

The Guidebook for Dementia Care (excerpt)

～ for the standardized practice in **Japan** ～

Japanese Nursing Association



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Foreword

“How does Japan manage the issues of aging?”

We’ve been routinely asked such a question for some years at the international conferences and meetings including ones hosted by the ICN. With all the baby boomers turning 75 years of age or over in 2025, Japan will experience an unprecedented super-aging society in the world.

We thought we knew, but when asked for an answer by the countries from which we had been learning, it made us, the nurses in Japan, realize that we were facing to “unprecedented issues” that had to be solved.

Around that time a projection was announced by the Ministry of Health, Labour and Welfare that the number of people with dementia in Japan will reach over seven million in 2025. Dementia will no longer be a rare disorder if one out of five aged 65 or over is diagnosed with it.

While JNA had been offering programs to prepare dementia care specialists, now we strongly recognized that we needed to give support to every nurse so that she/ he might provide appropriate care to the people with dementia based on appropriate knowledge.

Our goal is to establish a society where the people with dementia can spend their time comfortably throughout their lives, together with their loved ones and families and people in their community. This coincides with the philosophy of “Community-based integrated care systems” currently promoted in Japan.

As described in the JNA’s Future Vision of Nursing, nursing practice is to support and sustain human life, living and dignity of all generations with any health condition including people with dementia, as well as the elderly in the local community.

Then, where do we start? As a professional association of nurses, we, first, decided to create the primer of fundamentals for all the nurses involved in dementia care, which goes back to Nationwide Forum for Nurses (II) in June,



2015.

Responding to my declaration to create “*The Guidebook for Dementia Care*” by the following June, the Executive and staff members in charge together with the authors made a great effort, and their hard work paid off and came to remarkable fruition.

The book covers all subjects from fundamentals of dementia, the latest health-care policy, care practice to cases of community collaboration, and is strongly recommended for practicing nurses, newly graduated nurses and nursing students.

Suga Sakamoto, RN, RNW, PhD

President of JNA

June 2016

Preface

Requested by the Japan Academy of Gerontological Nursing, JNA authorized dementia nursing as one of the designated fields of the Certified Nurse System and started preparing Certified Nurses in Dementia Nursing in April, 2005.

However, given the rapid increase of the elderly that need dementia care in Japan, not only the specialist nurses but also all the nurses should learn dementia care.

In addition to the education of specialist nurses and CE courses for general nurses on dementia care, JNA has been sharing issues and challenges in dementia care at the Nationwide Forum for Nurses II (including nursing care, residential care facilities, home care and etc.) , responding to the “Five-Year Plan for Promotion of Measures Against Dementia (Orange Plan)² announced by the Ministry of Health, Labour and Welfare in 2012. This Forum is targeted at nurses working in long-term care and home care settings and held by the JNA Professional Committee for Nurses II, which was established in 2011.

Given dementia measures evolved from the “Orange Plan” to the “Comprehensive Strategy to Accelerate Dementia Measures (New Orange Plan)” and the practice of dementia care would particularly be of great significance in Japan, President of JNA delivered a keynote speech titled “The Future of Dementia Care that JNA Promotes” at the Nationwide Forum for Nurses II in 2015.

When she declared that JNA would create a guidebook for dementia care by our next General Convention, I was completely startled because it was not on our agenda for the year.

Yet, it was true that there was not an appropriate textbook in Japan that fills the needs of those nurses who'd practice and/ or learn dementia care.

Started in the end of 2015 FY, the editorial board had extensive meetings to develop a plan of a guidebook, to which a number of the specialist nurses and other healthcare providers contributed. The product, *The Guidebook for Dementia Care*, is comprised of nine sections including fundamentals of symptoms of dementia, ethical standard, symptom assessment, ADL assessment,



fundamental of care management, support for families and so on. It is easy to understand with multiple illustrations, graphs, charts and diagrams.

As its contents are broken down into short sections, the reader may start reading at any part.

This guidebook is assuredly valuable to all the nurses from those who take care of people with dementia for the first time, those who are striving for better outcomes, to the leaders responsible for developing a care system in their practice settings.

I invite you to read and employ it for practice, education and training.

Last but not least, I'd like to thank all the contributors and editors for working so hard under such an extremely demanding schedule.

Noriko Saito, RN, PHN, MNS

Executive Officer of JNA

June 2016

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References Assessment tools for dementia care

Part IV

Assessment of symptoms and treatment of PWD

4. Assessment and care for people with BPSD

① Approach for accepting care and treatment

Approaches predicting anxiety and confusion of PWD upon admission to the hospitals and assisted living facilities.

PWD are likely to be anxious and confused. They may become anxious, wondering, “Where am I?”, “Why does my body ache?”, or “What are all these tubes around me?”, even though they were already informed of the need for admission.

First, a team of care providers need to find which approach would help them perceive their surroundings (verbal/ nonverbal comprehension), to take account of their retention of memory (impairment of short-term memory), then to repeat a message with patience, accordingly.

Allocate a room to the PWD which is near enough to the nurse station for easy observations and visits.

It is necessary to detect complications early and to reduce stress, observing patient's response to frequent visits and monitoring alterations in facial expressions, sleep condition, restlessness, ag-

itation and other conditions.

It is also advantageous to create a dementia-friendly environment using signage and visual aids to show the name of the hospital and disease, and placing a calendar and a clock at a place where they can see from their bed.

Give explanations patiently and thoughtfully, assess person with dementia the PWD's abilities and apply them in practice.

Some of PWD may have a concern that they don't have enough money; that they don't know if they have a place to sleep or food to eat; that they have to “go home” because their families are worried. When faced with such a case, explain to them they don't need to worry or ask their families to stay on the admission day, until the evening. Asking them what makes them concerned is also effective.

Understanding a causal relationship among physical, social and psychological contributing factors

Dementia, in addition to the development of multiple cognitive deficits is often exhibited with BPSD (behavioral and psychological symptoms of dementia), which can be major contributing factors that diminish the quality of life of PWD and their caregivers.

BPSD, associated with the damaged regions of the brain and progress of cognitive dysfunctions, appear with the influence of other physical and psychological states, inadequate interpersonal stimuli and other environmental factors.

For example, some person with dementia PWD accidentally pull out the tubes and catheters,

while they are receiving the IV treatments and tube feedings. When it happens, they often don't comprehend why they need the IV or why they have tubes in their nose. Even though they were informed of the need of care and treatment, they can't help but react, as physical sensation such as discomfort and pain precedes because of memory impairment.

In such actions, care staff are apt to consider using physical restraints, thinking providing safe care and treatment is impossible.

However, if the care staff alter the ways of communication, person with dementia may be able to retain in mind the need of care and treatment.

Perhaps, some clues can be found by altering the predisposition of the care staff, so that they may consider the possibility of oral rehydration, antibiotics and feeding instead of tubes and IVs.

Avoid assuming that PWD cannot understand medical treatment; that they will not understand what types of care they receive, but think of the method, timing and arrangement of information provision appropriate for their impaired and limited cognitive ability.

For instance, by placing display boards which illustrate the treatments and care process, person with dementia PWD may see the same familiar information anytime and by giving the same explanation repeatedly, they may have a better recognition of their situation.

Care staff should understand the temperament of each PWD and try to engage in persistent but thoughtful message delivery. Be sensitive to the causal relationship among the person with dementia PWD's physical, social and psychological factors, and grasp the person-specific clinical presentation of each PWD.

The importance of observing facial expressions and behaviors

In the case of people without dementia, their direct complaints of pain and numbness can be more crucial than objective observations and could lead to early detection of complications and identification of stressors.

In contrast, because the PWD rarely complain of symptoms or contrary they present a variety of them, it is difficult to make accurate assessment and diagnosis.

It is important to make observations of their physical conditions as well as monitoring through frequent visits their responses, changes in facial expressions and complaints, sleep conditions, restlessness and agitation.

Even if the person with dementia do not complain of pain or discomfort, carefully look at their facial expressions and behaviors for any change when the care staff moves their body.

When encountering refusal of physical movements and care, review the procedures and anticipate any possible pain and discomfort concurrently.

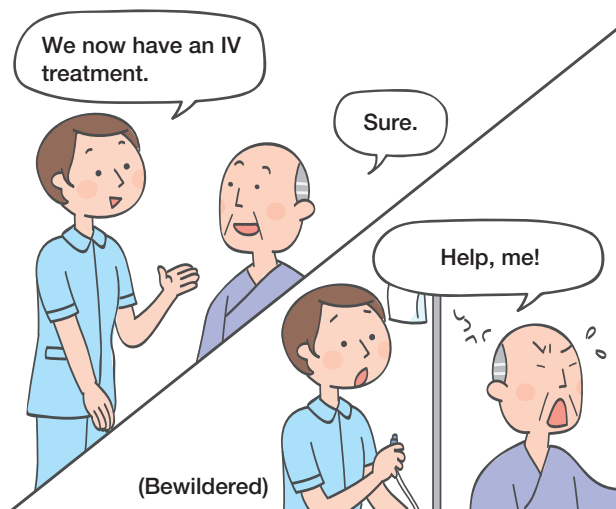
The care team should develop the care plan that minimize the person with dementia PWD's pain and discomfort, employing validated non-verbal pain assessment tools and measuring the pain levels by the their reaction before and after administering analgesics.

CASE ▶ A Patient refusing to receive the IV treatment previously agreed

Mr. A, in his 80's, had Alzheimer's disease (middle-stage), and was admitted for a femoral fracture and underwent the hip replacement surgery.

1) Condition after surgery

After the surgery, patient A agreed on an IV treatment such as administering antibiotics, yet when receiving venipuncture later, he started screaming for help and resisted the treatment, making it difficult.



2) Care we actually provided

Because of memory impairment, patient A, being incapable of understanding the validity of any treatment accompanied by discomfort, may have reacted at the moment of venipuncture.

Following this incident we asked him to use his glasses and hearing aids he had been using, and explained the purpose of the treatment with some visual aids so that he could thoroughly understand it. Then while having him confirm the IV bottle, the catheter and the insertion point, we explained the procedures in order and were able to insert the needle without resistance.

Then, we secured the venous access applying dressing without pressing a hard catheter hub against his skin, looped the IV tubing on his limb to prevent dislodgement of the catheter from tension on the line and secured the tubing with tape.

Furthermore, venous access was covered with a towel so that it might not be visible to the patient, and we explained to him that he was with an IV each time of visit. Now, patient A neither touched the tubing nor did he pull out the IV line.

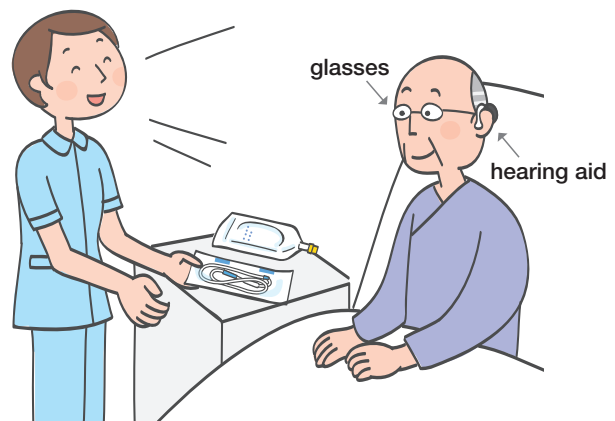
3) Key points of care

First, it is vital, as a team, to discuss the manners of explanation suitable to the patient's comprehension (verbal/non-verbal comprehension) and his capacity of memory retention (immediate memory), then customize the approaches to explain the procedures in order.

If a patient regularly uses the glasses and hearing aids, suggest their use continued for smooth communication, with the aid of both writings and drawings.

Or, show them the IV bottles, needles and insertion sites so that he can retain a solid, uninterrupted image until the time of the IV treatment and keep a sense of security.

An IV treatment makes anybody uncomfortable, causing pain and discomfort. Therefore, it is essential for nurses to be watchful to eliminate possible discomfort factors such as redness and itch caused by fixing the insertion sites.



Part IV Assessment of symptoms and treatment of PWD

4. Assessment and care for people with BPSD

② Restlessness

The state of restlessness

Tranquility indicates the state of being tranquil, of calm behaviors and of being calm. The state of restlessness in clinical practice includes fidgeting, jittering, wandering and inattention and it can be a hindrance for the bed rest or increase the risks of falling, which can be a direct cause of the secondary health problems and administrative difficulties. Thus, it is considered as BPSD.

In our hospital, the Dementia Support Team (DST) is assigned to support nurses caring for PWD in the wards. Restlessness is one of the top-listed subjects among the cases reported to the team. It could be, among BPSD, a symptom which creates more difficulties in the person with dementia care process.

Key points in assessment

First, consider such fundamental extraneous factors as in **Table 1**, then observe the PWD. Next, evaluate the possible contributing factors

for restlessness (**Table 2**). Analyzing what causes restlessness in detail is essential in order to make suitable care plans.

Key points in care

First, extraneous factors in Table 1 need to be removed. Next, approaches meeting each factor

in Table 2 should be developed.

Table 1 Observation checklist

physical symptoms	Does a person with dementia have constipation, fever, dehydration, pain, acute exacerbation of chronic diseases and etc.?
Environmental factors	Are there unpleasant stimuli (noises, lights, odors)? Are there familiar objects in the person with dementia surroundings?
Timing of the appearance of symptoms	Do the symptoms emerge at certain times of the day
Triggers and purpose of the behaviors	Find out the triggers preceding the episodes of restlessness. (Think how old person with dementia think they are (in their cognition) and what responsibilities they think they have to fulfill?)
Sleep/awake cycle	Observe hours of sleep, frequency of night-time arousals and day-time drowsiness and sleep quality.

1. Delirium

(skipped)

2. Akathisia

Akathisia is a condition marked by uncontrollable motor restlessness. It is hard for patients, but is often overlooked.

Because it develops as a side effect of antipsychotic medications, consult with the attending physician to modify the drugs or the dose.

3. Sundowning syndrome

Because it is a behavior related to the habit of returning home in the evening it is often called sundowning syndrome. It is a common symptom in a clinical practice, but its mechanism has yet to be known.

It is believed to be related to the busy hours of the shift changes in the evening or the preparation of suppers in the hospitals and care facilities in the evening. Therefore, creating a calming environment is significant. Furthermore, circadian rhythm disturbance is also considered to be a contributing factor. Providing daytime activities and moderate rest to ensure nighttime sleep are crucial.

It may also be helpful to conduct an interview regarding the person with dementia life cycle and to create an approach to meet the person with dementia purposes for “going back home”.

4. Wandering

Wandering, defined as “to move about without a definite destination or purpose” in American Heritage Dictionary. Each pattern has its own contributing factor, therefore planning an approach suiting each pattern is needed.

The examples of patterns are shown in **Table 3**.

If patients appear to be restless but not troubled, be flexible, monitor them carefully for accidents such as falls, allow them to enjoy walking around freely to a certain degree, overseeing patient’s fatigue.

Sharing documents of their daily conditions in order to find potential risk factors for wandering can also be a clue to a plan for the care and treatment.

Table 2 Contributing factors and assessment for restlessness

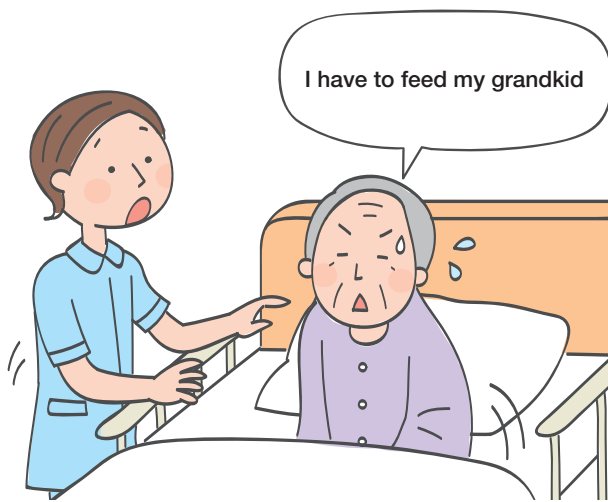
	Definition	Contributing factors	Point in assessment
Delirium	<ul style="list-style-type: none"> ● Acute onset ● Exhibiting slight deterioration of consciousness 	<ul style="list-style-type: none"> ● Predisposing and precipitating factors interacting with multiple aggravating factors 	<ul style="list-style-type: none"> ● Demonstrating restlessness within a few days ● Low responsiveness
Akathisia	<ul style="list-style-type: none"> ● A type of extrapyramidal symptoms ● Showing such involuntary movement as long-stepped gait 	<ul style="list-style-type: none"> ● Adverse side-effects of antipsychotic medication 	<ul style="list-style-type: none"> ● Complaints of fidgeting ● Unable to keep still while complaining
Sundowning syndrome	<ul style="list-style-type: none"> ● BPSD emerging and worsened in the afternoon or evening 	<ul style="list-style-type: none"> ● Often appearing at the time of minimum staffing in the facilities 	<ul style="list-style-type: none"> ● Occurs in the evening ● The PWD try to perform former roles, showing the occasional signs of impatience
Wandering/pacing	<ul style="list-style-type: none"> ● Wandering around with no apparent aim ● Looking for an exit 	<ul style="list-style-type: none"> ● Disorientation (confusion in sense of direction) ● Boredom, anxiety 	<ul style="list-style-type: none"> ● Patterns depending on contributing factors and patient’s aim or purpose

CASE ► Restless throughout day and night during the hospitalization

Mrs. B, in her 90's, had Alzheimer's disease, and was admitted for acute decompensated heart failure.

1) Conditions at the beginning of admission

With dyspnea, being agitated and incapable of staying in bed, she spent most of the time in a wheelchair, saying, "I don't have time to lie in bed" or "I have to feed my grandkid". She was restless day and night, but occasionally was drowsy because of sleeplessness at night.



She periodically complained of pain for peripheral edema, apparently caused by long hours of being in a sitting up position.

2) Care we actually provided

We allotted time for letting her lie on the bed and elevate her legs during the day for pain relief. And we also let her take a nap for a half an hour

after lunch, ensuring she could rest for a while.

Given her heart conditions, we positioned her in semi-Fowlers' position for the night.

Since she used to spend a great deal of time for taking care of her grandchild, we made a request of her grandchild to write a letter which wished for her quick recovery and employed consistent approaches to inform her of the importance of treatments together with the well-being of her grandchild by showing the letter.

Oral medication, fluid restrictions and diet therapy for heart failure were concurrently implemented during hospitalization.

3) At a later time Outcome

Because impairment of her short-term memory was severe, she often forgot about the need of leg elevation and her hospitalization; however, an approach with the help of the letter from the grandchild improved her recognition of surroundings.

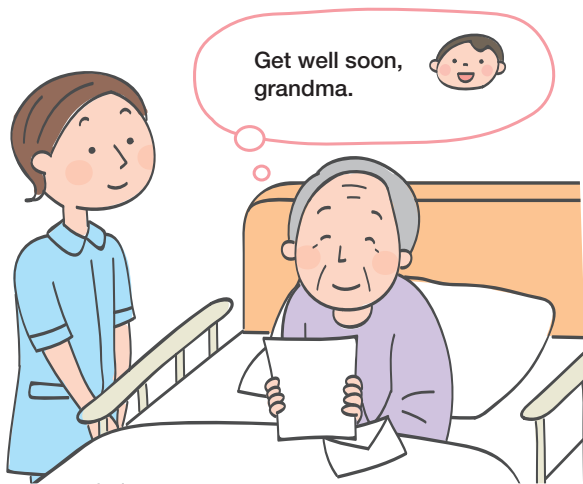
At the beginning, she remained uneasy even when encouraged to take a nap. Gradual reduction of physical symptoms (dyspnea on exercise, leg edema) because of the effectiveness of treatment made it possible for her to take rest, improving her daytime drowsiness.

Table 3 Wandering patterns

False recognition	<ul style="list-style-type: none"> ● When disorientation worsens, PWD suddenly lose the idea where they are. ● Wandering off on the way back or while looking for the exit
Inclination (impatience)	<ul style="list-style-type: none"> ● Goal-oriented: e.g., leaving their home believing they are going to work in the morning (former workers) or going shopping in the evening (former house wives). ● Accompanied with compulsion and impatience
Aimless stereotyped behavior	<ul style="list-style-type: none"> ● Aimless or purposeless walking
Alterations of consciousness	<ul style="list-style-type: none"> ● Wandering with slight disturbance of consciousness even in the daytime ● Wandering half awake ● Often accompanied with hallucination and/ or delusion

We found that she became physically active in the morning when she awoke and in the evening, trying to prepare a meal to fulfill a responsibility from her earlier life.

After developing consistent approaches, we repeatedly told her that “we have arranged supper for three people (for her, her husband and grandchild)” in the evening, and that “breakfast for three people is ready” in the morning. Hearing this, she became calm.



4) Recommendation

Aside from being unable to recognize admission because of impairment of short-term memory and disorientation, this is an example that abominable symptoms such as dyspnea and edema caused by heart failure induced confusion.

When a person with dementia exhibits difficulties to keep still in bed, consult with the attending physician and ask instructions for the right position.

In the case, what made her taking a rest possible was the comfortable positioning and the effectiveness of treatment.

Arranging surroundings is also essential, so that PWD necessary treatment and nursing care may be provided to PWD.

As described in the case, in which we took advantage of the letter and approaches considering her life history and routines, it is vital to build an familiar approaches which enables person with dementia to give their full attention to the treatment.

4. Assessment and care for people with BPSD

6 Treatment refusal

What is refusal of care?

Not accepting care and treatment, refusal or resistance in other words, is generally considered part of aggression. No major differences are recognized in the approaches to both “refusal” and “aggression”.

PWD tend to show aggression when they receive offensive stimuli from the outside, which may be distorted by the visual and hearing impairment and/ or by their persecutory delusion.

Decline in frontal and temporal lobe function causing loss of control, decline in the function of the brain serotonin system, and acceleration in norepinephrine functions and other factors activate sense of anger.

There are other related cases affected by psychology symptom such as hallucination, misidentification and impatience (Table 1).

The causes of anger in PWD described in the section of “Aggression” are also applied to a refusal of care.

Before discussing approaches for rejection of care, the effects which assistance and care bring about to the PWD must be taken into consideration.

For example, when one is absent from work because of a fever and need to ask somebody for help, he or she may have the sense of guilt, inferiority, anxiety of the job, irritation over things they cannot control, impatience, uneasiness of recovery and fatigue for the ill.

Other person may become more dependent, demanding more attention and care, which also indicates anxiety.

PWD are not exception. When assisting, keep in mind that they become resistant to care and treatment because they experience fatigue from illness (PWD may feel psychological and cognitive fatigue caused by overthinking and too much attentiveness), anxiety, impatience and self-accusation.

In our hospital, we have a dementia support

Table 1 Contributing factors for to irritability

Physical factors	<ul style="list-style-type: none"> ● Functional disorder of neurotransmitter (serotonin, norepinephrine) ● Visual and hearing impairment ● Adverse side effects of anti-dementia drugs ● Frontal and temporal lobe dysfunction
Psychological factors	<ul style="list-style-type: none"> ● Persecutory delusional cognition ● Hallucination (visual, auditory, olfactory) ● Premorbid personality (nonreciprocal behavior, self-restraint/inhibition, impatience, misidentification)
Environmental factors	<ul style="list-style-type: none"> ● Unpleasant stimuli ● Offensive stimuli

Source: early period of BPSD dorrespondence guidelines

team (DST), multi-disciplinary dementia support team. The DST is dispatched to each ward, conducts an assessment of troubling cases, and discusses care plans together with nurses in the ward.

Among the reports to the DST, the following are the examples of treatment refusal: rejection of

oral medication, daily personal care services (including changing diapers, bathing, dressing, oral and dental care, ambulation and etc.), urethral catheterization, eating and others.

We'll discuss rejection of oral medication and bathing in the next case.

Approaches for rejection of oral medication

CASE 1 ▶ A question from a family: "Can we mix medications with food?"

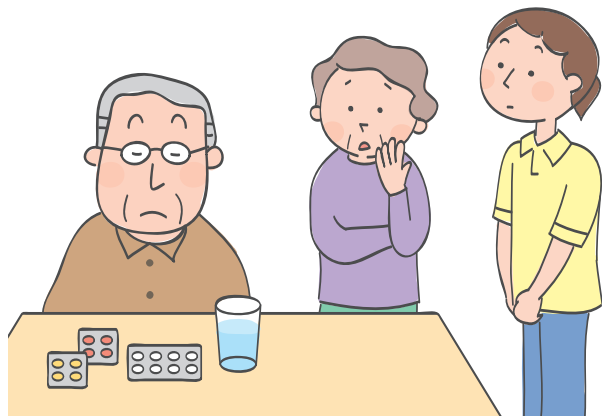
Mr. C, in his 80's, had Alzheimer's disease. We were consulted by his family regarding mixing medications with food.

1) Key points in care

① Investigate the causes for rejection

The patient used to take his drugs himself, but when the family decided to manage the schedule and gave it after a meal, he forgot to take it. Next time, the family tried to put them into his mouth, he spit it out. Later they attempted again, but he refused and firmly said he would not take it.

We concluded he grew suspicious because his family suddenly took over the matter. We proposed them that they should let him handle it as he used to, encouraging him and watching over him so that he would take it.



② Confirming the prior procedures of his medication management

Because he wasn't prescribed multiple medications, he managed the medication himself. He used to open the package, put the pills in his hand, then swallowed them. This time he had one kind of pill prescribed. As it was in a blister pack, the family took it out and put it in his mouth, ensuring he took it.

③ Evaluating progress of cognitive functions deterioration and BPSD, discussing methods for oral intake.

Total score was 20 on MMSE. He sometimes repeated the same questions.

We advised the family to hand him a pill in a blister pack one at a time at first. If he would swallow it with the package still on it, then, the family should take the pill out, place it in his hand and ask him to take it. We also suggested that the family should explain to him it was prescribed by his primary care physician and then put it in his hand, if he is stuck.

2) Recommendation

Following the procedures, he took the pill.

Avoid mixing medications with food as much as possible. He might even stop eating, if he thought the mixture tastes terrible. In addition, support should be minimal so that it may not interfere with his ability.

There are some occasions to mix medications with strong-tasting food (e.g., chicken noodle soup or chocolate pudding) to mask the flavor. It should be saved as a last resort to avoid food-drug interactions. Consult with a pharmacist or physician before doing so.



CASE 2 ▶ Noncompliance to medication regimen despite repeated explanations by nurses

Mr. D, in his 80's, had vascular dementia and exhibited verbal aggression and agitation. He was prescribed liquid medicine but highly resistant, being continuously agitated.

1) Key points in care

① Organizing medications

Because the elderly patients may see multiple physicians, medications are not consolidated. Not knowing about their medications, they are unable to discontinue, thus would routinely keep taking them.

They may lose track of their medications. And more medications may be added without being noticed, which could cause a physical disorder.

Their medications need to be organized sorted out at some point.

② The vicious cycle of obsessions to take medications as directed

Nurses think their job is to administer drugs, thus they are determined to do it by all possible means. In fact, the nurse was baffled, saying that the patient B ignored explanation and refused medications.

When a person with dementia is adamant in refusal and is agitated, efforts to create a good interpersonal relationship could worsen the aggravation.

We suggested that nurses try once and give up

if an attempt failed, because the patient needed to be ready to listen.

Forcing him to take medication when he is not ready only makes procedures harder and daunting to perform.

Discussing with his physician, we let him grasp the situation.

③ Consistent methods and assessment of administering oral medications

We proceeded with avoiding repeated reminder for medication, giving the patient time and shuffling the nurses.

The ward nurse tried this approach for a week and was able to find the timing somehow. The patient, slowly but surely, started taking his medication with the approach.

④ Find shape, size, and other attributes of medications which suit to the patient

We asked person with dementia B's pharmacist to find forms of medications adapted to him, which include tablets, capsules, powders and liquids. Tablets come as chewable tablets, oral disintegration tablets, extended-release tablets, sugar-

coated tablets, enteric-coated capsules and sublingual tablets. Patches are increasingly becoming common these days.

2) Recommendation

Try not only to develop a regimen for the patient's drug intake but also evaluate it, when the patient rejects oral medications. Making it as daily routines, with setting a regular time, will help nurses seeing the efficacy.

In addition, consultation with the pharmacist and the physician in regard to sorting out the medications and prescribing as minimum number as possible for easy oral intake should be necessary.

In this case, we consulted the pharmacist since it was particularly about medications; however, asking for expert advice and professional knowledge from other specialists may be also helpful in pursuit of effective care.

Approaches for bathing resistance

CASE 3 ► Refusing to bathe even when nurse invited

Mrs. E, in her 80's, had dementia with Lewy bodies. She was noncompliant to regular bathing, and was aggravated when asked persistently.

1) In the beginning

In our hospital, bathing is implemented during the day. She had cataracts, being almost blind. She didn't even want to be touched, much less to be assisted by another person. She was also cold-sensitive, and hardly took a bath at home.

Her family said it would be fortunate, if she could bathe once a month at the day care center.

When she bathed at home, the family assisted her just the right time that she went to bathe, but they had difficulty in predicting exactly when she did.

2) Key points in care

As she had dementia with Lewy bodies (DLB), we stopped getting her to bathe, but just found out the time she was in a good mood or exhibited delusional behaviors. Since she could not take bathe for herself, we arranged some nurses to attend her, but to a minimum of one or two, taking into account her need for privacy.

Nurses felt rushed when other patients lined up in turns. So we prompted her twice a day in the morning and afternoon to bathe after other patients had finished bathing trying not to disturb

her preferences. When she was still resistant, we only gave her a foot bath and cleaned only the genital areas after her using the toilet.

We ensured that the bath room was warm enough, then invited her when she went out of room, at the end of rehab, before meal times and at other occasions.

Using the same approach and a familiar nurse, we tried to encourage her telling that she would have some fun after bathing or that she was expecting visits of her family or guest, but any attempt did not work well. We asked her family to invite her and bathe together, but couldn't ask many times over, because it was burdensome to them.

3) Recommendation

Bathing three times a week is not required. In our meeting, we decided that we would prepare the environment that might lead her to bathe, and that we would keep on encouraging with patience. Later, she started responding to the nurse's invitation and bathed once a week or every other week.

There is no "universal approach" but we need

to be flexible to the person with dementia preferences and find an approach for each individual and assist the person.

Both success and failure are learning experiences, which help nurses enrich their knowledge and skills.

The more challenging the cares are the more the care staff gain.

It may be because we give our full attention to the person trying to figure out what is best for her/ him.

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