

THE MDTEA GUIDE TO CARING FOR OLDER ADULTS WITH COGNITIVE IMPAIRMENT



MDTea
Podcast



Welcome to the MDTea guide to caring for older adults with cognitive impairment.

Set up by Dr Iain Wilkinson and Dr Jo Preston, the MDTea started with an interest in podcasts and the using power of storytelling for learning and has grown into a suite of resources for those health and social care professionals that are lucky enough to work with older people.

We wanted to share our infographics and show notes in an easy to access way to support learning for all members of the multidisciplinary team. This book will give you information and questions to consider when caring for an older person with a temporary or long-term cognitive impairment.

On each page you will find information all about a condition or a topic related to the care of older adults with cognitive impairment. This will include understanding mental capacity assessments, delirium and dementia. You'll also find a copy of each episode infographic which gives you the quick information about the topic.

On each infographic there is a QR code which if you hold up your phone camera it will open your browser on the episode webpage.

Have a go with this QR code which will take you to our first ever and most popular episode all about Comprehensive Geriatric Assessment!



You can find all of our episodes on our website.

You'll find episode show notes, links to all references and sources, curriculum mapping and a CPD log where you can record your listening.

You can also find us on your favourite podcast provider we are the MDTea Podcast.

Scan this QR to find us and listen right away!



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A SIP OF MDTEA EPISODE 6

CAPACITY

SUMMARY OF
PRINCIPLES
MCA 2005

**CAPACITY IS ASSUMED UNLESS
PROVEN OTHERWISE**

Reference: all 80's fashion

SALT
Interpreter
Family

Quiet Area
Free From
Distractions

**PEOPLE ARE ALLOWED TO MAKE
'UNWISE' DECISIONS**

**TAKE ALL PRACTICAL STEPS TO
SUPPORT DECISION MAKING**

Hearing Aids
Glasses
Write It

**IF LACK CAPACITY: ANY ACTIONS MUST
BE IN THEIR BEST INTERESTS
& BE THE LESS
RESTRICTIVE
OPTION**



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Capacity (1.6)

There are 5 key principles in the Mental Capacity Act (2005):

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Capacity is **DECISION SPECIFIC** and must be assessed for each individual decision. A person may have capacity for some decisions but not for others depending on the complexity of the question. There is no such thing as a blanket capacity assessment.

Assessment of capacity is a two-stage process.

- 1- **Diagnostic Test**- asks is there is a disorder of the mind or brain which may be influencing a person's ability to make decisions at the present time?
 - a. If yes- is the impairment temporary? E.g. are they likely to recover?
 - b. How urgently does the decision need to be made?
- 2- **Capacity test**- for a capacity test to be valid you **MUST** demonstrate and document each of these areas of decision making. In order to demonstrate capacity the person must be able to:
 - a. Understand the information around the decision and why they need to make it
 - b. Weigh up the risks and consequences of making or not making the decision
 - c. Retain the information long enough to make the decision
 - d. Communicate the decision- via any communication form eg verbal, written, sign language. *A speech and language therapist may be involved to support the person to understand and communicate and may use additional tools and methods to support communication.*

IMCA: Independent Mental Capacity Advocates are people who can act as an advocate for a person who does not have anyone else to do so in making a decision.

The Court of protection: is a government organisation that makes decisions on financial or welfare matters for people who do cannot make decisions at the time

they need to be made because they lack capacity. The court can appoint deputies to make decisions on behalf of people, or give people one off permission to make a decision on a persons behalf. The court also makes decisions as to whether a person can be deprived of their liberties under the mental capacity act.

Lasting Power of Attorney: A person legally appointed to make decisions on another person's behalf in the event that they lose capacity to make decisions for themselves. They must be appointed whilst a person has capacity and only becomes effective when a person loses capacity. LPA can be held 'jointly' meaning all LPA parties must agree decisions, or 'jointly and severally' meaning they can make decisions jointly or independently. There are two types of LPA, health and welfare or financial and some people may have both in place. A person acting as LPA should act in the best interests of the person they support, considering their wishes and supporting them to make decisions themselves as far as possible.

How does considering capacity impact your daily work?

What might lead you to consider assessing a persons capacity? ?



A SIP OF THE MDTEA PODCAST EPISODE 2

DELIRIUM

IT IS COMMON

Delirium is common affecting around 20% of medical patients in hospital

THE 2 TYPES

HYPERACTIVE - agitated
HYPOACTIVE - sleepy, drowsy



DRUGS ARE BAD

Usually make things worse.
The Anti-Cholinergic Burden (ACB)
Scale ranks drugs by their likelihood to worsen the confusion

KEY FEATURES

Acute Onset
Fluctuating Course
Altered Consciousness
Disturbed Perceptions
Impaired Cognition

MEDICAL CONDITON

It is a sign of an underlying problem that needs treating. There are many many causes, so a comprehensive review is required.



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Delirium (1.2)

“Any acute change in normal cognitive state for that person.” It is a temporary and reversible state. It can be **HYPERactive** (restless, agitated with poor concentration) or **HYPOnactive** (withdrawn, quiet and sleepy), and often people experience both.

Delirium is common with 20-30% of medical inpatients, and 50% of orthogeriatric patients post-operatively, developing delirium at some point.

Assessing delirium

Assessment models for screening delirium include the Confusion Assessment method (CAM) and 4AT. The 4AT is commonly used, it is quick and easy to use, and well validated across health settings. A score of 4 or more is indicative of delirium, and 1-3 is indicative of cognitive impairment. However, it is important to remember that a score of 0 does not exclude delirium or cognitive impairment.

Alertness	0= Normal 0= Mildly sleepy 4= Clearly Abnormal	Attention (months of the year backwards)	0= 7 months correctly 1= starts but <7 named 2= untestable
AMT4 (Age, Date of Birth, Place, year)	0= No mistakes 1= 1 mistake 2= 2 or more mistakes	Acute or fluctuating course.	0= No 4= Yes

Causes of delirium:

PINCH ME is a useful mnemonic for considering the causes of delirium.

P	Is the person in pain? Have they got wounds or injuries? Have they had analgesia?
I	Is there a potential infection?
N	How is their eating? Have they eaten well?
C	Are they constipated?
H	Are they hydrated? Do they have drinks available?
M	Have they had any changes in medication? Consider medications with anti-cholinergic properties? Are they withdrawing from a medicine? Are they withdrawing from recreational drugs or alcohol?
E	Is the environment supportive? Is it light? Is the name of the ward clearly displayed? Are clocks and windows visible? Are they in a new location?

Treating delirium:

Alongside treating the underlying cause for delirium, there is good evidence for the use of multicomponent interventions to reduce delirium by a third with the benefits are seen within the first couple of days. Multicomponent interventions require attention to many elements of care which require time and skill to deliver, but evidence has shown they are cost effective.

Prognosis:

Delirium is a marker for increased mortality for hospital in patients. It is particularly predictive for patients without dementia. Once identified and treated two thirds of people with delirium will improve within a week. However, some people may remain delirious for weeks or months and some will not get better. People with dementia are less likely to recover.

What features might lead you to suspect a delirium in the people you care for?

What are some of the things you could do to support a person experiencing delirium? Think of multicomponent interventions.



Diagnosing Dementia

...to be done when the person is stable (i.e. not generally during a hospital admission)

History

Take a detailed history from the patient. Look for a cognitive impairment and ask what the functional result from this is?

STEP
01



STEP
02

Collateral History

The whole MDT can get information from others. What have they noticed the person finding difficult?

Examination

Physical, mental state and specific cognitive tests. Eg. Addenbrooke's, MMSE, MOCA, Clock drawing etc.

STEP
03



Investigation

Rule out other causes using blood tests and imaging. CT or MRI can sometimes help decide subtype of dementia

Diagnosis

Put it all together to make a diagnosis. Think about possible subtype as this will affect management

STEP
05



60% is Alzheimer's Dementia
30% are vascular or mixed dementia



Diagnosing Dementia (2.4)

"Dementia is a progressive and largely irreversible clinical syndrome caused by pathological changes to the brain which are not simply due to ageing. It is not an inevitable part of the ageing process".

The key difference between normal ageing and dementia is that dementia leads to a **functional** impairment for your patient.

Generally, a diagnosis of dementia should not be made during a hospital admission as there are too many variables and delirium is common. One small study looked at OT assessment of a patient's functional abilities in clinic vs home, and assessments should be performed in a person's usual environment.

To make a diagnosis:

- 1) Take a really detailed history looking for cognitive decline AND functional problems associated from this. Also review medications to identify and minimise use of drugs, including over the counter products that may be affecting cognitive function, along with other causes such as alcohol or toxins.
- 2) Complete an examination:
 - a. Cognitive and mental state examination looking at a number of cognitive domains:
 - i. Attention and concentration
 - ii. Orientation
 - iii. Short and long term memory
 - iv. Praxis
 - v. Language
 - vi. Executive function
 - b. Physical examination
 - c. In some cases neuropsychological testing may be needed
- 3) Investigations:
 - a. Basic dementia screen including:
 - i. Routine bloods looking for reversible causes of cognitive impairment e.g. delirium, high calcium, low glucose, encephalopathy, thyroid function tests, serum, Vitamin B12 and folate levels.
 - ii. Imaging of the brain: MRI is better than CT. HMPAO single photon emission computed tomography (SPECT) may be used to differentiate between types of dementia if it is in doubt.

There are 4 main subtypes of dementia:

Alzheimer's Dementia (80%)	Mild symptom onset. Problems with memory especially making new memories. May lose belongings, forget recent events or conversations and forget how to make familiar journeys. People with Alzheimer's may go on to have visuospatial problems and get disorientated.
Vascular dementia (15%)	Memory loss is not usually an early symptom in vascular dementia. Instead, people may have problems with decision making or problem solving. They may forget how to carry out daily tasks and have slower speed of thinking.
Lewy Body Dementia (5%)	Has some similar memory and concentration problems as Alzheimer's, but additional unique symptoms such as hallucinations, movement difficulties and sleep problems.
Frontotemporal Dementia (rarer)	A less common dementia, the most common initial symptoms are changes in behaviour, personality and language.



INTERVENTIONS IN

EARLY DEMENTIA

PREVENTION



Changing specific risk factors in mid-life can reduce the risk of dementia

- smoking
- lack of physical activity
- alcohol consumption
- poor diet
- being overweight



MODIFYING THE DISEASE COURSE



- Neuroplasticity/adaptive potential in early dementia
 - Functional and cognitive decline can be DELAYED
- | | |
|--|---|
| <p>PHYSICAL ACTIVITY</p> <ul style="list-style-type: none"> - Can delay onset of cognitive impairment - Reduces falls | <p>COGNITIVE STIMULATION THERAPY</p> <ul style="list-style-type: none"> Strengthens communication skills, thinking and memory |
|--|---|



REMINISCENCE

Focuses on using preserved memories rather than disability

COUNSELLING & PSYCHOTHERAPY



- Adjusting to the diagnosis
- Managing anxiety and depression

LIVING WELL



CREATIVE ART THERAPY



- Alternative to talking therapy
- Provides cognitive stimulation

ASSISTIVE TECHNOLOGY



Can help someone stay safe and keep their independence for longer

CBT



Can reduce stress and anxiety

MEMORY CAFES



- General info
- Help for families & caregivers



YOU CAN HELP by signposting to the right services

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Interventions in Early Dementia (2.10)

In this episode we explored potential opportunities to modify the disease course of dementia.

Changeable risk factors in the midlife that may influence the risk of dementia include smoking, lack of physical activity, alcohol consumption, poor diet and being overweight. These are risk factors that we can address.

Doing exercise may not prevent the onset of a cognitive impairment, but it may delay the onset. Getting people to do just a little more is beneficial, encouraging those who are most sedentary to do a little has the most benefit.

Psychosocial interventions describe different ways for people to overcome challenges and maintain good mental health. Psychosocial interventions may support a person to come to terms with a new diagnosis of dementia, maintain a social life a relationship's, reduce stress and improve mood.

Below are some examples of psychosocial interventions:

<u>Service</u>	<u>Helps with</u>	<u>What can they do?</u>
Dementia advisors	Provide general information	Advisors can provide ongoing support to enable people to live well with dementia. Can provide information, advice and support to the person with dementia and families.
Dementia/Memory cafes	General information/ Help for families and care givers.	People with dementia, carers, volunteers and professionals meet to share information. Informal drop in basis, aiming to minimise social isolation.
Post-diagnostic counselling	Adjustment to diagnosis	Support for coming to terms with a diagnosis of dementia. An opportunity to discuss worries or fears, and plan for the future.
CBT	Stress/Anxiety/ Depression	A talking therapy to overcome emotional and psychological problems. Provides new skills to overcome life challenges. Evidenced for people with new dementia, carers and families.
Reminiscence	Stress/Anxiety/ Depression/	For anyone with a diagnosis of dementia. Usually done in a group

	Maintaining cognitive function/ Maintain quality of life.	setting. Focuses on using a person's preserved memories, rather than focusing on disability
Assistive Technology	Maintaining cognitive functioning/ help for families and care givers/Maintain independence	Devices and technology that can help maintain independence, keep you and family safe. Broad ranging. An OT can advise. Includes communication aids, GPS, medication monitor / alarm to prompt medication, gas supply, temperature regulation, tablets to keep in touch.

What are are some risk factors that can change the risk of developing dementia ?

What services are available local to you to support a person with a new diagnosis of dementia?



COMMUNICATING IN COGNITIVE IMPAIRMENT

1 KNOW THE PERSON

- Use their 'This Is Me' document
- What do they enjoy - can you incorporate this?

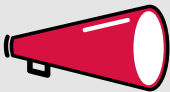


2 KNOW WHAT YOU'RE ASKING

- Closed questions may be helpful
- Could you rephrase it?
- Direct the conversation non-confrontationally

3 OPTIMISE SENSORY IMPEDIMENTS

- May rely on glasses to help lip read.
- May use visual clues as to who you are / what the conversation is about.
- Can they hear you?



4 UP TO 90% COMMUNICATION IS NON-VERBAL

- Be conscious of the tone of your voice and your facial expressions.
- Raising your voice may sound threatening.
- Smile. Be nice. Be patient.

5 YOU NEED TO ADAPT

- Before hand, think: what deficit might they have?
- How will you work around that?
- It is your responsibility to find another way to make the communication work, not theirs.



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Communication in cognitive impairment (1.4)

Communication is both verbal and non-verbal.

In order to be able to communicate we need to be able to:

1. Decide what to say
2. Control your mouth and tongue to articulate
3. Process information
4. Recognise and understand speech
5. And interpret all the non-verbal cues

This is a number of steps and might mean a person with dementia struggles to correctly express themselves. This can lead to frustration for both the person with dementia and those caring for them as they both experience difficulties understanding and expressing information.

As much of 90% of communication can be non-verbal, this is particularly relevant for people with a dementia or cognitive impairment.

Non-verbal communication can include many things including:

- facial expression
- eye contact
- body language
- gestures
- touch
- tone of voice

Dementia is a progressive process which causes specific, then global, losses in function, and cognitive impairment that affects activities of daily living. As each different type of dementia affects the brain differently, patients may experience different challenges when communicating depending on their diagnosis.

When communicating with a person with dementia, use a person-centred approach that utilises a person's strengths rather than focusing on their impairments. This approach focuses on supporting the person with dementia to use and retain their skills and abilities.

There are a few alternative means of communication in cognitive impairment.

- Validation therapy- a specific type of communication therapy (see page 26)
In Validation therapy staff validate the patient's concerns and experiences and explore the reason behind them.

- Memory books can provide alternative forms to compensate for a persons deterioration in linguistic and cognitive skills. Bourgeois et al used index cards in a binder with words and images relevant to personal care on each page. They supported residents to express their wants and needs and increased quality conversations residents experienced.
- Music can enable you to find alternative ways to communicate with a person, and use music to access emotions and memories.
- Namaste- 'to honour the spirit within' involves compassionate nursing care with music therapeutic touch, colour, food treats and scents. This approach has been shown to reduce behavioural symptoms for residents in care homes. Namaste links nicely to the idea that behaviours are all an attempt to communicate and the meaning of these can only really be understood when you understand the person you are looking after.

What challenges have you experienced or observed when communicating with a person with cognitive impairment?

How can you use person centred communication in your role?





Reduced Oral Intake

in Dementia

85% of people with advanced Alzheimers have an eating problem



Weight loss in dementia can be multifactorial



Meal fortification improves weight, but is unlikely to affect other outcomes



Little evidence to support long term tube feeding

Find out what people like to eat!

 Tastes may change

 Remember cultural variation



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Reduced Oral intake in Dementia (8.10)

There is an association between stage of dementia and weight loss. The mechanisms underlying weight loss in dementia are complex, multifactorial and only partly understood. Some studies highlight neurodegenerative processes for nutritional changes in Alzheimer's dementia (AD), and brain atrophy may impact regions of the brain involved in appetite regulation and eating behaviour. In the CASCADE study, 86% of persons with advanced dementia developed a feeding problem, and onset was associated with 39% mortality at 6 months (Hanson et al, 2012).

There are a range of nutritional problems that might impact someone with dementia at different stages of the disease. In earlier stages patients might experience olfactory or taste dysfunction. In mild and moderate stages of disease attention deficit, impaired decision-making ability and executive functions deficit may present challenges in making and eating food. As disease progresses, dyspraxia, agnosia, oropharyngeal dysphagia and behavioural problems may impact intake, with refusal to eat in the severe stages of disease.

Physiological problems such as dysphagia occur at different points in disease progression between different dementias.

Eating problems lead onto great stress for relatives, caregivers and, one assumes, the patients themselves. Men have expressed more concern about nutrition than women when adopting a caregiver's role, as they were less familiar with household activities, and often have poor cooking skills and poor nutritional knowledge

Tips to improve oral intake include:

- providing high calorie finger food or smaller portions,
- food stations around residence to pick up food whilst walking around,
- fortification of foods
- having different temperatures or textured foods,
- using coloured plates and cups
- sitting with patients or having family visit at meal times
- if patients eat alone normally allow them to eat alone rather than in a dining room
- providing sweet foods first then savoury.
- Look in the patient's mouth- consider undertaking mouthcare or referring to mouthcare teams in appropriate.

When supporting a person with reduced oral intake in Dementia, taking a multidisciplinary approach can be beneficial. Include dieticians and speech and language therapists.

Scan the QR code to listen to MDTea 11.09 when we spoke to dieticians about their role within the MDT. They gave us useful information to consider including food selection, nutrition in older adults and options for food fortification.



Whilst fortification of food with high calorie supplements can help patients to gain weight, it is unlikely to improve other outcomes.

What approaches might you try or suggest when working with a person with reduced oral intake and dementia?

What food fortification might be useful for these patients?



BPSD vs Delirium

Behavioural and Psychological Symptoms of Dementia (BPSD) are symptoms of the impact of dementia on communication +/- language, rather than the dementia itself

BPSD if answer yes to all of:

- Does the person have known dementia?
- Is it in the severe stages?
- Are the behaviours present for longer than a short period?
- Has a physical cause been ruled out?
- Is there significant persistent agitation, psychosis or apathy?



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Behavioural and Psychological Symptoms of Dementia (BPSD) (4.10)

Consciousness can be altered in Dementia with Lewy Body and in the late stages of any dementia, when the pathological changes have affected the whole brain. When a person living with dementia starts to experience different or exaggerated behaviours, that would not have been usual for them, it can have a significant impact not just the person with dementia but also their family or carers.

Many of the behaviours which are called “behavioural” symptoms of dementia are not actually symptoms of dementia itself but are other symptoms/problems which cannot be communicated because of the impact of dementia on language and communication.

These behaviours can include:

- Agitation: up to 75%
- Depression: up to 50%
- Screaming/calling out: up to 25%
- Aggression: up to 20%
- Wandering: up to 60%
- Psychosis: up to 30%
- Sexual disinhibition: up to 10%

PIECES is a framework can help guide your assessment and help you consider potential causes for a person’s behaviours.

P:	Is there a Physical problem or discomfort? Are they in pain? Have they had analgesia? Are they hungry, tired or thirsty?
I:	Consider the persons individuals Intellectual or cognitive changes
E:	Are there any Emotional influences- depression, anxiety or psychosis?
C:	What are the persons normal Capacities ? What are their normal habits? Are they Bored? Unused energy? Do demands exceed capabilities?
E:	Are there any Environmental influences? New place, can they see outside? Do they feel lost or a need to go home? Is the space lit? Noisy
S:	Are there any Social and cultural needs? Any spiritual needs? Language needs? Can family and friends visit?

It can be difficult in acute settings particularly to differentiate between behavioural and psychological symptoms in dementia and a delirium. Below are questions to consider when differentiating BPSD and dementia:

- 1) What is the ‘problem’ exactly?
 - a. What are the behaviours that challenge?
 - b. How long has this been happening for?
 - c. What triggers it?
 - d. What makes it better or worse?

- e. What is the course of the behaviours?
 - f. Why is it happening now?
- 2) What is the relevant past medical and psychiatric history?
 - a. Is there a known diagnosis of dementia?
 - b. If so- what type? what stage is it? Are they on any medications?
 - c. Are any other teams involved?
 - d. Have they been seen by the diagnostic memory clinic?
 - 3) What is the relevant personal and social history?
 - a. Is there a 'This is me?' or 'Reach out to me' documents to give you an understanding.
- Day time activity and occupation to reduce boredom especially when family are unable to visit.
 - Distraction and behavioural approaches when agitation builds.
 - Identify if the staff who are able to manage better are doing anything differently from those who struggle with her
 - Encourage good sleep hygiene
 - If there aren't risks to self/others or distress, watchful waiting can also be appropriate.



BPSD MANAGEMENT

A SIP OF MDTEA EPISODE 5.05

TIPS FOR COMMUNICATION

- USE ONE STEP INSTRUCTIONS
- GET GOOD EYE CONTACT
- ACTIVELY LISTEN
- REPEAT & REPHRASE
- USE EMOTIONAL TONE
- AVOID OVER-NUTURING

TRY TO UNDERSTAND AND PREVENT THE BEHAVIOURS

ANTI-PSYCHOTIC USE SHOULD BE A LAST RESORT OR UNDER SPECIALIST GUIDANCE



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reflection & curriculum mapping on website



BPSD Management (5.05)

Effective communication takes practice and may feel uncomfortable at first. It is important to remember that when validating your patients' feelings, you should not feed into the confusion by making statements such as "I saw your husband a few minutes ago" or "I'll help you find your husband."

Validation approaches believe that by taking part in a person's confusion, the staff member undermines the patient's trust.

In the case that a person is asking to see a family member who is not there or has died, trying to reorientate the person by saying "your relative has died" or "you're not at home" is not helpful because the person cannot retain the information you are giving them, meaning it is very likely that this method of communicating will result in the person becoming increasingly agitated.

Validation therapy

Using validation therapy, staff member's can validate the patient's need to see her husband and explore the reason she is concerned about him. This may enable the person may be able to realise that they are confused. This method of communication uses empathy to help people regain dignity and reduce anxiety. The method is kinder and will usually result in the person communicating her needs to the staff member.

Use the QR code to watch Naomi Fells's excellent TED talk about Validation Therapy for communicating.



Practical tips for caring for a person with BPSD.

When supporting a person with BPSD, step back and see the situation through the persons eyes.

- Are you in a busy environment? Are staff roles and uniforms clear? Who are the people asking questions? Is the name of the place e.g hospital or ward clearly displayed?
- What are the ways you can connect with the person- do they have hobbies? what did they do for work? Where have they lived in the past?
- Using 'This is me' or 'Reach out to me' hospital passports can help patients information help staff to make a connection with the patient. Family and friends of the person can complete the passports giving care staff information to make connections.

- Behaviours should be seen as a way of communicating unmet need such as pain, discomfort, needing the toilet and not knowing where it is, social isolation. Use PIECES to consider what needs may not be met?
- Is the environment set up to be dementia friendly? Is there anything you can move or change to make it more dementia friendly?
- Would the person be more orientated if they had a familiar person around?
- Music therapy has shown good evidence for reducing agitation and depression in dementia care homes.

What phrases might be useful using validation therapy approaches?

How could the spaces in which you work be more dementia friendly?



MUSIC & DEMENTIA



Music engages areas of the brain responsible for emotional memory, thought to be the last areas affected by dementia.



There is evidence to suggest music can improve behavioural and psychological symptoms.



Music therapists use a wide range of instruments and musical styles.

They also use improvisation and co-creation, tailoring sessions to the needs of a group or individual.



Person-centred care is key: the right music, by the right person, at the right time.



For more information about musical activities and services near you, visit www.musicfordementia2020.com



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Music and dementia (9.06)

Oxford dictionary definition of Music as a mass noun:

“Vocal or instrumental sounds (or both) combined in such a way as to produce beauty of form, harmony, and expression of emotion.”

In general, the creative arts play an important role in many aspects of dementia. Engagement with intellectual, social, physical and creative activities is associated with slower cognitive decline in older adults. Benefits of personalised musical care extend beyond the person living with dementia, with a positive impact for carers as well as the places and spaces that people are in. Participation in the arts may delay onset and reduce severity of dementia, as well as improving quality of life for those living with dementia and their carers.

NICE guidelines 2015 for Older People, Independence and Mental Wellbeing:
Recommend group activities for people living with dementia “including singing programmes and choirs led by professional qualified people”

Listening to music has a positive impact on mood and reduces stress. Music, memory and emotion are tightly interwoven, and music often triggers emotional memories such as holidays, falling in love, births and deaths, which are less likely to be affected by dementia.

Music engages auditory, visual and motor regions of the brain. These are thought to be the last areas affected by the neuropathology of dementia, which may explain why people with dementia respond to music even when they already exhibit signs of significant cognitive decline.

Personalised music helps with seeing a person for who they are, beyond their dementia. Their connection with music comes to the fore and you see their relationship with that music come to life. There is some evidence that retaining memory for music enjoyed between the ages of 10 and 30 is much more enduring.

Music should be specifically tailored to the choices and preferences of individuals, these preferences can be expressed by people whose verbal skills have declined or are no longer available.

Personalised music is all about the right music, at the right time, in the right way, by the right person - the Musical Menu of Choice. Use the QR code to visit the playlist for life website and view resources and information about creating a playlist of personally meaningful music.



Music therapy is the use of music (improvised, live, interactive, recorded) to meet someone's unique and personal needs. These could be psychological, emotional, social, physical, cognitive or spiritual needs. Central to how music therapy works is the therapeutic relationship that is established and developed between therapist and client, through engagement in live musical interaction and play. Music therapy can help to develop and facilitate communication skills, improve self-confidence and independence, enhance self-awareness and awareness of others, improve concentration and attention skills. Music can be a social process engaged in with others and it can also provide the sanctuary of a more private experience. Depending on the individual needs of the client, music therapists offer individual or group music therapy sessions.

What music would be on your personalised playlist?




Is there a way you could utilise the principles of music therapy in your day-to-day role?



Use this space to write, doodle or draw any thoughts, ideas or reflections of your experiences working with people with dementia.

Has this book changed your perceptions and ideas?

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