lines between the different stages and that the progression from mild to severe/late stages is a usually a very gradual, insidious process which may nevertheless be punctuated by unexpected sudden severe bouts of deterioration or even some improvement depending on a number of conditions apart from the underlying dementing process. Patients who develop Alzheimer's disease at a young age tend to deteriorate faster than those who develop it at a late age.

Mild stage. In the "mild stage," patients with Alzheimer's disease may give the impression of being essentially "normal" to people who have not known them. They may appear to be slightly "eccentric" but not really cognitively impaired. However, as their judgment is impaired, they easily become victims to unscrupulous predators in society and therefore should be protected from such individuals.

In the "mild stage," patients may also appear to be "normal" to even people who know them but are not in direct contact with them on a regular basis as may happen, for instance, when a son or daughter is only in contact with the patient on an irregular basis.

The main manifestations of "mild stage" Alzheimer's disease include the following:

- Language impairment

Even before anomia (discussed in Case 1) becomes manifest, patients may exhibit changes in their language. Essentially language consists of a series of words interspersed by pauses. Patients with Alzheimer's disease tend to have shorter series of words and therefore more frequent pauses. The pauses between words series also become longer. Patients seem to be searching not only for words but also ideas (Depletion). As this progresses, they may have difficulties remaining focused on the particular issue at hand, especially when they are anxious and under stress.

- Impaired learning ability

Patients find it difficult to learn new skills. This is one of the earliest manifestations of the disease, when the patient may become unable to adjust to changes in the workplace, such as the physical layout of the workstation, computer system used, or changes in the hierarchical lines of authority. Patients also may find it difficult to adapt to changes in the daily schedule and therefore may report to work when they're not expected to and conversely may not turn up for work when they are expected to. This is indeed what happened to Bill in the present case discussion: He had to retire from his job because he found it difficult to adjust to the new computer system.

In some instances, premature retirement is due to the patients' inability to cope and adjust to relatively minor changes at work because they are just unable to change their ingrained habits.

Patients who drive may find it difficult to adjust to a change in the route they usually take as may occur when there is a detour or a new traffic light installed or a new one-way system. Patients may find it difficult to adjust to these changes and to learn new ways of reaching their destination and as a result may get confused and lost. Similarly, they may find it difficult to adjust to relocations to new living quarters and may appear confused and lost trying to find their favorite stores, Church, or other destinations.

- Social withdrawal

Early in the disease process, many patients with Alzheimer's disease tend to avoid social gatherings: They often are uncomfortable being surrounded by people who seem to know them, but they have no idea who these people are. Furthermore, the multiple stimuli generated during social gathering are also

taxing to patients with Alzheimer's disease as they are unable to process all these stimuli. So many patients with Alzheimer's disease tend to withdraw from social events and isolate themselves.

- Depression, suicidal ideation

Depression is not uncommon in patients with mild Alzheimer's disease. In the early stages even before the diagnosis is made, the patients often realize that their cognitive functions are deteriorating and are afraid they may have Alzheimer's disease. They often realize they are no longer as sharp mentally as they used to be and find it difficult to make decisions. This is discussed in Case 1. They may worry about the possible diagnosis before it is made, and once the diagnosis is made, they get depressed because they often still have enough cognitive functions and insight to understand the implications of such a diagnosis. They may contemplate suicide.

As depression and anxiety further aggravate the cognitive impairment, the patient may unwittingly enter a vicious cycle: Impaired cognitive functions lead to anxiety and depression which, in turn, worsen cognitive functions thus worsening the depression and anxiety. Given the presently available medications for anxiety and depression, a consultation with a psychiatrist or health care professional may be appropriate. Electroconvulsive therapy is not recommended in patients with dementia as it may worsen memory impairment.

- Paranoid delusions

Patients may have paranoid delusions and accusatory behaviors. They accuse their caregivers, loved ones, or even strangers of interfering with their affairs and hiding things from them. They sometimes feel they are victims of a conspiracy. It is of interest to note that the very first patient described by Dr. Alois Alzheimer repeatedly accused her husband of being unfaithful to her when she had no reason to believe he was being unfaithful. Paranoid delusions will be discussed in another case study.

Other manifestations of mild-stage Alzheimer's disease include altered diurnal rhythm with nocturnal wakefulness and sleepiness during the day, sleep disturbances, mood changes, anxiety, deeper depression, exaggerated paranoid feelings, and accusatory behavior. These will be discussed in a separate case study.

Moderate stage. Patients in moderate-stage Alzheimer's disease have so much cognitive impairment that it is obvious even to total strangers who have not previously met the patient. The phrase "The lights are on, but nobody is home" is often used to describe these patient's cognitive impairment. Depending on their social skills, they may give a false impression of being cognitively good. Patients in moderate stage should be protected from themselves as they may inadvertently get involved in hazardous activities. These are largely due to the underlying agnosia and lack of insight, have been described in Case 1, and will be further discussed in other case studies.

Severe/late stage. Patients in severe-/late-stage Alzheimer's disease essentially need nursing care. The late manifestations of this stage herald the "Long Goodbye." Patients are gradually less able to meet most of their basic daily activities including personal hygiene and feeding themselves. They sustain repeated falls and gradually become chair-bound and bed-bound, adopt the fetal position, and develop muscular contractions and eventually pressure sores which become infected. They develop urinary tract infections and may become incontinent of urine and later incontinent of feces. They often die of septicemia complicating pneumonia, urinary tract infection, or infected pressure ulcer. The main goal of managing these patients is to provide them with good nursing care.

Unlike nondement patients, however, those in severe-/late-stage Alzheimer's disease are disoriented in time, space, and people and therefore need to be told repeatedly (because of their poor memory and short attention span) and in very simple terms what is entailed by the procedure about to be undertaken. For instance, before attempting to give a bed-bath to a patient in severe-/late-stage Alzheimer's disease, the purpose of the procedure and details of the procedure must be given to the patient BEFORE engaging in it. Furthermore, throughout the procedure, the patient must be told step by step what is happening. These issues are discussed further in other case studies.

Summary

- Because of impaired judgment and agnosia, patients with dementia, especially in the early stages, are vulnerable to predators.
- Legal steps to preserve the person's and the family's financial assets should be taken as soon as possible. A consultation with a lawyer with expertise in this area should be considered.
- Caregivers should neither disagree with nor contradict patients with dementia. Instead, they should first get them to relax by praising their action/intention, and then quickly try to distract them, change the conversation, and deflect the argument or present alternatives.
- The patient's easy distractibility can be exploited to move the focus away from the critical situation. The patient may be offered food or drinks or to get involved in some other activity.
- Patients can also be distracted by the caregivers seeking their advice on some totally unrelated issue

such as the kettle not working or the faucet leaking. Many caregivers find it useful to have a series of activities or objects that "need fixing" such as an electric plug or light bulb that needs replacement, a light frame that should be hung on the wall, clean linen to be folded, . . . Apart from the intended goal of distracting the patient, seeking his advice will make him feel important, relevant, and needed.

- Arguing with patients who have dementia should be avoided as it often triggers paranoid delusions.
- Several staging scales are available. The FAST is useful for moderate and severe Alzheimer's disease while the classification into mild, moderate, and severe/late stages is more useful for early Alzheimer's disease.

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