

## TABLE OF CONTENTS

Overall Aims of the PLST Program

PLST Intervention

Symptoms of the Dementing Illness

Description of Three General Levels of Behavior

Diagrams

- Stress Response in Normal Aging

- Progressively Lowered Stress Threshold

- Patterns of Dysfunction Behavior -- ADRD

- Care Plan Compensating for PLST

Common Behavioral Problems (2 page document)

The Plan of Care

Interventions: Management & Care Planning (3 page document)

Interventions: Managing Delusions and Hallucinations

Interventions: Reality vs. Validation

Interventions Based on Principles of Validation Therapy

Interventions: Communication (2 page document)

Interventions to Improve Communication

Bathing the Alzheimer's Patient

Behavior Logs

Schedule for Mailing Records

Return Envelopes

Caring for Memory-Impaired Elders: Family Reading

Activities for Alzheimer's Patients - A Selected List of Resources

Cue Cards

Brochures

- Home Safety Checklist for Older Consumers

- Information about Dementia

- Planning for Incapacity

- Caregiving at a Glance

- Directory of Senior Services in Johnson County

### **Overall Aims of the PLST Program**

1. Provide ongoing education for patients and families about the disease process.
2. Assist the patient and caregivers with development of routines and strategies that enhance appropriate behavior patterns.
3. Help patient and caregivers to simplify day-to-day care tasks such as bathing, toileting, and dressing.
4. Assist with problem-solving strategies over the course of the illness as behavior and functional abilities change.
5. Locate resources and develop support networks.
6. Provide ongoing emotional support and counseling for patients, caregivers, and other network members.
7. Assume a role of advocacy, service coordination, and liaison with the primary physician as indicated.

## PLST Intervention

### Visit #1

#### Activities with caregivers

- List aims of your interactions.
- Do a behavioral assessment with caregiver input. Patient need not be present.
- Describe the PLST Theory briefly.
- Describe how the theory and the assessment are useful in formulating a plan of care. Go through the plan of care, individualizing it for the particular patient. Ask for ideas from the caregiver. Discuss what might be ways to implement the plan.
- Describe the purpose of the nursing notes and request that caregivers keep a running record using them. Provide concrete examples. Specify that you will be looking forward to reviewing them when you visit next week.
- Fill in the GDS form by asking the caregiver for information about level of deterioration. This is for a reliability check on the instrument and its use.
- Leave professional card or at least a note with your name and phone number. Encourage caregiver to call with questions, etc. You can field the calls and make referrals, look up the answers and call back, etc. Make it clear to the caregiver that if you can't answer the question, you will find someone who can. You will need to start compiling a group of willing "experts" who agree to act as resources.
- Leave the loose-leaf binder with the information with the caregiver.

#### Printed Materials

- Overall aims of intervention
- Behavioral Assessment
- Illustration of PLST Theory
- Low Stimulus Care Plan
- Nursing notes
- Global Deterioration Scale
- Professional card

## Visit #2 (one week or so later)

### Activities

- Review the nursing care plan and the PLST model asking whether there are questions and how the care plan was implemented during the week.
- Review the nursing notes and discuss the incidents recorded.
- Ask the caregiver to continue making the notes and to send them in every two weeks or so. Provide a schedule for doing so and envelopes. Stress the usefulness to others to hear how this caregiver has solved specific problems of care with her/his dependent.
- Briefly discuss the content of the pamphlets on safety and legal considerations and emphasize that it may be useful for the caregiver to read them and follow the suggestions at their leisure. Stress the importance of the safety evaluation. Both subjects are important but are too long to include in the visit.
- Also leave the AD pamphlet with a brief statement that it gives a bit of background information that might be of interest.

### Materials

- Schedule for mailing nursing notes
- Stamped, addressed envelopes
- Alzheimer's Disease Pamphlet
- Safety Pamphlet
- Legal Pamphlet



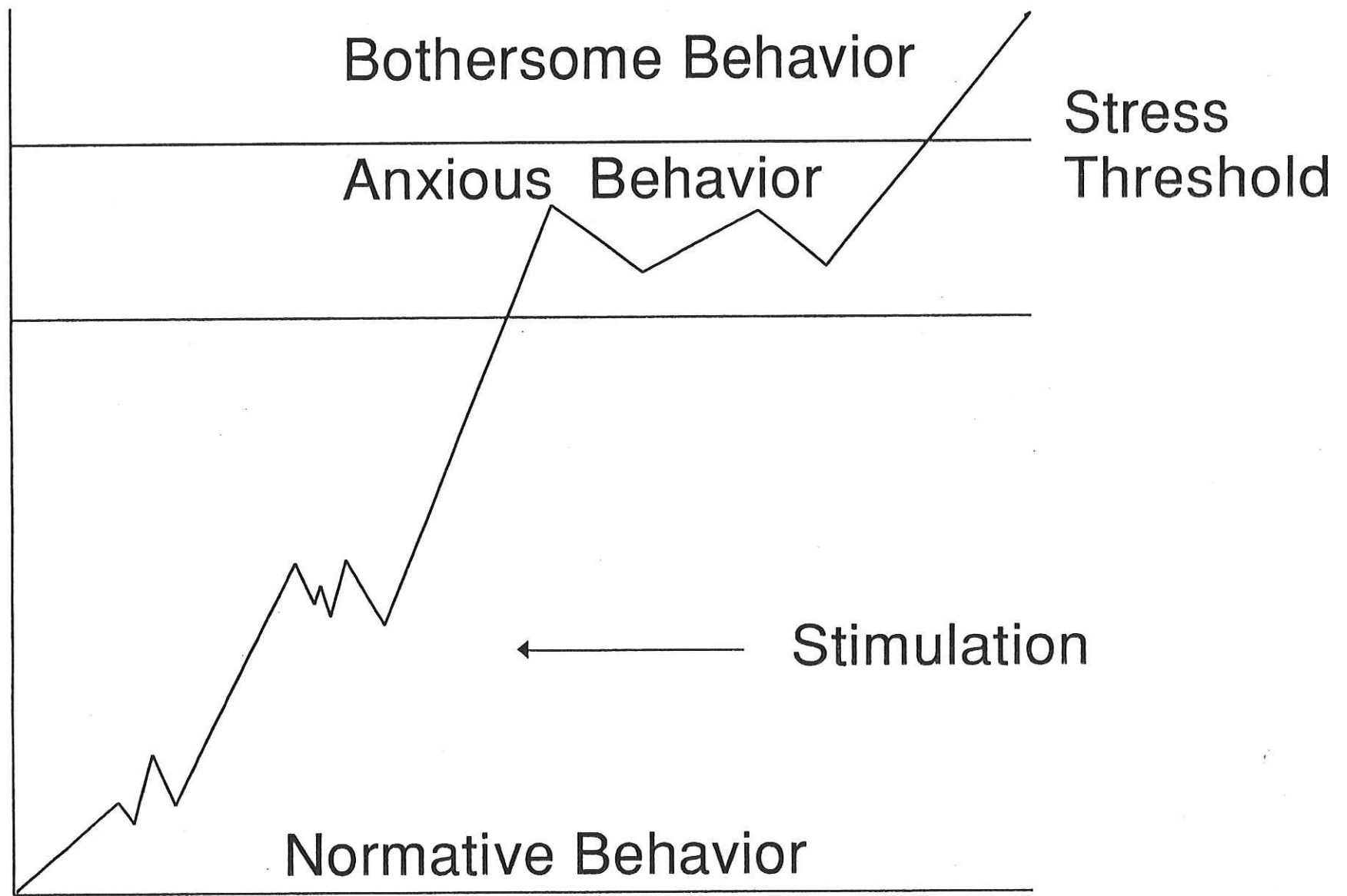
The symptoms of the dementing illnesses can be thought of as clustering into four groups:

1. Intellectual losses
2. Emotional or personality losses
3. Loss of the ability to plan activities
4. A lowered tolerance to stress that may lead to the following: "catastrophic behaviors", violent, agitated or anxious behavior, purposeful wandering, confused or agitated night awakening, noisy behavior, purposeless behavior, and compulsive repetitive behavior and verbalizations.

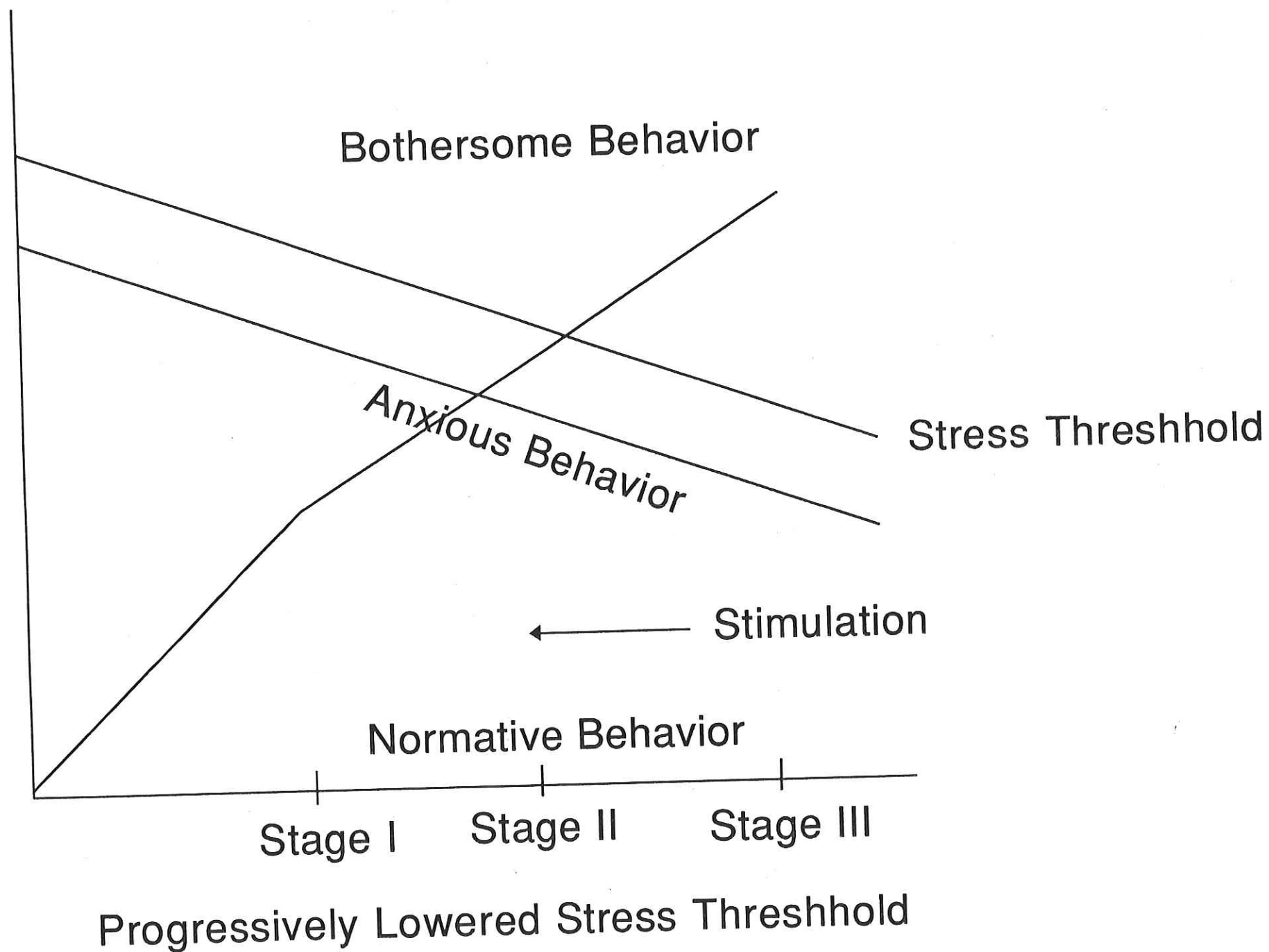
### Description of Three General Levels of Behaviors

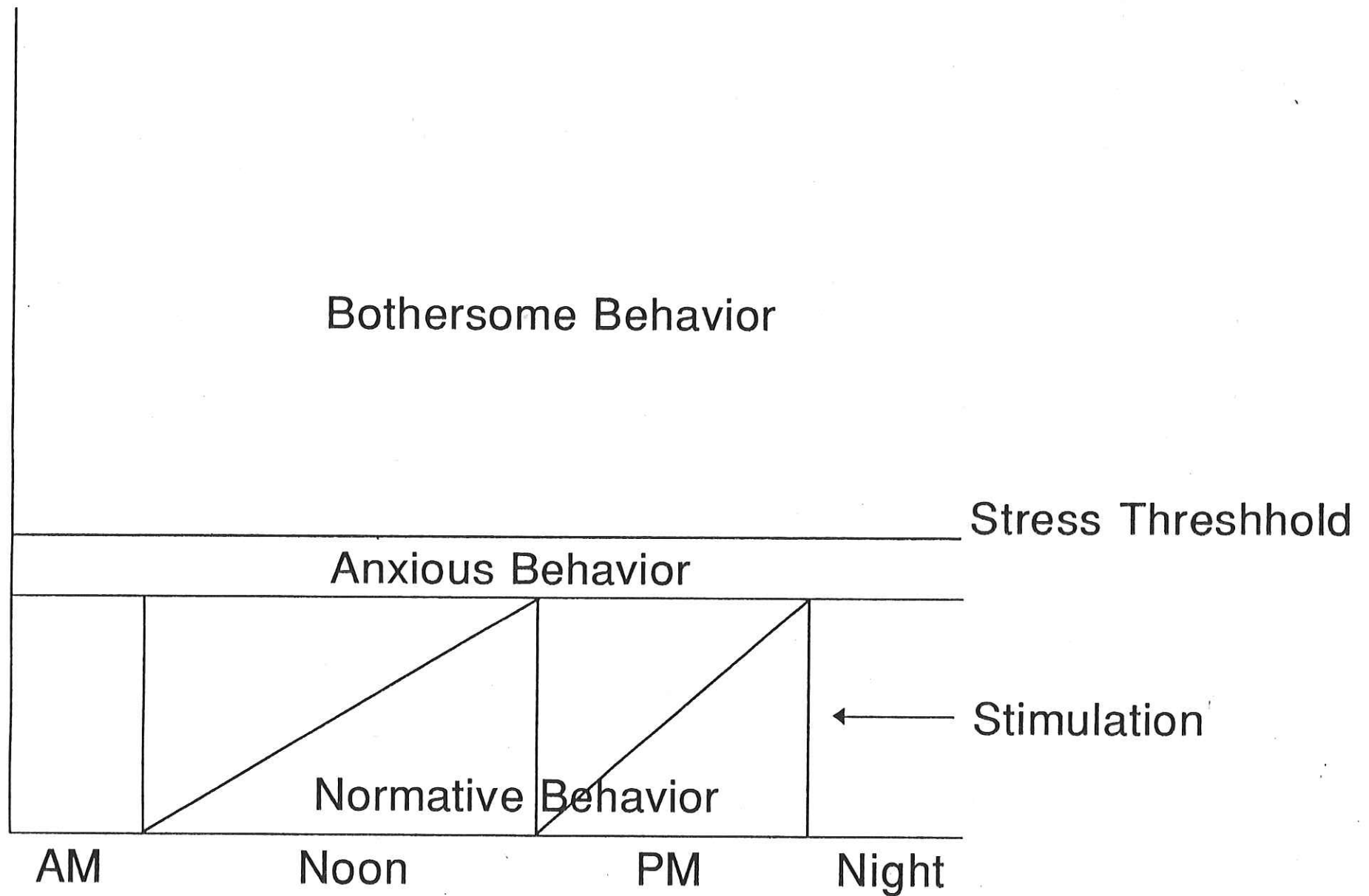
1. Baseline or "normal" behavior, a calm behavioral state in spite of the symptoms of ADRD. Clients exhibiting baseline behavior are able to function within the limits of their neurologic capacity.
2. Anxious behavior, occurring when the impaired adult experiences stress. Caregivers are still able to communicate with the patient but if the stress is allowed to continue or increase the next level of behavior ensues.
3. Dysfunctional or catastrophic behavior, resulting when the patient is unable to communicate effectively and responds to the environment inappropriately compared with the usual level of impairment. Dysfunctional behaviors usually appear suddenly and last a short time. Episodes increase as fatigue and stress increase throughout the day.

The levels of behavior and symptoms are related to the progression or stage of the illness. Baseline behaviors change or deteriorate as the disease progresses. Anxious and dysfunctional behaviors occur more frequently. The sensitivity to stress increases over the course of the disease until the patient reaches the end stage.

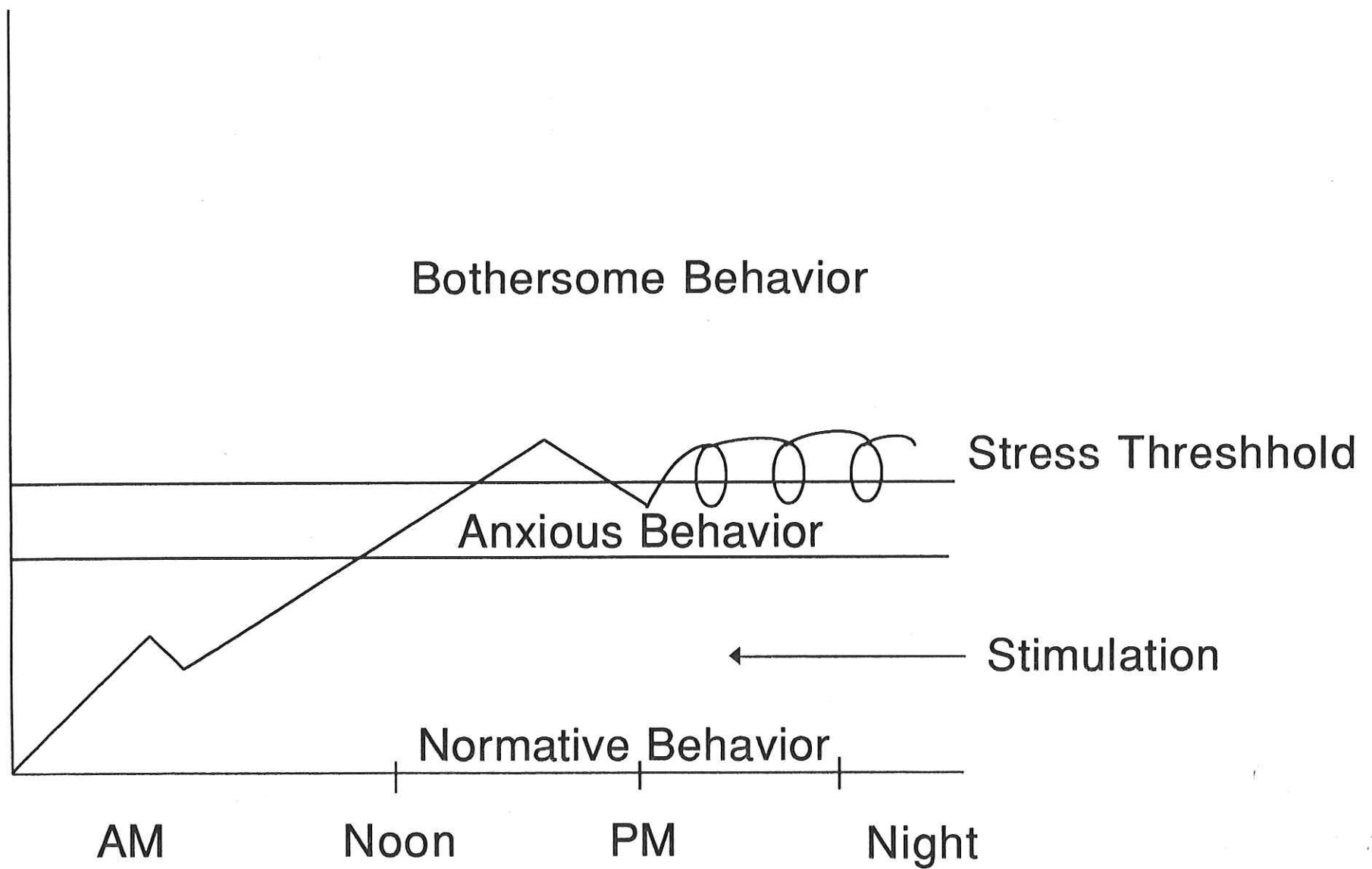


Stress Response in Normal Adults





## Care Plan Compensating For PLST



Patterns of Dysfunctional Behavior -- ADRD

## Dementia

### Common Behavioral Problems

#### Problems Resulting From Lost Abilities

*Concealed memory losses:* skill at covering up what they don't know; seem to be better off than they really are

*Wandering:* causes anger & resentment; risk of injury or getting lost if go outside

*Sleep Disturbance:* wake others

*Losing and hiding things:* accuse others of stealing; families express frustration & concern

*Inappropriate sexual behavior:* upsetting to staff and residents

*Repeating questions:* monotonous repetition due to memory loss

*Repetitious actions:* clapping, rocking, pulling hair, rubbing

*Territoriality:* protective of own space; e.g. push others away at their dining table

*Hallucinations:* seeing, hearing, smelling, tasting, or feeling things that are not really there; hearing most common type

*Delusions:* false beliefs that are maintained (fixed) in spite of clear and obvious proof

*Illusions:* misinterpretation of something real in the environment

#### Catastrophic Reactions/Behaviors

*Agitation:* increased physical movements, restless, "worked up"; may be accompanied by calling out; can lead to combativeness

*Combativeness:* strikes out at others

*Confusion:* mixed up about time, place, person, thing; says things that indicate they don't know "who, what, where"

*Fearfulness:* becomes frightened without clear cause; seen in facial expression, body posture, words & phrases

*Night waking:* episodes of confusion, wandering, and sleeplessness that are linked to daytime stresses

*Noisy behavior:* calling or yelling out words, phrases

*Purposeful wandering:* wandering results from some unmet need, drive, or internal tension; agitated purposeful wandering often results from a desire to leave and "go home"

*Sudden withdrawal:* pulls back from activity or action (walking out of their room) suddenly and without apparent cause

*"Sundown Syndrome":* confusion and behavioral problems tend to increase in late afternoon, as the "sun goes down"

### **Factors That Increase Risk For Catastrophic Behavior**

*Fatigue:* become tired more easily and have a diminished (lower) reserve of energy than in the past

*Multiple competing stimuli:* too much going on at once; may include television, radio, noise or voices outside the room, public address system announcements, etc.

*Physical stress:* illness, medications, discomfort, hunger, full bowel or bladder

*Changes:* in caregivers, the routine, or the physical environment (even holiday decorations or new furnishing, paint, etc.)

*Demands:* to achieve beyond their abilities; e.g. being asked to make decisions that are too complicated for them

Note: Also remember the stressful effects of "negative and restrictive feedback":

"No, this isn't your room."

"No, you're not going to work today"

"No, this is your home now."

"Your parents are dead. They have been for years."



## The Plan of Care

### 1. Reduce environmental stressors

#### Eliminate:

- Caffeine.
- Misleading stimuli, (no TV).
- Unending spaces.
- Unnecessary noise (background radio).
- Extra people.
- Large groups.

### 2. Compensate for patient's inability to plan

- Provide calm consistent routine.
- Eliminate changes of pace and environment.
- Keep choices to those the patient can tolerate.
- Do not ask the patient to "try harder".
- Do not try to teach new routines.
- Do not encourage the patient to recover lost skills.

### 3. Provide unconditional acceptance and positive regard

- Avoid trying to teach or drill on "right answers".
- Provide one to one communication.
- Use touch to reassure.
- Allow patient to use remaining social skills.
- Reminiscence together about former pleasant experiences.
- Eliminate "you're wrong" from the environment.
- Do not confront, distract instead.

4. Allow for lowered tolerance of stress and diminished energy reserve

- Provide rest periods twice daily.
- Alternate stimulating activities with rest.
- When the impaired person gets "upset", decrease stimuli and identify the activity associated with the upset behavior. Explore possible physical reasons also (pain, hunger, constipation).
- Keep careful records to note possible causes for the "upset" behavior.

5. Take care of the caregiver

- Plan respite care regularly.
- Arrange for legal and financial advice.
- Arrange day care as needed.
- Arrange home services as needed.
- Prepare visitors and day care help by teaching them key elements of this "lowered stress" approach.
- Join a support group if it seems helpful.

## Dementia

### Interventions: Management & Care Planning

#### Eliminate or Reduce Environmental Stress

*Caffeine:* promotes restlessness, agitation, sleeplessness

*Misleading stimuli:* TV, radio, PA system are not understood and can cause fear

*Unending spaces:* long corridors that seem to go on & on may cause fear; break up with color & texture

*Unneeded noise:* radio, TV, people talking outside their room

*Extra people:* limit visitors to one or two people at a time; avoid large groups that increase noise, confusion

*Large rooms:* dining room, dayroom, activity room may be overstimulating to the person

#### Compensate for Loss of Ability to Think and Plan

*Calm, consistent approach & routine:* provides security and allows to use remaining memory abilities

*Do not try to reason with client:* ability to think abstractly is lost so only creates stress and tension

*Do not ask to "try harder":* lack of cooperation isn't intentional

*Do not try to teach them new routines:* loss of memory means they won't be able to remember changes in where they sit, which room, etc.

*Do not encourage them to recover lost skills:* lost ability (reading, knitting, etc.) will not be recovered

*Limit choices to those the resident can make:* limit the alternatives; eg, "Would you like to wear the blue dress or the pink dress?"

*Monitor changes in the environment:* holiday decorations, new furniture, unfamiliar people all create stress

*Eliminate changes of pace:* use a moderate, unhurried pace even when you feel like pushing along to get done

### Provide Unconditional Positive Regard

Remember person is an adult who deserves respect & consideration.

*Address by last name:* formality sometimes increases cooperation; address by preferred name, first or last, if they can tell you

*Allow to use skills or abilities that are intact:* encourage to brush hair, eat, dress self, giving encouragement and simple instructions

*Communicate respect thru care:* tone of voice, attitude, pace

### Show respect through communication methods.

*One to one communication methods:* simple phrases, eye contact, exaggerated nonverbal gestures

*Use touch to reassure:* gentle, anticipated touch offers reassurance; don't take by surprise

*Eliminate "You're Wrongs" from the environment:* "No, this is your home now."

*Do not confront -- DISTRACT!:* "Yes, I imagine you do miss your mother... What did she look like? Let's walk down the hall here and sit together a while ... How about something cool to drink?"

### Show respect through validation vs. orientation.

*Avoid reality orientation:* loss of memory means they are unable to retain information on time, place, person and it becomes another "You're Wrong"

*Don't confront delusions or hallucinations:* belief or experience is very real to the person; attempt to distract or reassure that they are safe

*Use reminiscence & validation:* review of past experiences may promote feelings of security & happiness

*Listen carefully for meaning:* repetitive words, phrases sometimes have meaning that can be interpreted and responded to in a way that promotes comfort

*Provide reassurance of safety:* "You're safe here with me. I won't let anything happen."

Allow for Lowered Stress Threshold

Maximize the routine and monitor the environment!

*Plan rest periods* in morning and afternoon to reduce stress

*Maximize routine:* Rise, eat, rest at same time each day

*Alternate high and low stimulus activity:* quiet time following bathing, eating, visitor, doctor visits, etc.

*Reduce stimuli when reactions occur:* move into a quieter space without TV, noise, etc. Check for physical stressors like wetness, hunger, pain, etc.

*Keep records:* Be specific and descriptive in your charting!

- Demanding? In what way?
- Disoriented? In what sphere? Time, place, person, thing?
- Delusional? What about? What did she say? Do?
- Repeating herself? When? What does she say? What did you try?

Evaluation of Care

Monitor progress in concrete terms.

Number of hours of sleep

Weight

Food intake

Incidents (falls)

Number of stress-related events (hitting, yelling)

Sedative and tranquilizer use

Family's expression of satisfaction with the care

## Interventions: Managing Delusions & Hallucinations

### In General:

Keep in mind all of the factors that affect communication with the demented person. Pay particular attention to your nonverbal messages: the look on your face, the tone of your voice, the way that you move, gesture, and touch.

Try to "put yourself in the resident's shoes." Think about the experiences from their perspective and appreciate how distressing these feelings or beliefs can be.

### Then try to remember the following:

1. No matter how odd or absurd the delusions or hallucinations may seem to us, **ALWAYS** remember that the false beliefs or experiences are **quite real** to the person who is having them.
2. The experience may be upsetting or frightening to the person, and they may need our reassurance that they are safe. For example, that may mean assuring them that you will "make sure they are cared for," and that this is a safe or nice place even though it "isn't their house."
3. When the person is having paranoid delusions (e.g. believes that they are being poisoned by chemicals or fumes) we may need to recognize that they are afraid without agreeing that it's really happening. For example, "I don't smell the fumes but I can see that you are quite upset."
4. At times, we may need to offer information that contradicts the delusion by saying that you don't "share their reality." That is, that you don't see or hear the voices or people that they do. Again, offer reassurance that they are safe with you.
5. Listen carefully to the type and extent of the delusional content. The demented person may be responding to a real life event or stimulus in the environment. For example, after watching TV, a person might begin to have delusions that his/her room is filled with little people .
6. Monitor whether the delusions are getting worse or more exaggerated, especially if they are paranoid in nature. The more fearful the person, the higher the risk that they will strike out to protect themselves.
7. Remember, any action or movement that "catches them off guard" may provoke a protective response, including aggression. Stay in their field of vision, use gentle touch to connect with them, and don't press them to continue something if they are trying to withdraw.

### Interventions: Reality vs. Validation

**REALITY ORIENTATION (R.O.)** -- Stresses the importance of bringing the disoriented person back to the "here and now" by constantly emphasizing the four spheres of orientation (time, place, person, thing). R.O. is based on the belief that disoriented persons are able to return to the present, if given enough information to do so. Consequently, the method encourages us to correct persons who are disoriented or confused, and to provide accurate information that will help them stay in "the present."

**Advantages** -- Useful with persons who are, in fact, temporarily confused but not permanently impaired. A person who is acutely confused (delirious), because they have an infection or because they recently moved to the nursing home, needs to be provided accurate information to become reoriented (e.g. reminded of the correct time, place, person, and things that are happening).

**Disadvantages** -- Is not useful with persons who have memory loss and are intellectually impaired, particularly those with dementia caused by any disease process. The progressive loss of memory means that the person lacks the ability to retain the information. Constant orientation, or contradiction of their stated beliefs (even when false) only functions as "negative feedback" -- the message that "you are wrong."

**Remember:** Negative feedback, those various messages that **YOU ARE WRONG** typically irritates, agitates, and embarrasses the resident. At some level they "know" and their self esteem is damaged by constant reminders that they are "wrong."

**VALIDATION THERAPY (V.T.)** -- Stresses the importance of "going with the person" to their reality to better understand what they are experiencing. V.T. suggests that some elderly may withdraw from the "here and now" because it is too painful and distressing. They return to their past, which is more pleasant and comforting, to avoid the present. V.T. suggests that we listen carefully to the words, phrases, and statements that the person uses to understand what they mean. Then we may be able to "bring the person to the present" by gently prompting their memories about both the past and the present.

**Advantages** -- Validation of the person's reality avoids sending negative feedback to the demented resident who may believe that they are "going to work" or that they visited with "mother or father." Instead of contradicting the person, we can "go with them" and talk about what they are remembering at that moment. Through the reminiscence we may be able to help them feel more positive, instead of sending the message "you are wrong" that is likely to bring out sad/bad feelings.

**Disadvantages** -- The demented person may respond to validation techniques at the time that they are being used, but will not retain the abilities that they may momentarily show. For example, validation techniques may help the person realize that their daughter is their daughter (and not their mother) during the time she visits. However, that realization will be lost after the visit and the process will need to be repeated on the next visit. In addition, validation techniques may be inconsistent in "bringing the person to the here and now," which may be frustrating.

### Interventions Based on Principles of Validation Therapy

1. Don't confront the person's delusional ideas. Instead distract and redirect the person whenever possible.

**Example:** "I'm going home!" Instead of pointing out that their home has been sold, and that this IS their home, suggest that "It's too cold (late, whatever) to go home right now, so why don't you stay here tonight? We've reserved this room just for you."

**Example:** "I've got to get to work." Try to redirect them to some activity that may parallel work. One aged nurse sat at the nurse's station in the middle of the night and wrote "nurses notes" dated 1932 until she became tired and returned to bed.

2. Validate the person's reality instead of confronting them with "you're wrong" messages.

**Example:** "Papa's coming to get me." Instead of saying, "No, Papa is dead," try something like, "And you love your Papa. Papa's a good man." Let the person respond to the idea of the lost person and go with the flow of their ideas. Direct them to think about the person, rather than the idea that he/she is alive or coming to take them away.

3. Listen carefully to content of what seems to be "nonsense." What is person doing? or saying? in their reality? By doing so you may be able to offer them some reassurance that is meaningful.

**Example:** A demented resident calls out the name "George" over and over again. By asking family who "George" is/was and what relationship the person had with George, staff may be able to ask questions to redirect the person or find out what they are thinking about that disturbs them.

4. Encourage reminiscence that taps their long-term memory. Memories from the past may help reduce anxiety and have a calming effect. Use all five sense (taste, smell, vision, hearing, touch).



## Dementia

### Interventions: Communication

#### Verbal

##### *Speech construction:*

1. Short words.
2. Simple sentences ("Sit in the chair"); not compound or complex ("Sit in the chair and put on your socks").
3. No pronouns (it, that, they, them, she, he, here, there); only nouns (chair, dress, bathroom).
4. Begin each conversation (particularly at night) by identifying yourself and calling the person by name.

##### *Speech style:*

1. Speak slowly.
2. Say individual words clearly.
3. If you increase your speech volume, lower the tone; raise the volume only for deafness, not because you don't get a response you understand.
4. If you ask a question wait for a response.
5. Ask only one question at a time.
6. If you repeat a question, repeat it exactly.
7. Use self-included humor whenever possible.

#### Non-verbal (facial expression, body position, hand gestures)

##### *General:*

1. Convince yourself that your nonverbal style can be felt all the way across the room and by several people, not just the patient or staff person you are addressing.
2. Deliver every verbal communication with proper non-verbal gestures.

##### *Specific:*

1. Stand in front of the person.
2. Maintain eye contact.
3. Move slowly.

4. If the person starts or continues to walk while you are talking to him, do not try to stop him as your first move. Instead keep moving along in front of him and keep trying.
5. Use overemphasis and exaggerated facial expression to emphasize your point, particularly if vision or hearing is impaired.

### General Guidelines

1. Listen actively. If you don't understand, say you don't understand and ask them to repeat the statement. If the person becomes more upset offer your best guess about what the problem is. If you receive a "no," try another guess but monitor their level of frustration.
2. If you have not really "gotten anywhere" in five minutes or less, you will probably do better to leave and either return in five minutes or have a colleague try. When possible have another staff member watch you interact with a resident, make suggestions, and perhaps trade off with you.
3. Assume they know what they need. If the resident refuses to participate in an activity assume that there is a reason (he has become sad, angry, frustrated, embarrassed, anxious about his condition). Your first job is to check it out -- not just ask something vague like, "Are you okay?" Get specific: "Are you uncomfortable? hurt? angry? sad?" (whatever).
4. Be sure to share all words, phrases, techniques that work for a particular person and a particular situation (write it in the Kardex). Use each other's techniques. Compare notes on successes and failures.
5. When encouraging participation in activities, use the following guideline: If you push the person too hard, they may have a catastrophic reaction. Do you have the time to manage a problem if one occurs? How hard you push should be determined by how much time you can afford to spend resolving problems.
6. Finally, if you say you are going to do something, DO IT. If you forget, find the person and apologize. Assuming that the person has forgotten the episode insults both your intelligence and his/hers.
7. If you need to stop a patient-patient interchange, do it firmly and quickly, get them out of each others territory, wait five minutes then return and explain to each one why you acted as you did. Use factual explanations, not "guilt trips."

Source: Adapted from Mari Anne Bartol, RN, MA, and Michael C. Storrie, MD published in Bartol, M. A. (1979). Nonverbal communication in patients with Alzheimer's Disease. Journal of Gerontological Nursing, 5(4), 23.

## Communication

### Interventions to Improve Communication

#### *Compensate for sensory losses:*

- Provide more light so that the resident can see you.
- Avoid standing too close so that you don't get blurry.
- Stay in front of the person where they can see you.
- Use yellows & reds vs. greens and blues for signs or markers.
- Make sure that glasses are clean, comfortable, and ON the person!
- Make sure that the person can read your lips.
- If you need to talk louder, try to lower your tone of voice.
- Check for earwax buildup.
- Make sure hearing aides are IN and batteries are fresh!

#### *Look carefully at the effects of the environment:*

- Is noise interfering with your attempt to communicate?
- Is the room light enough for them to see you and read your lips?
- Are they afraid that someone else will hear what they are saying, or that you will be interrupted? (e.g. Is their privacy being respected?)
- Are they physically comfortable? Or are they distracted by hunger, thirst, pain, needing to use the toilet, etc.?

#### *Adjust how you interact with the resident:*

- Give them time to answer your questions or tell you what they have to say.  
(Remember: reaction time slows!)
- Give them cues to help them think about "when" something happened or "how long" it's been going on.
- Check out what they are "telling you" with their nonverbals.
- Take time to be interested in the things that are right (positive parts of their life) as well as to talk about their problems.
- Communicate that you are concerned about the person and want to help them, through
  - \* the tone of your voice;
  - \* your facial expression;
  - \* your words and gestures;
  - \* *your ability to listen to criticism, complaints or sadness!*

## BEHAVIOR LOG

**INSTRUCTIONS:** This log provides information on what behaviors your Alzheimer's patient experiences and how frequently and how much these behaviors bother or trouble you. Please fill in the number of times each behavior occurs each day for the next two weeks, starting at Day 1 and going through Day 14 on the form. Then check the answer that tells how much that behavior bothers you and describe how you managed the problem and how well it worked. Please include any other details below under care notes.

### CARE NOTES

Date & Time

Description of behavior:

Strategy used by caregiver:

Response by the care recipient:

---

Date & Time

Description of behavior:

Strategy used by caregiver:

Response by the care recipient:

---

### DEFINITIONS

#### FALLS:

Any incident where the patient loses balance and/or trips and falls to the floor or on some other object (even if a person partially breaks their fall) or if a patient is found lying on the floor.

#### PHYSICAL RESTRAINTS:

Any physical mechanism that is used to curtail freedom of a patient's movement (e.g., locking doors, tying in bed or chair, tying patient to self, siderails on bed)

#### PARTICIPATION IN ACTIVITIES:

Engaging in spontaneous or planned activities at home or away from home with one or more persons.

#### OTHER INCIDENTS:

Incidents other than falls that result in injury or potential injury (e.g., choking, skin tears, abrasions, hitting another person, wandering away from house, getting lost)

MAIL BACK EVERY TWO WEEKS

### Daily Totals

How much does this bother  
or upset you?

### How well does it work?

Behavior	1	2	3	4	5	6	7	8	9	10	11	12	13	14	None 0	Not much 1	Some 2	Very much 3	What do you do to cope with or handle this? (describe)	None 0	Not much 1	Some 2	Very much 3
Wakes up confused at night																							
Becomes agitated, irritable late in the day (sundowning)																							
Refuses to help or to participate in care. Is belligerent, yells, curses																							
Wets or soils clothing																							
Has purposeful wandering, tries to leave home																							
Violent, hits, or strikes out																							
Repeats a word or behavior over and over																							
Withdraws, unsociable, refuses to participate in activities																							
Paces, fidgets																							
Increased social interaction or participation in activities																							
Falls																							
Restraints																							
Other incidents (please describe)																							

## WHAT ACTIVITIES WORK BEST?

**MUSIC** - Undemanding. recalls past pleasures.

Active - making music, dancing, sing-a-longs, exercising.

Passive- listening to records, tapes, band music or concerts.

Choose music the patient enjoyed.

**EXERCISE** - Promotes fitness and mobility, reduces tension/anxiety.

Walking, exercise programs/video, exercise bike, sports engaged in previously, bowling, outdoor chores, exercising a pet.

**HOUSEHOLD CHORES** - Allows person to contribute and feel useful.  
Simple and repetitive activities are best. Some degree of assistance and supervision may be required, depending on level of impairment.

Raking

Dusting/polishing furniture or silverware

Window washing

Vacuuming

Mopping/sweeping

Shoveling

Gardening/hoeing/watering/weeding

Washing/drying dishes

Laundry - sorting, hanging, folding

Food preparation - chopping, cleaning, paring, peeling, mixing, stirring, grating, shelling

Setting or clearing table

Emptying wastebaskets

Feeding/brushing a pet

**SOLO ACTIVITIES** - Demand little from the caregiver, keep person occupied but may be difficult for patient to do as diseases progresses.

Reading (large-type) or "talking" books

Picture books/magazines

Photograph albums - to look through or help with assembly

TV- may be useful but patients often find television confusing and cannot maintain concentration. Try nature programs, sporting events, comedy.

Videos - Rent old favorite movies

Sorting activities - tools, coins, cards, keys, laundry

Rocking chair and music

Sanding wood objects



Coloring - provide adult pictures (not blank paper) and colored pens or markers.

Observing bird house or fish tank

**SOCIAL ACTIVITIES** - Best to avoid crowds, long visits, overstimulation. Easier for patient to interact with one person at a time.

Day activity/adult day care programs

Friendly visitors - neighbors, friends, senior companion

Children/grandchildren - short visits usually best

Family gatherings

Church services or church activities

Congregate dining

**OUTINGS** - Promote physical activity, help person keep in touch with the outside world. Don't overdo, keep brief.

Walks - in the park, to the store, in a shopping mall.

Window shopping - pet stores, outdoor markets, plant nurseries, or greenhouses

Bus rides

Restaurant, bakery for cup of coffee, ice cream, snack

Boating, fishing

Picnics

Bike riding if able

Sporting activities, spectator sports

Band concerts, especially an outdoor setting

**REMINISCENCE** - Non-threatening, capitalizes on long-term memory which stays intact longer than recent memory. Recalling past experiences and achievements can be very rewarding.

Scrapbooks, photograph albums

Looking at keepsakes

Make a "memory box" of favorite mementos

Home movies or slides from past family activities

Viewing old favorite movies

Musical memories

**REFERENCE: FAILURE-FREE ACTIVITIES FOR THE ALZHEIMER'S PATIENT: A Guidebook for Caregivers by Carmel Sheridan**  
Available from: Cottage Books  
2419 13th Avenue  
Oakland, CA 94606



# Activities for AD Patients That Work Some or Most of the Time

## CHORES

gardening outdoors  
folding laundry  
setting/clearing table  
carrying items  
sweeping, dusting  
sanding

## MUSIC

singing  
dancing  
hula  
listening

## FOODS TO MAKE

cookies, breads  
potato salad  
dough and raisins  
veggies

## ENTERTAINMENT

movies  
stories, poetry  
ice cream social  
fashion shows  
pantomime  
picture books  
babies  
humor  
see-and-say

## FIDDLING

strings, paper  
activity board

## MENTAL STIMULATION

reminiscence  
Elder Trivia  
book of questions  
baseball cards

## CRAFTS

bonnets  
sanding  
foil art  
poster/panel art  
tissue flowers  
sorting one inch tiles  
balloon drawings  
ceramic glazes  
fabric crafts

## EXERCISE

chair exercises  
ring toss  
nerf ball  
nerf ping-pong  
walking  
pool, pool ball

## ANIMALS

affectionate & mellow dog  
or cat  
outdoor bird feeders  
favorite stuffed animals

## SELF CARE

beauty hour (hair, nails)  
face, moistunzers  
hand massage  
accessories

## *Activities That Don't Work All or Most of the Time*

Formal reality orientation (makes  
patient feel foolish; futile.)

Sticky stuff (glue, finger paints.)

Community service projects:

collating, stapling, address labels, fold-  
ing, wrapping (exhibits impairment.)

Balloon ball (may startle.)

Bingo (exhibits impairment.)

Word games, board games, card  
games (requires a high level of cognitive  
skills.)

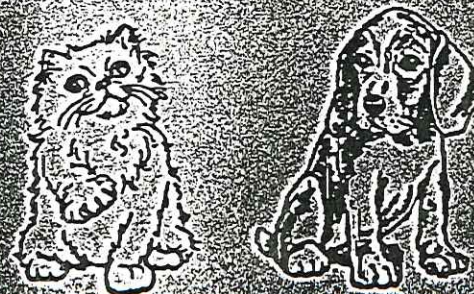
Homemade band (noise, irritation.)

Television (concentration, abstraction,  
confusion.)

Outings (can promote insecurity; use  
with caution.)

Plays (requires abstract thinking ability.)

*From Alaska Alzheimer's Society*







# *Caregiving at a glance*

FINGER TIP HELP FOR FAMILIES TAKING CARE  
OF PEOPLE WITH ALZHEIMER'S TYPE ILLNESSES

*Written by loving caregivers who have learned from doing  
Compiled by Lin E. Noyes Director, Family Respite Center*

## CAR AND HOME SAFETY

### What to try:

- Dementia proof your house. Secure cabinets that hold all poisonous liquids and put away tools that may be misused and result in a harmful situation.
- Provide chairs with high enough seat bottoms and arms for support so that the person can easily get up and down.
- Keep living areas well lit to help reduce falls.
- Put childproof tops on medication bottles.
- Disarm the stove so the person can't turn it on. (Electric stoves usually have a circuit breaker, gas stoves have removeable control knobs).
- Put away all electrical equipment or tools that shouldn't be used without supervision.
- Have grab bars installed near toilet and tub since these are common areas for falls.
- Use a secure gate at the top and bottom of the steps.
- Don't leave a judgment impaired person unattended at home or in a car.

### Car safety:

- Wear seat belts.
- Seat passenger in the back seat.
- Use child safety locks on the doors.
- Have a mechanic show you how to remove the distributor cap so the car can't be started without your knowing it.

n.b. See "Wandering" for further suggestions



## SLEEPING

### **Caregiver's corner:**

Night time should be for sleeping. Caregivers put in a long hard day and need their rest in order to replenish themselves for another day. Unfortunately, the person with dementia may not share this view. Night time may be worse than daytime. Confusion may increase, as well as incontinence and feelings of loneliness or being afraid. Night time wakefulness is often the behavior that breaks the caregiver's back and leads to the need for alternative living situations. Usually this behavior is a phase which people get through and so the need for institutionalization may be temporary.

### **Age changes:**

Older people require less sleep and their sleep is not as deep as a younger person's sleep. Four or five hours may be sufficient for an average 75-year old. Other age changes include:

- older people may require "cat naps" during the day or periods of rest between activities
- vision for older people is decreased and without increased night time lighting, familiar objects or places may look strange
- decrease in the kinesthetic sense (knowing where their body is in relationship to other objects in space) combined with dimmed vision may make navigating difficult even in familiar places

### **Dementia changes:**

With decreased input from the senses, the failing brain is more likely to misinterpret stimuli in the environment. A dark blanket in a dimly lit corner may look more like a big animal. TV voices from a nearby room may be misinterpreted as someone trying to talk to the person who can't figure out what the voice is trying to say. Other changes include:

- during the hypermotor phase in the course of a dementing illness, a person may be very tired but be unable to lie down long enough to fall asleep
- some people simply can't remember that the caregiver is sleeping in the next room (or bed!) and feel afraid being all alone
- sometimes a person may awaken to go to the toilet and then not be able to find the room or bed upon return
- sometimes a person will stay up all night and then sleep during the day, changing nights into days

## SLEEPING

### What to try:

- Establish a daytime routine that does not include a lot of naps. If the person has already reversed the day/night schedule, it may take some concentrated effort and some outside help to reverse the sleep/wake cycle, but it can be done. Day care often provides the necessary stimuli to keep the person awake.
- Limit fluids after late afternoon, don't serve caffeinated drinks and avoid exercise, strenuous activities and activities known to cause increased agitation or excitement.
- Leave a rather bright light on in the person's room so surroundings can be recognized upon awakening.
- Sometimes a dutch door type arrangement with the bottom half secured, allows the person to wander in the room without bothering others in the household.
- Warm milk contains tryptophane, a natural substance which induces sleep.
- Check with your doctor about medication. Sometimes a small dose of benedryl can help the person get sleepy enough to fall asleep without any side effects of the more powerful sleeping medications. (Ask your doctor before adding any medication.)
- Sometimes sleeping medications help but not always. Some "sleepers," as they are called, produce such a hangover effect that a person cannot function the day after taking the medicine.
- Life has been made bearable for some folks by hiring a nighttime companion who can be up with the person while the caregiver sleeps. For others, short term respite on a regular basis gives the caregiver a chance to revive drooping spirits and catch up on sleep.
- Relax a little. If the person gets up, changes back into clothes at midnight and then falls asleep on the bed or in a chair, let it be. Do not insist that the person wear pajamas or sleep in bed if sleeping in the chair is comfortable.



## GUIDELINES FOR GIVING MEDICATIONS

You are the person's health care manager. Use the physician wisely and be prepared for the person's visit to the physician.

Before your visit do the following things.

1. List all the questions you want answered.
2. Gather up all the medications the person is taking, including over-the-counter medicines, so the doctor can see what the person is on before prescribing another drug. Don't depend on the doctor to remember them. A lot of times medication dosages are changed over the phone between visits . . . it's up to you to keep track.
3. List allergies to medications, write them down when you learn about them, include the name of the medication and the type of reaction the person had to it. Knowing that the person is allergic to some antibiotic is not enough.
4. If you have tried various drugs for a particular problem, tell the doctor what they were and what the effects were.
5. If the doctor prescribes a medicine, ask the following questions:
  - a. What is the medication for?
  - b. When should it be given? (Some meds are ineffective on an empty stomach, others have to be given between meals.)
  - c. Are there side effects and if so what is normal and what should be reported to the physician?
  - d. Can the medicine be crushed or capsules opened if administering a pill is difficult? Does it come in a liquid form that might be easier to give? (Chocolate masks flavors very well. Try mixing crushed medicine with 1 teaspoon of cocoa powder and enough water or coffee to make a paste.)
  - e. If you miss a dose, do you take it the next time or skip it?
  - f. Capsules may become sticky when held in the mouth and are difficult to swallow. Ask if the medicine comes in a different form, or if the capsules can be emptied and mixed with apple sauce or chocolate. Liquid medications can be mixed with fruit juices.
6. If your doctor is busy and doesn't answer all your questions, you can ask the pharmacist.
7. Don't wait until the next visit if the person experiences a problem in between visits. Call your physician when in doubt.



## GUIDELINES FOR GIVING MEDICATIONS

### **Behavior modifying drugs:**

When a person starts displaying a behavior that is troublesome or unacceptable, and all the behavioral techniques have been tried and found unsuccessful, occasionally medications will work to decrease the frequency of the “bad behavior” or help lessen its intensity.

- Remember, for every good effect a medication has, there may be a corresponding bad effect. The real trick in modifying dementia behaviors is finding the right drug for the right person in an amount that will reduce the bad behavior and not strip away a person’s remaining skills.
- Because people with dementia may have changes in brain chemistry and often because of advanced age, drugs may react in a way different from the intended use.
- In some instances a drug given to calm someone down may, in actuality, cause greater agitation.
- Some drugs given for relief of depression and/or agitation have to be in the blood stream in the right amount for three or four weeks before they are effective.
- Giving drugs to a person with Alzheimer’s is not an exact science; a lot of times it’s really a trial and error approach.
- The doctor may not be able to make a bad behavior go away the day you go for the visit.

### **Things to ask about behavior modifying drugs:**

1. What dosage\* to give when. (Is this drug to be given regularly or only when the bad behavior appears?)
2. What are expected effects and the untoward effects of the medicine? Should you notify the doctor or stop the medicine if the bad effects appear?
3. How long will the person be on it before it becomes effective?

\* Generally medication for people with Alzheimer’s is started with the smallest possible dose and increased gradually until the desired effects are seen without side effects. If you don’t tell the doctor that you aren’t seeing any good effects, he may assume that it’s working at a low dosage. Many of the behaviors experienced are not troublesome to the person with Alzheimer’s but can be very disturbing to the family.

Many behavior modifying drugs come in a liquid form which may be easier for the person to take. Make sure you understand the dosage of the liquid form. Some are concentrates and are given in tiny amounts (less than ½ a teaspoon in some cases).



## BATHING AND GROOMING

### Caregiver's corner:

It may be difficult, and unpleasant to see someone neglect grooming, cleanliness and personal appearance. You may find yourself:

- frustrated and angry with the person who also refuses your offers of assistance
  - embarrassed about how your loved one looks to others
  - unaccepting of irrational claims like: "I just had a bath this morning" or "these are clean clothes"
  - wrongly thinking the person's lack of cleanliness is a reflection on you
- Set realistic goals that balance an acceptable level of cleanliness with the hassle factor involved and work on accepting that some bathing is better than no bathing at all.

### Age changes:

Today's older generation may have grown up with different values regarding bathing and changing clothes. Older people may also highly regard their privacy and modesty and become uncomfortable undressing in front of their relatives. They also may have bathed less frequently in winter or to conserve water. Older people experience changes in their senses and mobility that can affect their ability to bathe and groom. These include:

- less acute vision which may make it hard to see a white tub against white/pastel walls
- sense of touch is diminished making it harder to feel how hot/cold water is while being more sensitive to feeling chilly when undressing
- decreased mobility and flexibility that make it harder to get in and out of the shower or tub
- skin loses moisture and becomes drier; itching and flaking occur with frequent soap and water baths

### Dementia changes:

Many people with dementia go through a phase when they seem to be terrified of bathing/showering. They may also misinterpret requests to remove clothes and also have a terrible time admitting they need help with this process. People with dementia may have trouble:

- remembering to change clothes or to bathe
- completing the complex task of bathing (a series of simple tasks that has to be completed in specific order for the process of bathing to be successful)
- performing the motor tasks necessary to complete a bath
- realizing their need for assistance
- remembering or accomplishing toothbrushing



## BATHING AND GROOMING

### What to try:

- Identify the person's usual bath time and routine; you'll probably have more success if you continue this pattern.
- Try to break the task down into small steps and talk the person through: "here's the wash cloth, wash your face."
- Don't announce that it's "bath time" if you know you're going to get a negative response. Instead, get everything ready and invite the person to the bathroom, be friendly guiding and directive in approach.
- Arrange a "reward" after bathing (eg. having a cup of tea and cookies) to soothe and replace frustrating bath time feelings.
- Try a bath chair or bench (available in home health stores) and a hand held shower. This may be less frightening than immersion in a tub or having water sprayed from a stationary showerhead.
- Put nonskid strips on tub floor and attach grip bar to tub for safety. Don't use bath oil and keep radios, hair dryers, electrical equipment out of reach; wipe up spills on floor so people won't fall.
- Assure privacy and make sure the room is warm enough.
- Encourage person to do as much as possible to increase feelings of self-esteem and confidence.
- Approach the bath matter-of-factly and avoid whispering or using infantile words as these will increase discomfort and embarrassment.
- If you can't get the person in the tub/shower (spouses sometimes bathe together), give a "sponge bath." This can be done while the person is sitting on the commode or standing at the sink.
- A family member of the same sex or opposite sex may be more acceptable. You may need to call on a niece, grandson or enlist a "bather" from a home care agency.
- Utilize beauty/barber shops for hair care (one less task for you and most people with dementia enjoy being "pampered" in this way).
- Try fluoride sponge swabs for oral hygiene if a toothbrush is refused.



## TOILETING

### Caregiver's corner:

It's hard to watch someone you love lose the ability to regulate urination and defecation. It can often be embarrassing for both you and the person with dementia. Privacy itself may be the greater issue since going to the bathroom is almost always done alone.

- It is hard to see an adult you love lose the ability to manage his/her toileting needs
- Privacy issues may be harder to deal with than the actual incontinence
- Facing the embarrassment is hard for you and for the person with dementia

### Age changes:

Biologic changes may occur with aging, including:

- decrease in bladder muscle tone
- weakening of sphincter muscles for bowel and bladder
- frequent trips to the toilet, smaller amounts voided (men may have an enlarged prostate gland)
- increase in the incidence of urinary tract infections, especially in women

### Dementia changes:

Changes caused by the progression of the disease include:

- messages that the bladder needs to be emptied may be recognized too late or slow response to this stimuli may cause persons to be incontinent
- persons may forget where the toilet is
- persons may void in appropriate places, misperceived to be toilets/urinals (e.g., sinks, trash cans, corners)
- persons may lose ability to remove clothes for toileting
- persons may go to the bathroom frequently out of fear of soiling self
- true incontinence related to dementia decline usually occurs late in the illness
- some medications may cause or increase incontinence
- night-time incontinence (nocturia) may be physical or may be the result of increased confusion because of darkness or dim lighting



## TOILETING

### What to try:

- Use a matter of fact approach with toileting issues.
- Use adult words that are familiar to the person; give clear direct messages. (Don't whisper or use baby talk regarding toileting issues since this can increase embarrassment.)
- Try to figure out why the person is soiling his or her self. Can't find the bathroom? Show where it is. Can't find the toilet? Put a bright colored rug on the floor at the toilet so it stands out. Can't undo clothes? Give help or simplify clothing.
- Does the person go to the toilet frequently? (more than once every hour and a half?)
  1. Check with doctor to rule out urinary tract infection. The person may not feel burning or have other common symptoms of a urinary tract infection. Incontinence or frequent toilet trips may be your only clue. (Urine may turn very dark, cloudy and have a strong, foul odor.
- Has an accident on the way to the bathroom? Take the person at regular intervals (one person may need to go every one and a half hours, another may stay dry for three or four hours before needing to go.)
- Soils at night?
  1. Give plenty of fluids during day but stop fluid intake after 6 p.m.
  2. If wetting occurs at the same time every night, set alarm for a half hour before, get up and take the person to the bathroom. This may or may not be effective but is worth a try.
  3. Wets in hallway/bedroom—everywhere but toilet at night? Make sure bathroom is well lit and that door stays opened. Tie handle to towel rack or use door stop. Some people close the door after using the bathroom and then can't find it when they need it again.
- There are several brands of incontinence pads in different styles for different kinds of incontinence. Check with pharmacies or members of a support group to get advice on what to try and where to find them.
- Keep all soiled material, linens and pads in tightly closed containers until they can be discarded or washed. Wash the person well after an incontinent episode to reduce odor.
- Cover mattress with a plastic cover (large trash bags work well) to prevent urine from soaking in.
- Consider removing rugs or carpeting on frequently wetted spots.
- If incontinence begins all of a sudden, report it to the physician; it could be a sign of a physical problem or a side effect of a medication.
- Run water in the sink to stimulate urination.
- If resistance is encountered in toileting, try to develop a "bear hug" procedure in which the caregiver can remove loose fitting clothing and guide the person to sit on the toilet all in one operation. The disarming affection enables this to work with regularity.



## **PARANOIA, YELLING, REPETITIVE ACTIVITIES AND OTHER TROUBLESOME BEHAVIORS**

### **Caregiver's corner:**

When you think you've seen it all, another behavior that seems worse than all the rest may appear. It is important to keep in mind that Alzheimer's is an ever changing presentation of behaviors reflecting internal deterioration of brain cells. As more cells die, behaviors will change. It sometimes helps to know that a particular behavior will probably only last six to nine months. It helps to see the light at the end of the tunnel. It also helps to know that you are not the only one dealing with "bad" behaviors. Try and find out from others how they have handled them. **NOT EVERYONE WHO HAS ALZHEIMER'S WILL DEVELOP THESE BEHAVIORS.**

For better or for worse, caregivers must be aware that most behavior traits will change over time. Some will disappear entirely, but others will commence with no predictability.

When a caregiver encounters a new aspect of behavior, remember the common support group reminder: "This, too, will change."

### **Paranoia:**

Early in the illness, sometimes even before it is diagnosed, the person with dementia may become very suspicious and distrustful especially of the caregiver. If something is missing the person with dementia may think it has been stolen or worse, that the caregiver has hidden it. This distrust often leads to anger directed at the caregiver which is often hard to dissipate.

### **Yelling:**

Screaming, sometimes making sense, sometimes calling for help, sometimes profanities, words you didn't even know they knew: these are behaviors that can try the patience of a saint. No one really knows why these behaviors appear. Some speculate that a person feels very trapped and disconnected with anything familiar and is verbally searching for something he recognizes. Sometimes a person's hearing is bad but he can't remember that and isn't aware that he is shouting. Other people seem to be stimulated by every sound in their environment and respond to it by yelling.

Repetitive phrases: "I want to go home. . . I want to go home. . ." This phrase or a similar one may be repeated thousands of times during a day. Even if the person is at home, the phrase goes on and on.

Picking at clothes, smoothing things out, tearing paper into tiny shreds, collecting papers or assorted unrelated objects (which then become treasures) rearranging items on counters or in drawers, rubbing hands or heads, clapping, whistling, singing, making grimacing facial expressions, and grinding teeth are a few of the behaviors that sometimes develop in the middle to late stages of the disease.



## PARANOIA, YELLING, REPETITIVE ACTIVITIES AND OTHER TROUBLESOME BEHAVIORS

### What to try:

- Make sure that the person is not in pain, sitting on something uncomfortable or too long in one position, that clothes and/or shoes are not ill-fitting or that he is not constipated or needing to urinate. Any of these things can make a usually quiet person more vocal.
  - If you are confident that you have met the person's needs and the behavior still persists, you must move on to survival techniques. Although these behaviors are very annoying to caregivers, the person may be completely unaware that it is coming from him and may not be able to control it. (This is one area in particular to use your imagination and creativity. Listed below are things that have worked once in awhile and deserve a try.)
  - "Gum Therapy"—If the person can chew and swallow easily, try giving gum to chew so there is something in the mouth. Rarely will a person call out when his mouth is filled. Be sure and use gum that won't stick to dentures.
  - When the person is accusing the caregiver of hiding or taking something, try not to react defensively; instead say "I know you're worried about your purse (or whatever is missing). I love you, and I'll help you look for it."
  - "Cereal Therapy"—Give the person a non-breakable bowl of dry cereal to eat. It has lots of fiber and won't significantly add to caloric intake.
  - If a person insists on reorganizing papers, folding them and sticking them away, keep a basket of flyers, ads, or playing cards that are not important to you and can be sorted.
- Keep important mail and documents locked up, out of sight and out of reach. Remember that these papers are very important to the person and need to be treated accordingly while the person is interested in them. If it's time to take them away, say, "Let me take care of those for you," rather than: "o.k. put that mess in the trash and quit playing." Sometimes the mere motion of going through things makes them feel better.
- Wear ear plugs that deaden sound if the person is yelling all the time, or wear headphones with a tape of your favorite music. Occasionally putting headphones on the person with his favorite music will help.
  - If the house is big enough, arrange a safe place for the person where yelling will not disturb the rest of the family. Check on the person regularly and leave him be. Many people waste energy and time trying to get a loud person to be quiet with no good results.
  - Occasionally, and as a last resort, medications can be tried. Unfortunately, the amount of medication needed to stop the behavior is often the amount that takes away a person's remaining abilities to care for himself or to be safe on his feet. People may be zonked on medicine before there is a noticeable difference in yelling behaviors. Sometimes this is the only solution.
  - People discover new ways every day to deal with these behaviors. Support group members often have suggestions that have worked in similar situations and are glad to share these.



## ACTIVITIES... WHAT TO DO BETWEEN MEALS

### Caregiver's corner:

It is really hard to watch a once active person "do nothing" or, worse yet, misuse familiar tools or household objects. This loss in itself is the one caregivers frequently associate with a return to childhood. The person is no longer capable of complex games or enjoying usual types of grown up entertainment. Trying to fill this void, caregivers may try children's toys, books or activities. While the intention of presenting simplified activities is good and on the right track, children's formats may insult an older adult who is still capable of understanding what he sees. The guiding philosophy for anything you try should be:

- Help the person to feel useful and still be part of the family
- Recognize and capitalize on remaining strengths
- Accept the fact that without a lot of supervision from you, a task you want the person to complete will not get done.

### Age changes:

Age changes that make engaging someone in purposeful activities difficult include:

- Decreases in vision and hearing may make previous pastimes less enjoyable
- Decreases in dexterity and joint range of motion may make fine motor activities hard to do
- People may tire more easily and require longer to complete a task.

### Dementia changes:

- "Apraxia," the loss of ability to do routine motor activities which frequently occurs in the middle stages of Alzheimer's, prevents a person from completing even the easiest of motor skills. Thus even cutting a straight line can become very challenging.
- A person may still have awareness and realize that craft or work products have deteriorated and thus he will not attempt to make these. Trying to simplify an old hobby may be unacceptable.
- Work or activities that depend on a process of doing one thing after another are often left alone.
- Attention span may be greatly reduced for independent activities. During the hypermotor phase, it may be very difficult to help the person focus on anything for any length of time.
- Social skills may long outlast a person's other abilities. He may do nothing for the caregiver and yet be very cooperative with another relative or unfamiliar person.



## ACTIVITIES... WHAT TO DO BETWEEN MEALS

### What to try:

- Try to focus on the person's remaining skills even if they seem minimal.
- Your attitude will be important in determining how the person views an activity. If you see it as a "time fill," the person is likely to reject it and see it as useless.
- Simple activities that have an adult purpose can be useful.
- Things that involve repetition of the same motor skills seem to be satisfying. Activities like folding towels and stuffing envelopes, dusting, raking or sweeping seem to work well. Remember that the quality of the job may not be as good as you yourself could do. Thank the person for his help and know that you may have to redo the task later (when he is not there or after he has forgotten that he has done it).
- Including the person verbally in your tasks may work well. Tell the person what you are doing and comment on it. Ask them questions about how he/she likes doing similar activities.
- Sorting, especially in the later stages, seems to give the person pleasure. Keep old greeting cards or mail flyers or coupons in a basket and ask the person if he would like to sort them.
- Videos, either oldies that the person may have seen a million times, nature films or wildlife documentaries may move slowly enough for a person to enjoy watching.
- Sing-a-longs, if they are sung slowly enough, may be very enjoyable. To test a person's ability to sing, try Christmas carols or old church songs.
- Even after people have lost their ability to comprehend, they may enjoy the act of looking at a newspaper or thumbing through magazines.
- Arts and crafts are difficult with this population. Keep in mind that the process is more important than the product and often joint projects where you do the complex parts and he does the sanding or the cutting may be more acceptable.
- Exercise is good for the person with Alzheimer's and the caregiver. Walking is a great way to relieve stress and work off excess energy. It is also an activity that a demented person can do without any disabilities showing.
- Break down household tasks into simple steps; for instance, you put the place mats on the table, hand the person the spoons to put one on each mat, then give the forks, etc.
- If a person comes up with an activity he seems to enjoy and it is safe, inexpensive and keeps him occupied, encourage him to continue it even if it seems dumb to you. One man at our daycare center takes the newspaper, and systematically underlines each line of print with a pencil. Another goes through the yellow pages and puts a check on each page. While meaningless to us, these activities have a calming effect on the person, ongoing attention, and allowing caregivers to do other things.
- Some folks have even set up a mock office with a desk and "papers" that the person can arrange and rearrange and sign to his heart's content. Their caregivers call it their work and do not minimize the importance of the activity in front of the person.
- Day care with their peers may meet the needs for companionship and sense of purpose for persons with dementia. Being able to participate in a daily routine and activities on their level can prove useful and comforting.



## COMMUNICATION

### Caregiver's corner:

Being able to talk to a person is the basis for all of our relationships in life. When the communication system in any relationship breaks down, troubles begin to add up.

Have you ever had the word “on the tip of your tongue” and not been able to say it? Or, have you ever felt frustrated trying to follow instructions given by someone who speaks a foreign language much better than English? When Alzheimer's affects the brain's communication center, problems like this happen frequently and intensely. The simple act of talking is difficult and may become a battle between the caregiver and the person with Alzheimer's disease.

Although there are techniques that can help ease the problem of more difficult or lost communication, there is still likely to be a feeling of loss for that person and the communication you once shared. Try to recognize that some of your anger is based on grief and try not to direct this anger at the person.

### Age changes:

We rely on our senses to send and receive messages. Abilities which may diminish with aging and affect the quality of communication include:

- impaired hearing, especially the higher frequencies: “s” & “f” sounds are likely to be lost on older ears
- decreased vision makes lip reading and seeing facial expressions more difficult

### Dementia changes:

Language is usually affected early in the disease and communication becomes harder as time goes by. Problems occur throughout the process and include:

- not recognizing a word or a phrase almost as if the word were in a foreign language
- not being able to name things (noun finding), eventually not being able to say any words in a coherent fashion
- “perseveration”—repeating words or phrases without being able to continue to express the rest of the thought
- misnaming objects or people. . .but getting close (some may say mother when they mean wife, or pencil for paper)
- return to their language of childhood or more commonly combining languages with little insight into which language they are speaking at the time
- eventually people may lose all their words except for occasional expressions or nonsense outbursts
- REMEMBER . . .UNDERSTANDING WHAT IS BEING SAID OFTEN OUTLASTS THE ABILITY TO SPEAK APPROPRIATELY!



## COMMUNICATION

### What to try:

**ASSUME THE PERSON UNDERSTANDS EVERYTHING THAT YOU ARE SAYING.**

Nobody likes to be talked about, so include the person in your conversation; or wait until he/she is not around if you need to say something that may be upsetting.

Get the person's attention before you start talking.

- Look at him/her eye to eye—make eye contact.
- Use gentle touch.
- Call the person by name.
- Deliver your message using short, simple words.
- Keep communication on an adult-to-adult level. Avoid baby talk or demeaning expressions.
- Smile, and shake the person's hand so that he/she knows you are approaching them as an adult.
- S-p-e-a-k s-l-o-w-l-y (expanded speech).
- Give only one message at a time.
- If your voice is high, try lowering the pitch—don't shout.
- Limit choices. If it's time for lunch, don't ask the person if he/she is ready to eat; just say "it's time to eat."  
On the other hand, give the person choices when it's o.k.: "Would you like coffee or tea?"
- Watch your body language: if you are angry, your face or body tone may show it, even if your words are sweet.
- Ask uncomplicated questions one at a time, and repeat them, using the same words, if the person doesn't respond.
- Help the people put words to their thoughts if you know what they are trying to say, e.g. "You're trying to ask when your wife is coming aren't you?"
- Listen for a response. It may take up to thirty seconds for the person to figure out what you've said and come up with the right words in response.
- Use non-controlling, non-confronting statements.
- Try to agree with at least part of what the person is saying. Don't start every answer with "No, you can't!"  
For example, say "Could you please come here" rather than "No, don't go out the door!"; or "You're right, you are going home, as soon as your wife gets here", is easier to take than "You have a long time to wait."
- Change the subject rather than waste energy arguing. It's impossible to have a rational argument with someone who can't be rational. Instead, compliment them on their smile or ask for their help; this may derail their argumentative attempts and help you feel like you're still in charge.
- A simple written note can sometimes help to calm a person who is trying to remember a particular piece of information.
- Tell the person that everything is going according to plan.
- Although it often seems like a waste of time, it's important to keep on talking even when you are sure you aren't getting through. Explain what you're doing, update the person on familiar events, and use your gift of gab in an attempt to stay in touch with your loved one.
- Reduce background noise if possible, although you can hear over the radio or other's conversations, the person with Alzheimer's probably can't.



## EATING AND NUTRITION

Sharing a meal means more to most people than simple nutrition. Eating is a social event, an activity shared with family and friends.

In our society eating is a part of holiday celebrations, family get togethers and religious occasions, so when lifelong eating patterns change due to Alzheimer's, caregivers are naturally upset and can become very frustrated trying to meet the nutritional needs and the social needs that sharing meals once filled for both of them. Caregivers need to find alternative ways to meet their own needs for socializing through other family members and friends.

During the end stages of the disease, a person with Alzheimer's will have "body wasting" in spite of all the caregiver's efforts at good nutrition. Although it is hard to watch, caregivers need to prepare themselves and realize there is little they can do.

### **Age changes:**

- Chewing food may be more difficult, teeth may be worn down, gum disease may be present, dentures may be ill fitting due to normal shrinking of the lower jaw.
- Hiatal hernias may occur more frequently with older people, making it necessary to eat smaller and more frequent meals.
- Digesting food may slow down and constipation may be a frequent complaint. Certain items will be eliminated from the diet because it's "just too hard to digest." Lack of exercise and general slowing both contribute to constipation.
- With decrease in taste and smell, the desire to eat may diminish. Old favorites may not taste like they used to.

### **Dementia changes:**

- People may not recognize food as food or may think non-food items are edible.
- Early in the disease, people's judgment regarding food may be impaired; they may think they have eaten when they haven't or vice versa; they may go through a stage of gorging, especially sweets, and gain weight at a rapid rate.
- Later in the disease, people may forget that food served to them is in front of them; they may lose the ability to use silverware or to get the food to their mouths.
- Some will mix food and beverages together, occasionally adding their napkin, and not hesitate to continue eating their concoction.
- Table manners are forgotten and there are usually more spills with less regard for neatness or order.
- During the later stages of their illness, people are likely to lose their appetite, their ability to eat and their desire to eat. Some eventually lose the ability to swallow and or chew food put in their mouths. Choking may become a problem.



## EATING AND NUTRITION

### What to try:

- Streamline mealtime so that it's as easy as it can be for you, the caregiver.
- If the person is in a gorging mode, remove sweets from the house but have plenty of nutritious snack foods on hand (rice cakes, carrot sticks, apples etc). Realize that you won't be able to satisfy the person's urge to eat but you can offer healthy alternatives. During this phase, people may lose their manners and may eat off other people's plates, or eat non food items. Occasionally the urge to eat is overwhelming and the person may choke trying to eat too quickly.
- If the person sits with the food in front of him/her without eating or eats some and then stops, try reminding him/her that the food is there, or gently tell them to take a bite of something on their plate. They may have forgotten they were in the middle of a meal.
- If it looks like the food is being played with but eating isn't being accomplished, they may be losing their ability to use their silverware. Try offering finger foods; almost anything can be wrapped in a piece of bread and made into a sandwich.
- If cutting food is a problem, cut it in the kitchen and offer it ready to eat on the plate. Offer only one utensil at a time if spoon, fork and knife are too confusing.
- Sometimes you just have to help a person get started by holding the hand on the spoon, putting the spoon in the potatoes, and helping get it to the mouth. Once or twice with you doing it and the person may continue by himself.
- Difficulty swallowing may be a temporary condition. Many caregivers have gotten through this by giving thickened liquids during this phase. Eggnog, milk shakes, pudding, ice cream, hot cereals and sherbet can be swallowed more easily than watery liquids or foods that require a two step process of chewing, then swallowing. Thick soups are nutritious and relatively easy to eat and swallow.
- People at some stage may refuse to eat, or be unable to eat. Caregivers need to think about this and talk over the options with their doctor and the members of their support group and family.
- Unless the doctor has told you to limit fluids, try to offer water, fruit juices and other clear liquids frequently. If night time wetting is a problem, give fluids during the day and then limit them in the early evening.
- Check with your doctor about giving the person alcoholic beverages. Some medications don't mix well with alcohol, while some people have a calm relaxed evening after they have had a glass of wine before or with dinner.
- If people mix their food, offer only one item on the plate at a time and hold the liquids until they are finished eating. Limit access to condiments as they may be applied too liberally or just add another layer of confusion.
- Don't fill cups too full and only serve food and beverages at moderate temperatures. People may burn their mouth and throat before they realize the food/drink is too hot for them; they probably won't wait for it to cool down.
- **LEARN HOW TO DO THE HEIMLICH MANEUVER** in case a person chokes while eating.
- Occasionally, a person in the wandering or pacing phase may not be able to sit still long enough to eat. If this happens, you may want to consult your doctor about using a gerichair or some other device to limit pacing during mealtime.
- If a person seems to be able to chew the food but not swallow, sometimes stroking the neck can help initiate the process.
- If you have to feed the person, try to do it in a matter of fact manner and slowly. You may want to have a book to read or a recording to listen to in between mouthfuls since it can take a long time to chew up food and swallow it. Don't try to force a person to eat, teeth can break and lips and gums can get injured.
- Soft foods and those easier to chew and swallow are often more acceptable than items requiring much chewing.



## HOSTILITY AND AGGRESSION

### Caregiver's corner:

Avoiding a crisis is much better than having to get through one. But caregiving can be so frustrating that it can become very easy to enter into the cycle of aggression (See diagram).

It is also very easy to blame yourself for not being patient enough...not trying harder...not being a "superperson"—able to do all things for everyone calmly and correctly each and every time. And then there's guilt—"the gift that keeps on giving"; even after the person with Alzheimer's has long since forgotten what the argument was about, you're left feeling angry and guilty. Look at the aggression cycle, see if you can figure out the events leading up to the outbreak, and what you could do differently the next time. Review communication skills, since this is where many aggressive outbreaks begin. Then, take a deep slow breath, maybe two, and think about something that makes you laugh. These events have happened before and will happen again. It is part of caregiving.

Relationships with people probably weren't perfect before the illness and how you felt about each other before will definitely influence the caregiving scenario.

Children who become the primary caregiver of their parents may feel like the parents are a burden. Children may resent responsibility for caregiving for both older parents and their own children.

If you find yourself so angry that you are afraid you'll hurt someone or actually hit someone, you are getting a very strong signal that you need respite or more help with caregiving.

Angry feelings are normal; behaving in a negative way in response to these feelings means you need help. Look in the Community Resources section of this guide for specific places you can turn for help.

### Age changes:

It takes so much energy for some older people to do what they once used to do. Things that once were easy for them may tire them more quickly and they may become short tempered.

Older adults who value their independence may have a difficult time accepting help, even if they know they need this help.

### Dementia changes:

A person with dementia may have very little insight into his/her illness and not understand why there are limitations on activities ("What do you mean I can't drive the car? I've been driving the car since I was 14!"). As the disease progresses these changes may occur:

- impaired judgement combined with memory loss and decreased abilities to carry out simple motor tasks can result in unsafe situations
- frustration with the continual parade of losses that a person with Alzheimer's disease has to accept can make even the meekest person lose control or give up in despair
- a noisy, crowded or visually active environment can contribute to an explosive situation
- Although verbal skills may deteriorate, many people with Alzheimer's disease pick up on caregivers' moods and feelings. If the caregiver is upset, the person with Alzheimer's may become upset more easily.



COMMUNITY RESOURCES

Alzheimer’s Association National Headquarters

919 North Michigan Avenue, Suite 1000 Chicago, Illinois 60611  
800 272-3900

Family Respite Center

2036 Westmoreland St. Falls Church, Virginia 22043  
703 532-8899

Alzheimer’s Association (Local Chapter)

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Area Agency on Aging

Phone \_\_\_\_\_

Primary Doctor Name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Neurologist \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Other doctor \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Respite Companions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Numbers

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



EMERGENCY INFORMATION

Person's (with dementia) name \_\_\_\_\_

Nickname \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_

M \_\_\_\_ F \_\_\_\_ Skin Color \_\_\_\_\_ Blood Type \_\_\_\_\_

Ht \_\_\_\_\_ Wt \_\_\_\_\_ Age \_\_\_\_\_ Hair \_\_\_\_\_ Eyes \_\_\_\_\_

Glasses: Yes No

Identifying characteristics (scars, birthmarks, tattoos)

Is person wearing ID Bracelet? Yes \_\_\_\_ No \_\_\_\_

ID Bracelet # \_\_\_\_\_

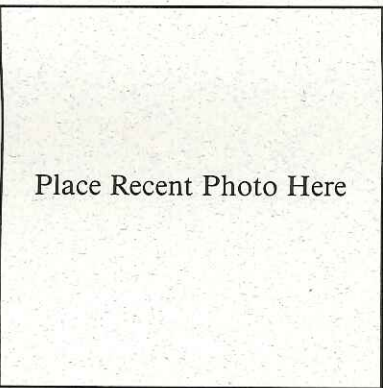
Significant medical problems:

Allergies \_\_\_\_\_

- Health Problems: 1.  
2.  
3

Current Medications:

Daily Routine/identifying habits:



Important Telephone Numbers

Police \_\_\_\_\_

Fire \_\_\_\_\_

Dr \_\_\_\_\_  
name

Telephone # \_\_\_\_\_

Relatives 1) \_\_\_\_\_

Telephone # \_\_\_\_\_

Relatives 2) \_\_\_\_\_

Telephone # \_\_\_\_\_

Neighbors \_\_\_\_\_

Telephone # \_\_\_\_\_

Who to call in event of serious problem:

\_\_\_\_\_

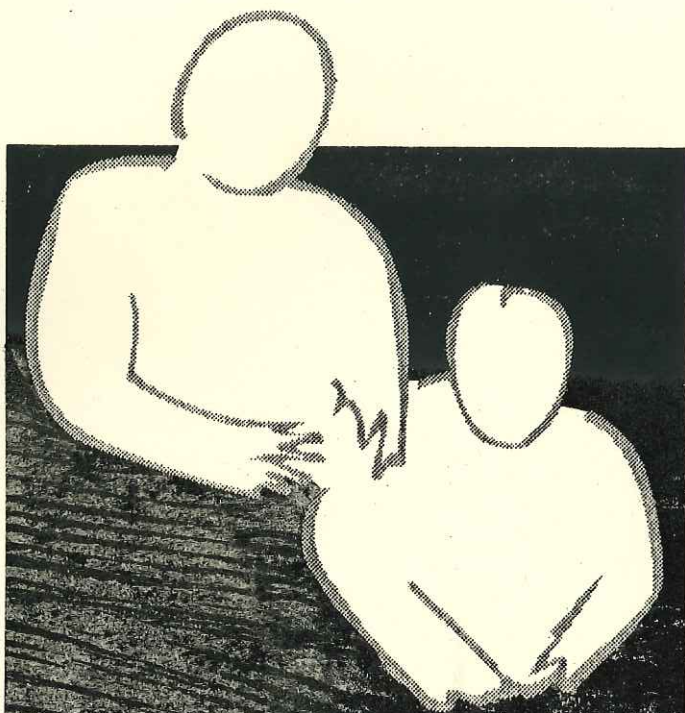
Telephone # \_\_\_\_\_



# **PLANNING FOR INCAPACITY**

**What is best for you?**

- **Living Trust?**
- **Conservatorship?**
- **Joint Bank Account?**
- **Durable Power of Attorney?**



**Minnesota Board on Aging  
and  
Minnesota Adult Protection Coalition**

## TABLE OF CONTENTS

Introduction	1
Why is planning for incapacity so important?	1
When should people plan for incapacity?	3
Who is "competent" to plan for incapacity?	3
What happens if a person who has not done planning for incapacity becomes incompetent?	3
Informal arrangements with family members	5
Formal arrangements and legal planning tools	6
Banking assistance	6
Adding a name to your bank account	7
Joint account	8
Authorized signer account	9
Payable on death account	9

Durable Power of Attorney	10
Trusts	14
Should you use a living trust to plan for incapacity?	15
Should you use a living trust to avoid probate?	16
Should you use a living trust to avoid paying nursing home costs?	18
Conservatorship planning	18
What are guardianship and conservatorship?	18
What is conservatorship planning?	19
Do I need conservatorship planning if I already have made other informal or formal planning arrangements?	20
Getting legal advice	22

## PLANNING AHEAD

- How to make sure your wishes will be respected if you ever need help handling your property or finances
- How to safeguard your independence and autonomy
- How to protect yourself now from the risk of financial exploitation in the future

## INTRODUCTION

**Why is planning for incapacity so important?**

Most people do not like to think about the possibility that they might become unable to handle their own affairs without help. But anyone could become "incapacitated" — that is, disabled by a car accident, stroke, Alzheimer's disease, loss of eyesight, etc. — and be unable to manage alone. In many such cases, family members step in and help. But some vulnerable people do not have family nearby. They may become isolated and unable to pay bills, balance bank accounts, or protect themselves from "rip-offs," before anyone notices they are in trouble.

And there can even be problems within families, for example, when children disagree among themselves over who should handle their parent's



financial and personal decisions.

Therefore, there are questions we all should ask ourselves —

- Who would help me handle my affairs?
- How can I make sure they would handle things according to my wishes and preferences?
- How can I protect myself from people who might try to take advantage of me?

Fortunately, if people take the time to think and plan ahead, there are many ways to make sure that their own wishes about the future will play a major role in controlling who makes decisions for them and what those decisions are. These planning arrangements include:

- informal arrangements with family members
- banking tools
- durable powers of attorney
- trusts
- conservatorship planning

Each of these planning tools will be discussed in this booklet.

**When should people plan for incapacity?**

**Who is “competent” to plan for incapacity?**

Ideally, everyone would do appropriate planning for incapacity before they need help. But it is important to remember that people can still take steps to plan ahead, even though they have begun to need some help. The legal planning arrangements described in this booklet can only be made voluntarily by a “competent” adult, but just because a person has some disability does not mean the person is “incompetent.” When a person discusses legal planning options with his/her lawyer, the lawyer can explain competency requirements. If you think that your competency might be challenged in the future by someone who does not agree with your wishes, your lawyer can take special steps, suited to your individual needs, to defend your planning arrangement against such a challenge.

**What happens if a person who has not done planning for incapacity becomes incompetent?**

If a person has lost the ability to make or communicate decisions, and did not plan ahead, a guardianship or conservatorship might be the only



way to handle that person's property and finances. Guardianship/conservatorship is a court proceeding, with attorneys' fees and costs generally paid from the disabled person's funds, whether or not the disabled person agrees with the proceeding. Sometimes, family members get into arguments over who should be the guardian or conservator for their mother or father; fighting such battles in court can be very expensive and destructive to family relationships. More details on guardianship/conservatorship are explained in the "conservatorship planning" section on page 18 of this booklet.

## **I. INFORMAL ARRANGEMENTS WITH FAMILY MEMBERS**

Many people can get all the help they need from family members. If you are comfortable discussing your finances with a trustworthy relative, that person could help you write checks, file tax returns, and manage property. For that relative's protection, it is best if your other family members know that this is what you want. And for your own protection you generally should not transfer money or property out of your own name. For example, even if a mother trusts a son to put her money into his own bank account and use it to pay her bills, or to let her keep living in her home after she has transferred it to him, she may not realize that if her son would die, get divorced, or go bankrupt, she could lose her money or her home to her son's creditors. Also, if you give away property, or sell it for less than it is worth, you might be temporarily disqualified from Medical Assistance, the program that helps pay nursing home expenses. For these reasons, you should not give your money or property to a relative without first discussing the matter with your lawyer.

In any case, make sure your relative agrees to keep good records and to go over them with you (and possibly another trusted person) at regular intervals.



Also, be aware that your informal arrangement with one family member may not work if other family members become jealous or suspicious. If you do become unable to handle your own affairs, anyone could try to get control of your finances through a guardianship or conservatorship. Therefore, it is often a good idea to protect your informal arrangement with a "back-up," that is, one of the following formal arrangements/legal planning tools.

## **II. FORMAL ARRANGEMENTS AND LEGAL PLANNING TOOLS**

Many people do not want to tell family members all about their money matters. Or they do not have close family living nearby. Or they want to avoid a family disagreement over who should handle their finances. They can choose one or more of the following formal arrangements and legal planning tools.

### **Banking Assistance**

Modern banking technology can help people who become ill or homebound keep control of their money matters. You can ask your bank to arrange automatic bill paying, banking by mail or telephone, or special communication devices for the blind or hard-of-hearing.

**Direct deposit** is available for Social Security checks and some other pension checks. To arrange for your Social Security checks to be deposited directly to your bank account, call Social Security at 1-800-234-5772 and ask for a Direct Deposit form.

### **Adding a Name to Your Bank Account**

People sometimes plan ahead by adding another person's name to their bank accounts, so that a trusted friend or relative can help them by signing checks, paying bills, or transferring money between accounts. Such accounts are easy to set up, just by going to your bank, but you should be very careful about the type of account you choose, and about the person whose name you add.

There are several different types of multiple-name bank accounts, each with different rules. First, you need to know which type is best for your needs, then you must make sure that the bank correctly gives you the type of account you request, because even bank employees can get confused about the different choices.

These are the choices for savings or checking accounts, certificates of deposit (C.D.s), etc.:



- Joint account
- Authorized signer account
- Payable on death account

1. "Joint account": The other person can make deposits and withdrawals and sign checks, and is considered a co-owner; therefore, that person could take advantage of you and withdraw all your money. Or that person's creditors could tie up your account (with a "lien" or "attachment") until you could prove how much of the account funds you contributed. You might not be able to take the other person's name off the account without that person's written approval. Also, you could be temporarily disqualified from Medical Assistance, the program that helps pay nursing home costs, because adding a co-owner to your account is considered to be like giving away property.

When you die, the survivor automatically owns the account, without having to go through probate, unless your Will specifically lists the account number and says that you did not intend the joint owner to receive the account.

Generally, you should only use joint accounts with your husband or wife, or for small accounts. If you do want to set up a joint account with someone other than your spouse, for over

\$10,000, you should talk with a lawyer first about gift tax and income tax laws.

2. "Authorized signer account": Also called a "convenience account" or a "power of attorney account." The other person can make deposits and withdrawals and sign checks, but does not become an owner of the account. So that person's creditors cannot tie up your account. However, there is the risk, as with joint accounts, that the other person could withdraw all your money.

Unlike a joint account, the account does not belong to the authorized signer when you die; rather, funds in this account belong to your estate.

3. "Payable on death account": Also called an "in trust for account" or a "totten trust": This account names one or more people to automatically own the account when you die, without having to go through probate. But during your lifetime, they have no right to the account; their creditors cannot tie up the account, and they cannot make withdrawals or sign checks. So this account is not a way to plan ahead for help with finances while you are alive. Rather, it is a way to give your property to loved ones after you die.



## Durable Power of Attorney

Most simply put, a power of attorney is just a written authorization for someone to handle property or financial matters for you, in whatever way you spell out.

The person signing the power of attorney document is called the "principal," and the person named to handle the principal's property is called the "attorney-in-fact." (This is not to be confused with attorney-at-law. The attorney-in-fact does not have to be a lawyer.)

If the document states that the power will continue to be valid, even if the principal becomes incompetent, it is called a durable power of attorney. (An ordinary power of attorney ends if the principal becomes incapacitated or incompetent. So, to use it for planning for incapacity, it must be a durable power of attorney.)

After signing a durable power of attorney, the principal still has the right to control his/her property, as long as he/she is competent. The principal, while competent, can cancel or revoke the power by signing a revocation paper before a notary public and giving a copy to the attorney-in-fact and any persons with whom the attorney-in-fact has done business on

behalf of the principal. If the principal becomes incompetent, the power can only be revoked by a guardian or conservator, if one is appointed for the principal.

For principals who do not want a durable power of attorney to go into effect unless they become incompetent in the future, the principal's lawyer can be instructed to keep the signed document and deliver it to the attorney-in-fact only if the principal becomes incompetent. You could even instruct your lawyer on how to determine if you have become incompetent; for example, you could tell your lawyer to deliver the document if your family doctor says that you can no longer handle your own finances.

A durable power of attorney can be limited to certain property or can give specific instructions; for example, you could give the attorney-in-fact the power to sell a certain piece of real estate, and give instructions to deposit the proceeds of the sale in a certain bank account. A durable power of attorney can be limited to one bank account; for example, to allow the attorney-in-fact to deposit the principal's funds and write checks to pay the principal's bills. (This type of "authorized signer" or "power of attorney" bank



account is also discussed on page 9 of this booklet.) On the other hand, a durable power of attorney can be written to give broad, general power over all the principal's property and financial affairs.

A durable power of attorney only works if it is accepted by third parties — that is, if persons and financial institutions believe that the durable power of attorney is valid and are willing to do business with the attorney-in-fact on behalf of the principal. Minnesota laws contain a "short form" durable power of attorney form. You are not required to use this "short form," but if you do, any third party who is obligated to deal with you (banks where you have accounts, people who owe you money, etc.) will also be obligated to accept your durable power of attorney and deal with your attorney-in-fact.

The "short form" is easy to complete, simply by marking "X" after each type of power you want to give the attorney-in-fact. But great caution is needed in completing the form — if you mark an "X" after every power listed, you have given the attorney-in-fact complete authority over your property, including legal permission to give all of your property away, even to transfer all your property to the attorney-in-fact himself/herself.

Sometimes there are valid legal reasons why a principal would want to give such broad power over his/her property; but such broad power could be misused, and you should not sign such a document without consulting your own lawyer.

There are many different ways to write safeguards into a durable power of attorney, to make sure that the principal's finances will be handled the way he or she intends. Even with the "short form," some extra safeguards can be written in. Every person's needs and circumstances are different; consider the following options and discuss them with your lawyer:

- Require that the attorney-in-fact give an annual accounting to you and to your lawyer or an independent accountant to review.
- Name two attorneys-in-fact on the document and specify that they must act "jointly" ("jointly" means that they must both agree and both sign checks, etc.).
- It might be possible to get a surety bond on the power of attorney, to cover the value of your property if it is stolen by the attorney-in-fact.



- Make sure that the trustworthy person you pick to be your attorney-in-fact is both willing and able to handle the responsibility; consider also naming a successor to take over the responsibility if the first attorney-in-fact dies or becomes incompetent.

## Trusts

A trust is a legal arrangement where a person or financial institution, called the "trustee," holds legal title and manages assets for the benefit of some person, called the "beneficiary." The person who creates and funds the trust is called the "grantor."

There are two ways a person can create a trust. If the grantor creates the trust in his/her Will, to take effect after the grantor dies, it is called a "testamentary trust." A testamentary trust can be an important estate planning tool, to provide for loved ones after the grantor's death.

A "living trust" (also called an "inter vivos" trust) is one that is created by a trust agreement during the grantor's lifetime. The "living trust" can be used to manage the grantor's property for the grantor's benefit; thus, the "living trust" can be used for planning for incapacity.

A trust can be made either "revocable" or "irrevocable." A "revocable" trust can be changed or terminated by the grantor at any time as long as the grantor is still competent. An "irrevocable" trust cannot be changed or terminated after it is signed. For property management purposes, normally a "revocable" trust is used. (Tax considerations may also be a factor in deciding whether to make the trust "revocable" or "irrevocable," where a substantial amount of property is involved.)

**Should you use a living trust to plan for incapacity?**

One way to use a "living trust" to plan for incapacity is to set up the trust but not put any money or property into it (or to just put a small amount of money into it). Then you also sign a durable power of attorney, instructing your attorney-in-fact to transfer your money and property to the trust only if you do become incompetent or incapacitated. This type of arrangement is often called a "standby trust."

Living trusts are a very flexible and useful tool for planning for incapacity, but because of their cost, trusts are generally only used for larger estates. There are legal fees



for setting up the trust agreement, and then the trustee charges a fee for handling the property (often a minimum fee plus an annual percentage of the amount in the trust). Institutional trustees (such as banks or trust companies) will usually not accept a trust unless it has a least \$50,000 to \$100,000 in assets, because the expense of maintaining the trust would be too great. Of course, a family member or other individual could be named trustee (if you are sure that person is trustworthy), but a fair amount of expertise is needed to handle the paperwork, tax returns, and property management tasks that may be involved.

**Should you use a living trust to "avoid probate?"**

A "living trust" can also be set up to continue after the death of the grantor, to provide for loved ones. Recently, "living trusts" have been advertised as a way to avoid probate. Before you decide to use a trust to avoid probate, you should get independent legal advice (that is, from a lawyer other than the person who is marketing the trust) regarding the other legal ways to avoid probate, and the cost of creating and maintaining the trust.

Many people fear the expense and delay of probate. But there are other ways, often less costly than living trusts, to avoid probate. For example, there is generally no need to probate real estate held in joint tenancy (such as your home owned in joint tenancy with your spouse or children) or joint or "payable on death" or "in trust for" bank accounts (see page 8 of this booklet for an explanation of the types of bank accounts).

If a married couple own all their property jointly, there will usually be no need for probate when one dies — all the property will automatically belong to the survivor. The same is true for life insurance proceeds; they automatically go to the named beneficiary, without probate.

To make sure that your property is passed on according to your wishes in the safest, fastest, least expensive way possible, you should get qualified legal advice. And do not be afraid to compare prices. Lawyers can give you estimates of their fees for setting up a trust, and you can get estimates of trustee fees from the persons or institutions (such as a bank) that you are considering naming as trustee.



### **Should you use a living trust to avoid paying nursing home costs?**

Some people try to use "living trusts" as a way to qualify for Medical Assistance, to avoid spending their savings on nursing home care. This can be very risky. The Medical Assistance rules are very complicated and are subject to change at any time. Do not try to use a trust for this purpose without getting competent legal advice.

### **Conservatorship Planning**

#### **What are guardianship and conservatorship?**

Guardianship and conservatorship are court proceedings to protect persons who are incapacitated and cannot handle their own financial or personal decisions. Under Minnesota laws, guardianship and conservatorship are very similar, except that guardianship takes away more civil rights, such as the right to vote — for this reason, conservatorship is usually used instead of guardianship. The protected person is called the "conservatee," and the person named by the court to make decisions is called the "conservator."

If a person becomes incapacitated and unable to handle finances, and did not previously make any of the planning arrangements discussed in this booklet, a conservatorship may be the only way to handle the person's property, pay bills, etc.. Anyone can petition to be the person's conservator, and a conservator may be appointed whether or not the person wants one. However, if you plan ahead you can protect your independence, even if a time comes when you need a conservator, by doing "conservatorship planning."

#### **What is "conservatorship planning?"**

"Conservatorship planning" (also called "nomination of conservator") is a written document, witnessed in the same way as a Will, where you can name the person you would want for your conservator, and give instructions on how you would want your personal and financial matters handled. For example, the conservator could be instructed as to how to manage your property, as to where you would like to live, and as to your wishes regarding health care.



Then, if you later become incapacitated and need a conservator, the court must name your chosen conservator and order that your instructions be followed, unless the court finds that this would not be in your best interests. (But be aware that the person you choose is not required to serve as your conservator — so choose a reliable person and discuss your plan with him/her in advance to make sure he/she agrees with it.)

**Do I need to do conservatorship planning if I already have made informal planning arrangements with relatives, or formal arrangements such as a durable power of attorney?**

Everyone's situation is different. If you have other informal or formal planning arrangements, you may not need to do conservatorship planning. However, if it is likely that someone would challenge your planning arrangements (for example, if there might be disagreements among the family) you should use conservatorship planning as a "back-up" to your other planning arrangements. Anyone can petition for conservatorship for an incapacitated person, and a conservator can revoke or terminate prior planning arrangements. By

naming the person you choose to be your conservator, you have the best possible legal protection against the appointment of someone you do not want to be your conservator.

While it is safest to plan ahead, conservatorship planning ("nomination of conservator") can also be used after someone has filed a petition for conservatorship, as long as the proposed conservatee has "sufficient capacity to form an intelligent preference." We can illustrate this with an example: Mrs. Smith's son John files a petition in court to be appointed Mrs. Smith's conservator. Mrs. Smith knows she needs help managing, but she prefers that her old friend Mary be her conservator, and Mary is willing and trustworthy. Mrs. Smith can ask the court to appoint Mary instead of John. If the court finds that Mrs. Smith can form an intelligent preference, Mary must be named conservator instead of John, even though John is a blood relative, unless the court finds that naming Mary conservator would not be in Mrs. Smith's best interest.



### **III. GETTING LEGAL ADVICE**

When looking for a lawyer you may want to ask a friend, relative, banker, accountant, or pastor to suggest someone.

Or you can call:

Minnesota State Bar Association  
Attorney Referral Service  
1-800-292-4152

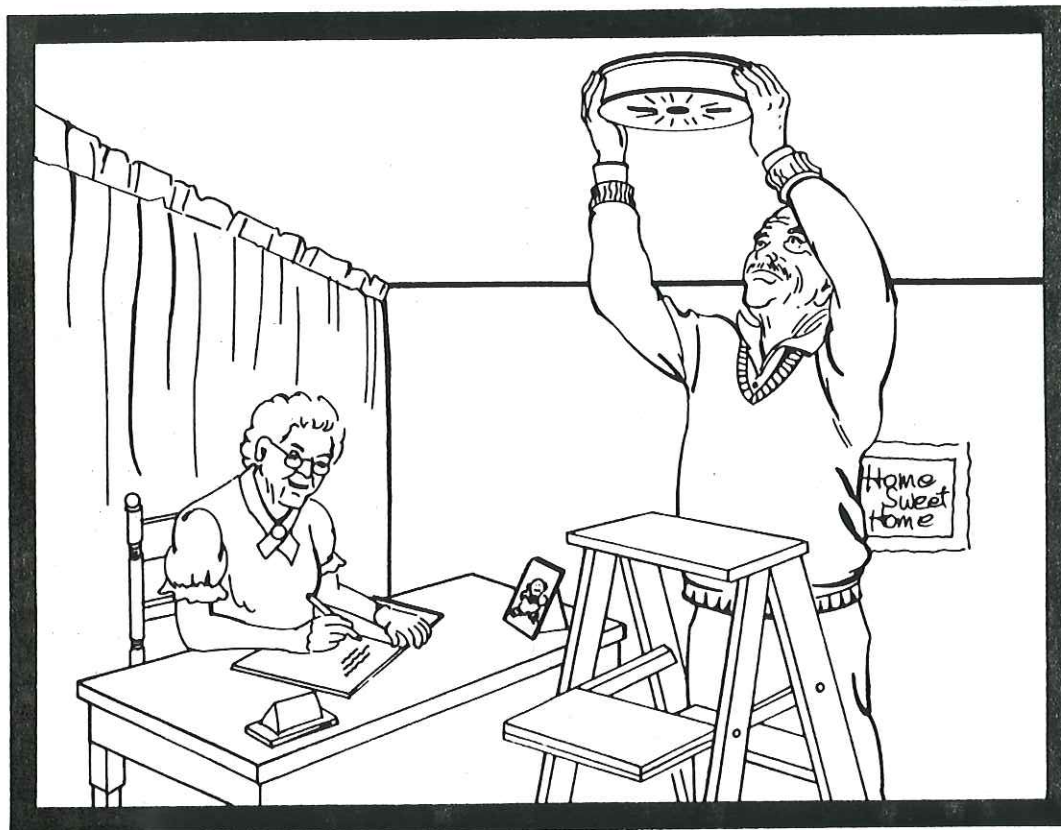
You may wish to interview more than one lawyer, including discussing fees, before making a decision. Never hesitate to discuss fees with your lawyer.

You can help your lawyer help you by following a few guidelines:

- Before you call a lawyer it is a good idea to gather and organize any written information you may have, and make a list of questions you intend to ask.
- Request copies of all materials prepared on your behalf.
- Do not sign any documents until you fully understand what you are signing.

# Safety

## For Older Consumers



# Home Safety Checklist

U.S. Consumer Product Safety Commission



## **Safety For Older Consumers**

### **Home Safety Checklist**

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Each year, many older Americans are injured in and around their homes. The U.S. Consumer Product Safety Commission (CPSC) estimates that in 1981, over 622,000 people over age 65 were treated in hospital emergency rooms for injuries associated with products they live with and use everyday.

CPSC believes that many of these injuries result from hazards that are easy to overlook, but also easy to fix. By spotting these hazards and taking some simple steps to correct them, many injuries might be prevented.

Use this checklist to spot possible safety problems which may be present in your home. Check YES or NO to answer each question. Then go back over the list and take action to correct those items which may need attention.

Keep this checklist as a reminder of safe practices, and use it periodically to re-check your home.

This checklist is organized by areas in the home. However, there are some potential hazards that need to be checked in more than just one area of your home. These are highlighted at the beginning of the checklist and short reminders are included in each other section of the checklist.

**We encourage photocopying or reprinting this information.**

# ALL AREAS OF THE HOME

In all areas of your home, check all electrical and telephone cords; rugs, runners and mats; telephone areas; smoke detectors; electrical outlets and switches; light bulbs; space heaters; woodburning stoves; and your emergency exit plan.

---

## CHECK ALL CORDS

### QUESTIONS

### RECOMMENDATIONS

Are lamp, extension, and telephone cords placed out of the flow of traffic?

☐  
yes

☐  
no

Cords stretched across walkways may cause someone to trip.

- Arrange furniture so that outlets are available for lamps and appliances without the use of extension cords.
- If you must use an extension cord, place it on the floor against a wall where people cannot trip over it.
- Move the phone so that telephone cords will not lie where people walk.

Are cords out from beneath furniture and rugs or carpeting?

☐  
yes

☐  
no

Furniture resting on cords can damage them, creating fire and shock hazards. Electric cords which run under carpeting may cause a fire.

- Remove cords from under furniture or carpeting.
- Replace damaged or frayed cords.

Are cords attached to the walls, baseboards, etc. with nails or staples?

☐  
no

☐  
yes

Nails or staples can damage cords, presenting fire and shock hazards.

- Remove nails, staples, etc.
- Check wiring for damage.
- Use tape to attach cords to walls or floors.

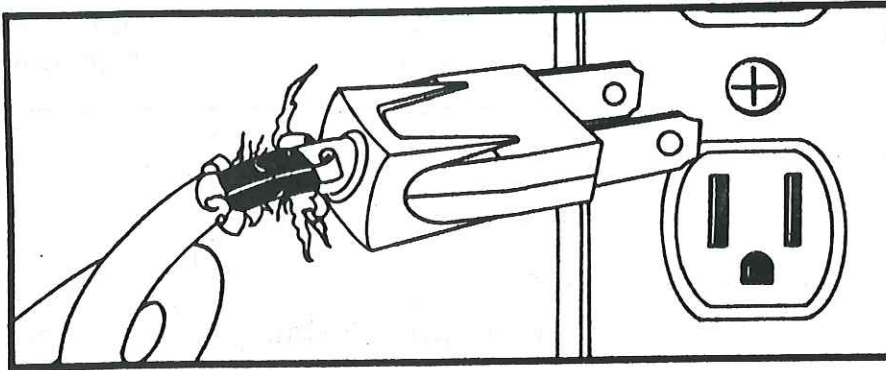


## CHECK ALL CORDS (Continued)

Are electrical cords in good condition, not frayed or cracked?

☐ yes

☐ no



Do not use frayed electrical cords.

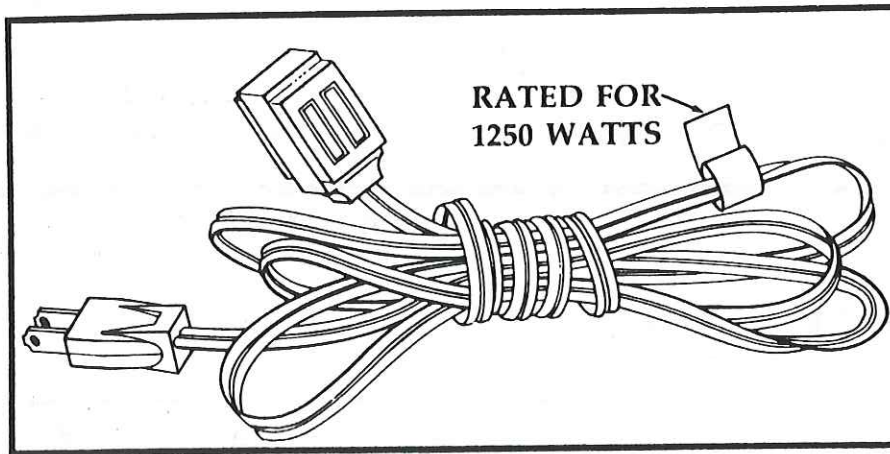
Damaged cords may cause a shock or fire.

- Replace frayed or cracked cords.

Do extension cords carry more than their proper load, as indicated by the ratings labeled on the cord and the appliance?

☐ no

☐ yes



Use within the electrical rating marked on the cord.

Overloaded extension cords may cause fires. Standard 18 gauge extension cords can carry 1250 watts.

- If the rating on the cord is exceeded because of the power requirements of one or more appliances being used on the cord, change the cord to a higher rated one or unplug some appliances.
- If an extension cord is needed, use one having a sufficient amp or wattage rating.

# CHECK ALL RUGS, RUNNERS AND MATS

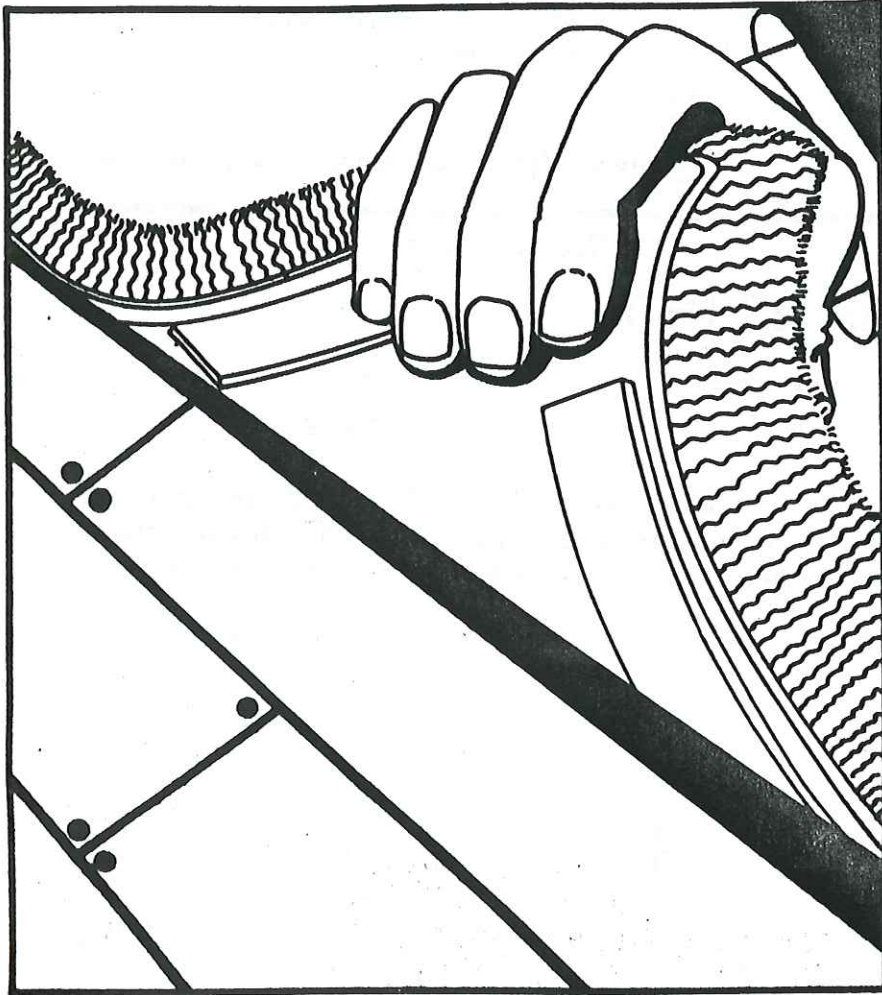
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## QUESTIONS

Are all small rugs and runners slip-resistant?

☐ yes

☐ no



Apply double-faced adhesive carpet tape or rubber matting to the backs of rugs and runners.

## RECOMMENDATIONS

CPSC estimates that in 1982, over 2500 people 65 and over were treated in hospital emergency rooms for injuries that resulted from tripping over rugs and runners. Falls are also the most common cause of fatal injury for older people.

- Remove rugs and runners that tend to slide.
- Apply double-faced adhesive carpet tape or rubber matting to the backs of rugs and runners.
- Purchase rugs with slip-resistant backing.
- Check rugs and mats periodically to see if backing needs to be replaced.
- Place rubber matting under rugs. (Rubber matting that can be cut to size is available.)
- Purchase new rugs with slip-resistant backing.

NOTE: Over time, adhesive on tape can wear away. Rugs with slip-resistant backing also become less effective as they are washed. Periodically, check rugs and mats to see if new tape or backing is needed.



# CHECK THE TELEPHONE AREA

## QUESTIONS

## RECOMMENDATIONS

Are emergency numbers posted on or near the telephone?

☐  
yes

☐  
no

In case of emergency, telephone numbers for the Police, Fire Department, and local Poison Control Center, along with a neighbor's number, should be readily available.

- Write the numbers in large print and tape them to the phone, or place them near the phone where they can be seen easily.

Do you have access to a telephone if you fall (or experience some other emergency which prevents you from standing and reaching a wall phone)?

☐  
yes

☐  
no

- Have at least one telephone located where it would be accessible in the event of an accident which leaves you unable to stand.

# CHECK SMOKE DETECTORS

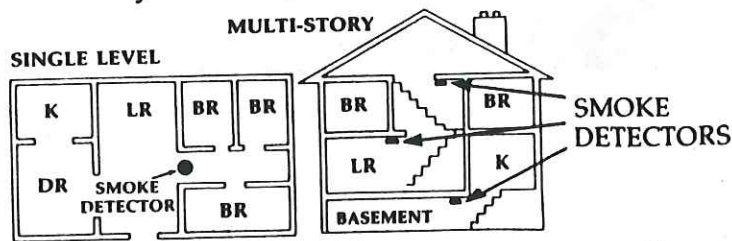
## QUESTIONS

## RECOMMENDATIONS

Are smoke detectors properly located?

☐  
yes

☐  
no



Make sure detectors are placed near bedrooms, either on the ceiling or 6-12 inches below the ceiling on the wall.

At least one smoke detector should be placed on every floor of your home.

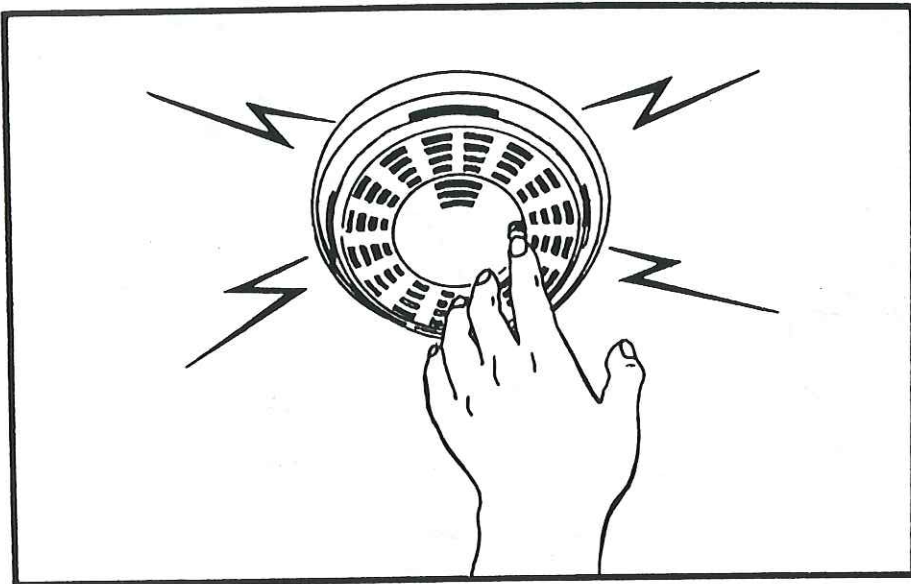
- Read the instructions that come with the smoke detector for advice on the best place to install it.
- Make sure detectors are placed near bedrooms, either on the ceiling or 6-12 inches below the ceiling on the wall.
- Locate smoke detectors away from air vents.

## CHECK SMOKE DETECTORS (Continued)

Do you have properly working smoke detectors?

☐  
yes

☐  
no



Follow manufacturer's directions for testing the detector.

Many home fire injuries and deaths are caused by smoke and toxic gases, rather than the fire itself. Smoke detectors provide an early warning and can wake you in the event of a fire.

- Purchase a smoke detector if you do not have one.
- Check and replace batteries and bulbs according to the manufacturer's instructions.
- Vacuum the grillwork of your smoke detector.
- Replace any smoke detectors which can not be repaired.

NOTE: Some fire departments or local governments will provide assistance in acquiring or installing smoke detectors.

## CHECK ELECTRICAL OUTLETS AND SWITCHES

### QUESTIONS

### RECOMMENDATIONS

Are any outlets and switches unusually warm or hot to the touch?

☐  
no

☐  
yes

Unusually warm or hot outlets or switches may indicate that an unsafe wiring condition exists.

- Unplug cords from outlets and do not use the switches
- Have an electrician check the wiring as soon as possible.



## CHECK ELECTRICAL OUTLETS AND SWITCHES (Continued)

- Do all outlets and switches have cover plates, so that no wiring is exposed?
- ☐ yes ☐ no
- Exposed wiring presents a shock hazard.
- Add a cover plate.

## CHECK LIGHT BULBS

### RECOMMENDATIONS

### QUESTIONS

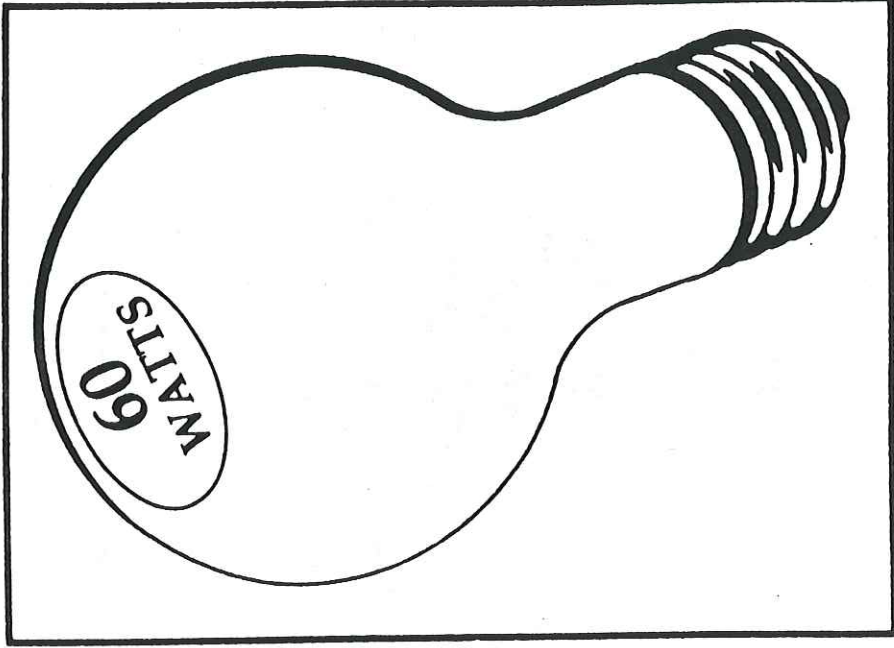
Are light bulbs the appropriate size and type for the lamp or fixture?

☐

yes

☐

no



Replace with a bulb of the correct type and wattage. (If you do not know the correct wattage, use a bulb no larger than 60 watts.)

- Replace with a bulb of the correct type and wattage. (If you do not know the correct wattage, use a bulb no larger than 60 watts.)
- A bulb of too high wattage or the wrong type may lead to fire through overheating. Ceiling fixtures, recessed lights, and "hooded" lamps will trap heat.

# CHECK SPACE HEATERS

## QUESTIONS

Are heaters which come with a 3-prong plug being used in a 3-hole outlet or with a properly attached adapter?

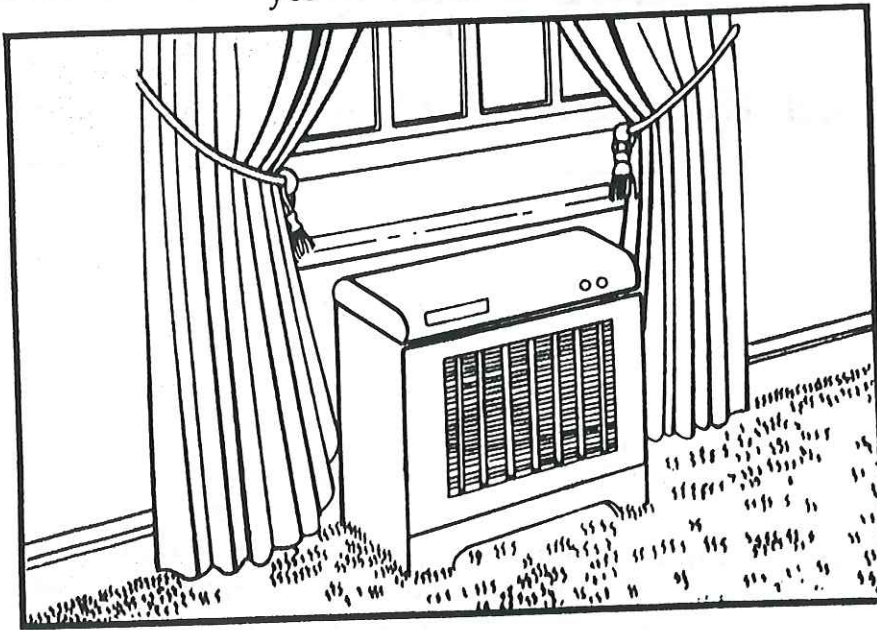
☐  
yes

☐  
no

Are small stoves and heaters placed where they can not be knocked over, and away from furnishings and flammable materials, such as curtains or rugs?

☐  
yes

☐  
no



Do not place heaters near curtains, rugs, or furniture.

## RECOMMENDATIONS

The grounding feature provided by a 3-hole receptacle or an adapter for a 2-hole receptacle is a safety feature designed to lessen the risk of shock.

- Never defeat the grounding feature.
- If you do not have a 3-hole outlet, use an adapter to connect the heater's 3-prong plug. Make sure the adapter ground wire or tab is attached to the outlet.

Heaters can cause fires or serious burns if they cause you to trip or if they are knocked over.

- Relocate heaters away from passageways and flammable materials such as curtains, rugs, furniture, etc



## CHECK SPACE HEATERS (Continued)

If your home has space heating equipment, such as a kerosene heater, a gas heater or an LP gas heater, do you understand the installation and operating instructions thoroughly?

☐  
yes

☐  
no

Unvented heaters should be used with room doors open or window slightly open to provide ventilation. The correct fuel, as recommended by the manufacturer, should always be used. Vented heaters should have proper venting, and the venting system should be checked frequently. Improper venting is the most frequent cause of carbon monoxide poisoning, and older consumers are at special risk.

- Review the installation and operating instructions.
- Call your local fire department if you have additional questions.

## CHECK WOODBURNING HEATING EQUIPMENT

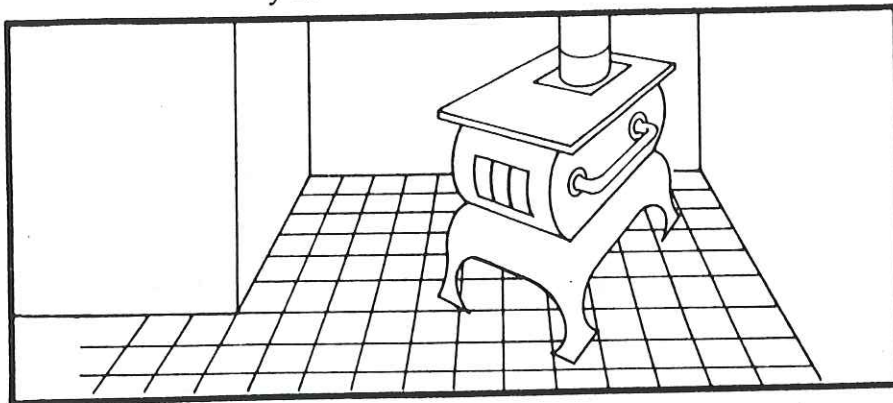
### QUESTIONS

### RECOMMENDATIONS

Is woodburning equipment installed properly?

☐  
yes

☐  
no



Install woodburning stove on a fire resistant floor and 3 feet from walls.

Woodburning stoves should be installed by a qualified person according to local building codes.

- Local building code officials or fire marshals can provide requirements and recommendations for installation.

NOTE: Some insurance companies will not cover fire losses if wood stoves are not installed according to local codes.

# CHECK THE EMERGENCY EXIT PLAN

## QUESTIONS

Do you have an emergency exit plan and an alternate emergency exit plan in case of a fire?

☐ yes

☐ no



Have two exits in case of emergency.

## RECOMMENDATIONS

Once a fire starts, it spreads rapidly. Since you may not have much time to get out and there may be a lot of confusion, it is important that everyone knows what to do.

- Develop an emergency exit plan.
- Choose a meeting place outside your home so you can be sure that everyone has escaped.
- Practice the plan from time to time to make sure everyone is capable of escape quickly and safely.

\* Remember periodically to re-check your home.

## KITCHEN

In the kitchen, check the range area, all electrical cords, lighting, the step stool, all throw rugs and mats, and the telephone area.

## CHECK THE RANGE AREA

### QUESTIONS

Are towels, curtains, and other things that might catch fire located away from the range?

☐ yes

☐ no

### RECOMMENDATIONS

Placing or storing non-cooking equipment like potholders, dish towels, or plastic utensils on or near the range may result in fires or burns.



## CHECK THE RANGE AREA (Continued)

- Store flammable and combustible items away from range and oven.
- Remove any towels hanging on oven handles. If towels hang close to a burner, change the location of the towel rack.
- If necessary, shorten or remove curtains which could brush against heat sources.

Do you wear clothing with short or close-fitting sleeves while you are cooking?

☐  
yes

☐  
no



Do not wear clothing with long, loose sleeves while you are cooking.

CPSC estimates that 70% of all people who die from clothing fires are over 65 years of age. Long sleeves are more likely to catch fire than are short sleeves. Long sleeves are also more apt to catch on pot handles, overturning pots and pans and causing scalds.

- Roll back long, loose sleeves or fasten them with pins or elastic bands while you are cooking.

Are kitchen ventilation systems or range exhausts functioning properly and are they in use while you are cooking?

☐  
yes

☐  
no

Indoor air pollutants may accumulate to unhealthful levels in a kitchen where gas or kerosene-fired appliances are in use.

- Use ventilation systems or open windows to clear air of vapors and smoke.

# CHECK ELECTRICAL CORDS

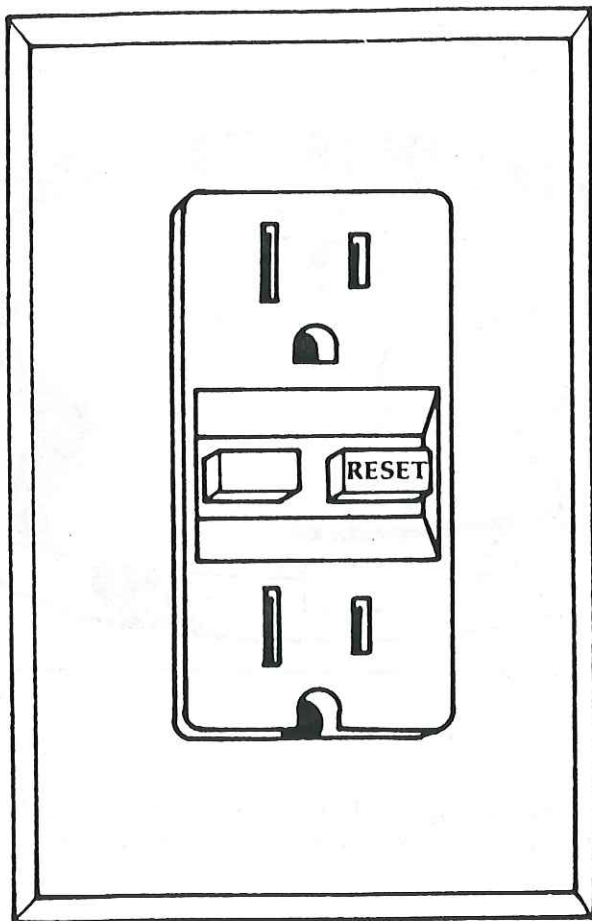
## QUESTIONS

## RECOMMENDATIONS

Are all extension cords and appliance cords located away from the sink or range areas?

☐ yes

☐ no



Electrical appliances and power cords can cause shock or electrocution if they come in contact with water. Cords can also be damaged by excess heat.

- Move cords and appliances away from sink areas and hot surfaces.
  - Move appliances closer to wall outlets or to different outlets so you won't need extension cords.
  - If extension cords must be used, install wiring guides so that cords will not hang near sink, range, or working areas.
  - Consider adding new outlets for convenience and safety; ask your electrician to install outlets equipped with ground fault circuit interrupters (GFCIs) to protect against electric shock. A GFCI is a shock-protection device that will detect electrical fault and shut off electricity before serious injury or death occurs. (See illustration).
- \* For more information on cords, refer to the beginning of the checklist (pages 1 and 2).

A ground fault circuit interrupter (shock protection device) protects against electric shock.



# CHECK LIGHTING

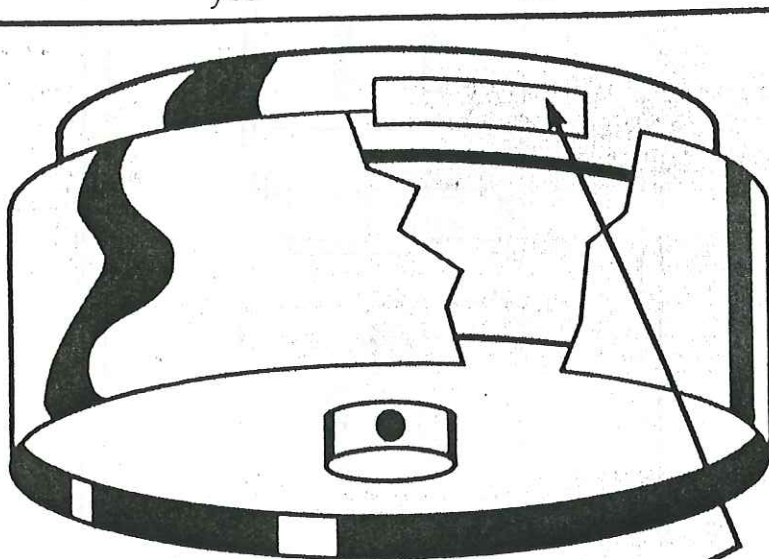
## QUESTIONS

## RECOMMENDATIONS

Does good, even lighting exist over the stove, sink, and countertop work areas, especially where food is sliced or cut?

☐ yes

☐ no



**WARNING: To Avoid Fire Hazard  
Use 60 Watt Lamp Maximum**

Look for safety warnings or bulb size on lamps and fixtures.

Low lighting and glare can contribute to burns or cuts. Improve lighting by:

- Opening curtains and blinds (unless this causes too much glare).
- Using the maximum wattage bulb allowed by the fixture. (If you do not know the correct wattage for the fixture, use a bulb no larger than 60 watts.)
- Reducing glare by using frosted bulbs, indirect lighting, shades or globes on light fixtures, or partially closing the blinds or curtains.
- Installing additional light fixtures, e.g. under cabinet/over countertop lighting.

\* (Make sure that the bulbs you use are the right type and wattage for the light fixture.)

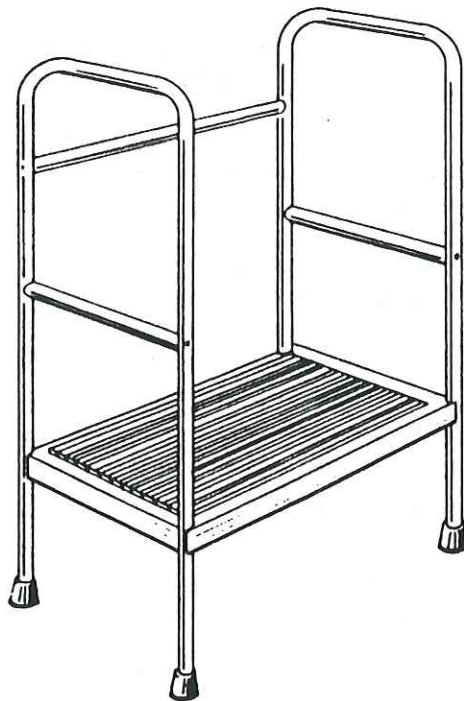
# CHECK STEP STOOL

## QUESTIONS

Do you have a step stool which is stable and in good repair?

☐  
yes

☐  
no



Use a step stool with a handrail that you can hold onto while standing on the top step.

## RECOMMENDATIONS

Standing on chairs, boxes, or other makeshift items to reach high shelves can result in falls. CPSC estimates that in 1982, 1500 people over 65 were treated in hospital emergency rooms when they fell from chairs on which they were standing.

- If you don't have a step stool, consider buying one. Choose one with a handrail that you can hold onto while standing on the top step.
- Before climbing on any step stool, make sure it is fully opened and stable.
- Tighten screws and braces on the step stool.
- Discard step stools with broken parts.

\*Remember: Check all of the product areas mentioned at the beginning of the checklist.

## LIVING ROOM/FAMILY ROOM

In the living room/family room, check all rugs and runners, electrical and telephone cords, lighting, the fireplace and chimney, the telephone area, and all passageways.



## CHECK FIREPLACE AND CHIMNEY

### QUESTIONS

Are chimneys clear from accumulations of leaves, or other debris that can clog them?

☐

yes

☐

no

Has the chimney been cleaned within the past year?

☐

yes

☐

no

### RECOMMENDATIONS

A clogged chimney can cause a poorly-burning fire to result in poisonous fumes and smoke coming back into the house.

- Do not use the chimney until the blockage has been removed.
- Have the chimney checked and cleaned by a registered or licensed professional.

Burning wood can cause a build up of a tarry substance (creosote) inside the chimney. This material can ignite and result in a serious chimney fire.

- Have the chimney checked and cleaned by a registered or licensed professional.

## CHECK THE TELEPHONE AREA

For information on the telephone area, refer to the beginning of the checklist.

## CHECK PASSAGEWAYS

### QUESTIONS

Are hallways, passageways between rooms, and other heavy traffic areas well lit?

☐

yes

☐

no

### RECOMMENDATIONS

Shadowed or dark areas can hide tripping hazards.

- Use the maximum wattage bulb allowed by the fixture. (If you do not know the correct wattage, use a bulb no larger than 60 watts.)
- Install night lights.
- Reduce glare by using frosted bulbs, indirect lighting, shades or globes on light fixtures, or partially closing blinds or curtains.

---

## CHECK PASSAGEWAYS (Continued)

- Consider using additional lamps or light fixtures. Make sure that the bulbs you use are the right type and wattage for the light fixture.

---

Are exits and passageways kept clear?

☐  
yes

☐  
no

Furniture, boxes, or other items could be an obstruction or tripping hazard, especially in the event of an emergency or fire.

- Rearrange furniture to open passageways and walkways.
- Remove boxes and clutter.

Remember: Check all of the product areas mentioned at the beginning of the checklist.

---

## BATHROOM

In the bathroom, check bathtub and shower areas, water temperature, rugs and mats, lighting, small electrical appliances, and storage areas for medications.

---

## CHECK BATHTUB AND SHOWER AREAS

---

### QUESTIONS

Are bathtubs and showers equipped with non-skid mats, abrasive strips, or surfaces that are not slippery?

☐  
yes

☐  
no

---

### RECOMMENDATIONS

Wet, soapy tile or porcelain surfaces are especially slippery and may contribute to falls.

- Apply textured strips or appliques on the floors of tubs and showers.



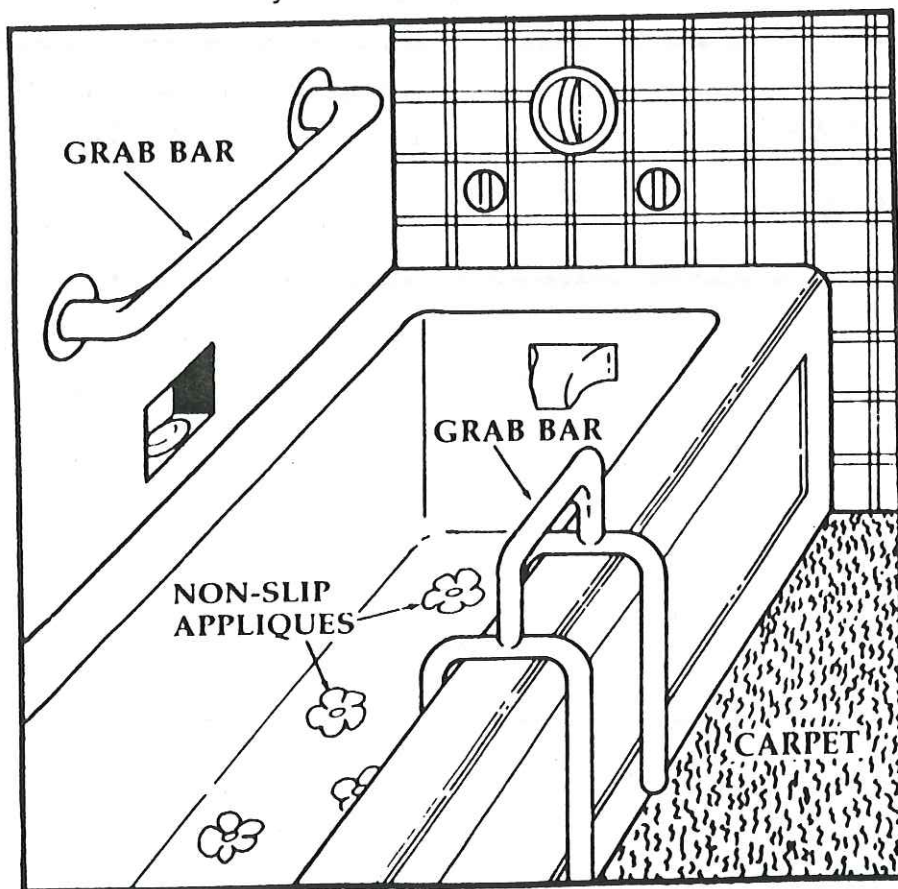
## CHECK BATHTUB AND SHOWER AREAS (Continued)

- Use non-skid mats in the tub or shower, and on the bathroom floor.
- If you are unsteady on your feet, use a stool with non-skid tips as a seat while showering or bathing.

Do bathtubs and showers have at least 1 (preferably 2) grab bars?

☐ yes

☐ no



Install grab bars and non-slip appliques in bathtubs and showers.

Grab bars can help you get into and out of your tub or shower, and can help prevent falls.

- Check existing bars for strength and stability, and repair if necessary.
- Attach grab bars, through the tile, to structural supports in the wall, or install bars specifically designed to attach to the sides of the bathtub. If you are not sure how it is done, get someone who is qualified to assist you.

# CHECK THE WATER TEMPERATURE

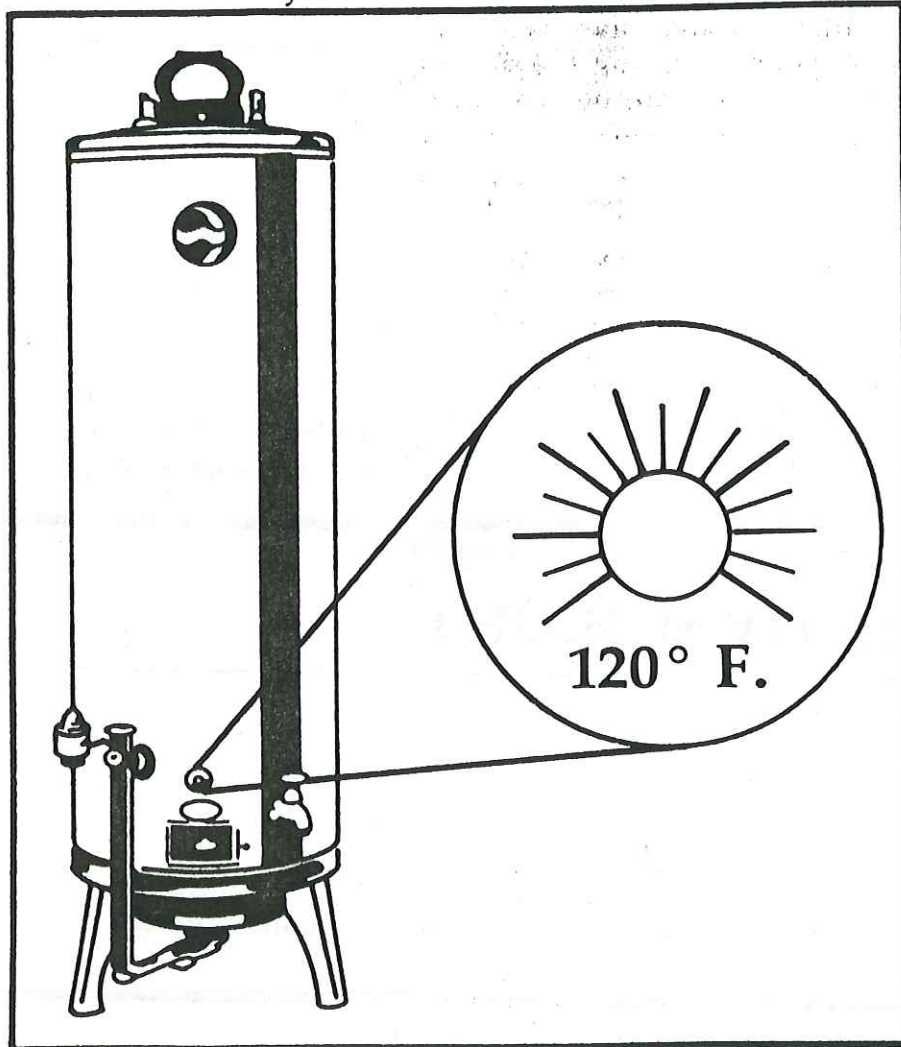
## QUESTIONS

## RECOMMENDATIONS

Is the water temperature 120 degrees or lower?

☐  
yes

☐  
no



Water temperature above 120 degrees can cause tap water scalds.

- Lower the setting on your hot water heater to "Low" or 120 degrees. If you are unfamiliar with the controls of your water heater, ask a qualified person to adjust it for you. If your hot water system is controlled by your landlords, ask them to consider lowering the setting.

NOTE: If the water heater does not have a temperature setting, you can use a thermometer to check the temperature of the water at the tap.

- Always check water temperature by hand before entering bath or shower.
- Taking baths, rather than showers, reduces the risk of a scald from suddenly changing water temperatures.

Lower the setting on your hot water heater to "low" or 120° F.



## CHECK LIGHTING

### QUESTIONS

Is a light switch located near the entrance to the bathroom?

☐  
yes

☐  
no

### RECOMMENDATIONS

A light switch near the door will prevent you from walking through a dark area.

- Install a night light. Inexpensive lights that plug into outlets are available.
- Consider replacing the existing switch with a "glow switch" that can be seen in the dark.

## CHECK SMALL ELECTRICAL APPLIANCES

### QUESTIONS

Are small electrical appliances such as hair dryers, shavers, curling irons, etc. unplugged when not in use?

☐  
yes

☐  
no

### RECOMMENDATIONS

Even an appliance that is not turned on, such as a hairdryer, can be potentially hazardous if it is left plugged in. If it falls into water in a sink or bathtub while plugged in, it could cause a lethal shock.

- Unplug all small appliances when not in use.
- Never reach into water to retrieve an appliance that has fallen in without being sure the appliance is unplugged.
- Consider installing a ground fault circuit interrupter (GFCI) in your bathroom outlet to protect against electric shock.

## CHECK MEDICATIONS

### QUESTIONS

Are all medicines stored in the containers that they came in and are they clearly marked?

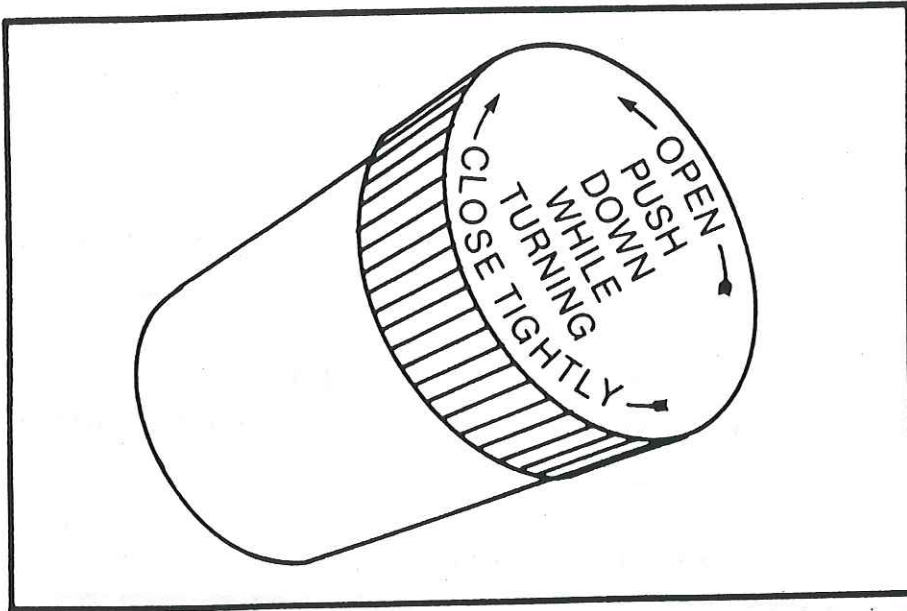
☐  
yes

☐  
no

### RECOMMENDATIONS

Medications that are not clearly and accurately labeled can be easily mixed up. Taking the wrong medicine or missing a dosage of medicine you need can be dangerous.

## CHECK MEDICATIONS (Continued)



Re-close child-resistant caps tightly, and put medicines out of reach of children.

- Be sure that all containers are clearly marked with the contents, doctor's instructions, expiration date, and patient's name.
- Dispose of outdated medicines properly.
- Request non-child-resistant closures from your pharmacist only when you cannot use child-resistant closures.

NOTE: Many poisonings occur when children visiting grandparents go through the medicine cabinet or grandmother's purse. In homes where grandchildren or other youngsters are frequent visitors, medicines should be purchased in containers with child-resistant caps, and the caps properly closed after each use. Store medicines beyond the reach of children.

\* Remember: Check all of the product areas mentioned at the beginning of the checklist.

## BEDROOMS

In the bedroom, check all rugs and runners, electrical and telephone cords, and areas around beds.

### CHECK AREAS AROUND BEDS

#### QUESTIONS

Are lamps or light switches within reach of each bed?

☐ yes

☐ no

#### RECOMMENDATIONS

Lamps or switches located close to each bed will enable people getting up at night to see where they are going.

- Rearrange furniture closer to switches or move lamps closer to beds.
- Install night lights.



# CHECK THE TELEPHONE AREA

## QUESTIONS

## RECOMMENDATIONS

Are emergency numbers posted on or near the telephone?

☐  
yes

☐  
no

In case of emergency, telephone numbers for the Police, Fire Department, and local Poison Control Center, along with a neighbor's number, should be readily available.

- Write the numbers in large print and tape them to the phone, or place them near the phone where they can be seen easily.

Do you have access to a telephone if you fall (or experience some other emergency which prevents you from standing and reaching a wall phone)?

☐  
yes

☐  
no

- Have at least one telephone located where it would be accessible in the event of an accident which leaves you unable to stand.

# CHECK SMOKE DETECTORS

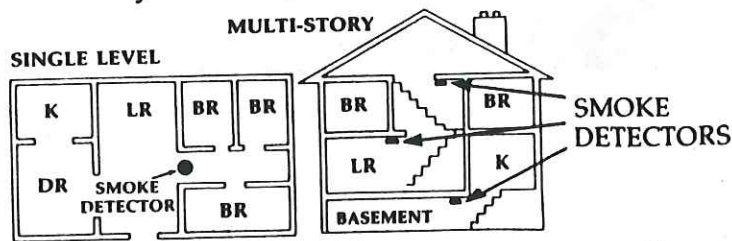
## QUESTIONS

## RECOMMENDATIONS

Are smoke detectors properly located?

☐  
yes

☐  
no



Make sure detectors are placed near bedrooms, either on the ceiling or 6-12 inches below the ceiling on the wall.

At least one smoke detector should be placed on every floor of your home.

- Read the instructions that come with the smoke detector for advice on the best place to install it.
- Make sure detectors are placed near bedrooms, either on the ceiling or 6-12 inches below the ceiling on the wall.
- Locate smoke detectors away from air vents.

# CHECK SPACE HEATERS

## RECOMMENDATIONS

## QUESTIONS

Are heaters which come with a 3-prong plug being used in a 3-hole outlet or with a properly attached adapter?

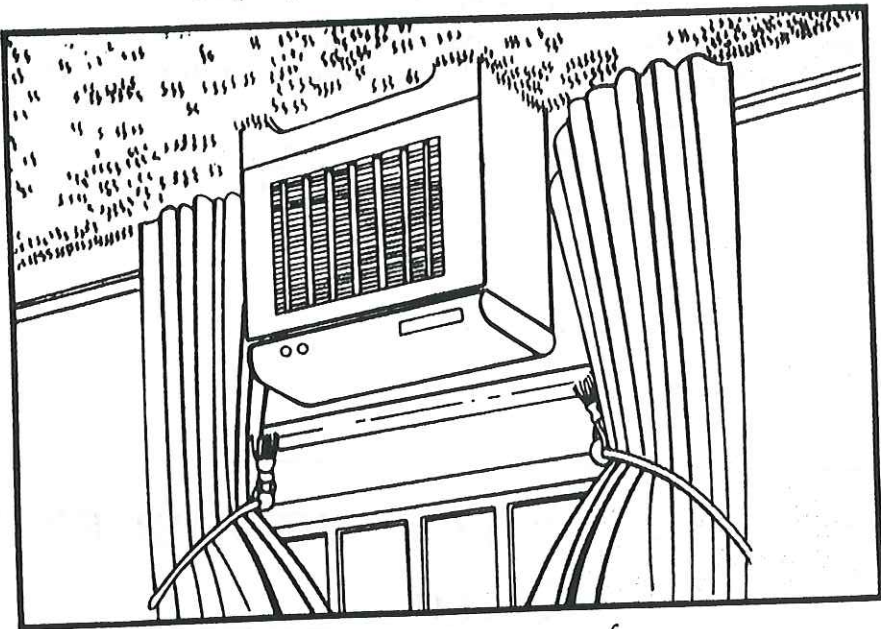
☐ yes

☐ no

- The grounding feature provided by a 3-hole receptacle or an adapter for a 2-hole receptacle is a safety feature designed to lessen the risk of shock.
- Never defeat the grounding feature.
- If you do not have a 3-hole outlet, use an adapter to connect the heater's 3-prong plug. Make sure the adapter ground wire or tab is attached to the outlet.

Are small stoves and heaters placed where they can not be knocked over, and away from furnishings and flammable materials, such as curtains or rugs?

☐ yes

☐ no


Do not place heaters near curtains, rugs, or furniture.

- Heaters can cause fires or serious burns if they cause you to trip or if they are knocked over.
- Relocate heaters away from passageways and flammable materials such as curtains, rugs, furniture, etc



# CHECK THE EMERGENCY EXIT PLAN

## QUESTIONS

Do you have an emergency exit plan and an alternate emergency exit plan in case of a fire?

☐ yes

☐ no



Have two exits in case of emergency.

## RECOMMENDATIONS

Once a fire starts, it spreads rapidly. Since you may not have much time to get out and there may be a lot of confusion, it is important that everyone knows what to do.

- Develop an emergency exit plan.
- Choose a meeting place outside your home so you can be sure that everyone has escaped.
- Practice the plan from time to time to make sure everyone is capable of escape quickly and safely.

\* Remember periodically to re-check your home.

## KITCHEN

In the kitchen, check the range area, all electrical cords, lighting, the step stool, all throw rugs and mats, and the telephone area.

## CHECK THE RANGE AREA

### QUESTIONS

Are towels, curtains, and other things that might catch fire located away from the range?

☐ yes

☐ no

### RECOMMENDATIONS

Placing or storing non-cooking equipment like potholders, dish towels, or plastic utensils on or near the range may result in fires or burns.

# CHECK ELECTRICAL CORDS

## RECOMMENDATIONS

Electrical appliances and power cords can cause shock or electrocution if they come in contact with water. Cords can also be damaged by excess heat.

- Move cords and appliances away from sink areas and hot surfaces.
- Move appliances closer to wall outlets or to different outlets so you won't need extension cords.
- If extension cords must be used, install wiring guides so that cords will not hang near sink, range, or working areas.
- Consider adding new outlets for convenience and safety; ask your electrician to install outlets equipped with ground fault circuit interrupters (GFCIs) to protect against electric shock. A GFCI is a shock-protection device that will detect electrical fault and shut off electricity before serious injury or death occurs. (See illustration).

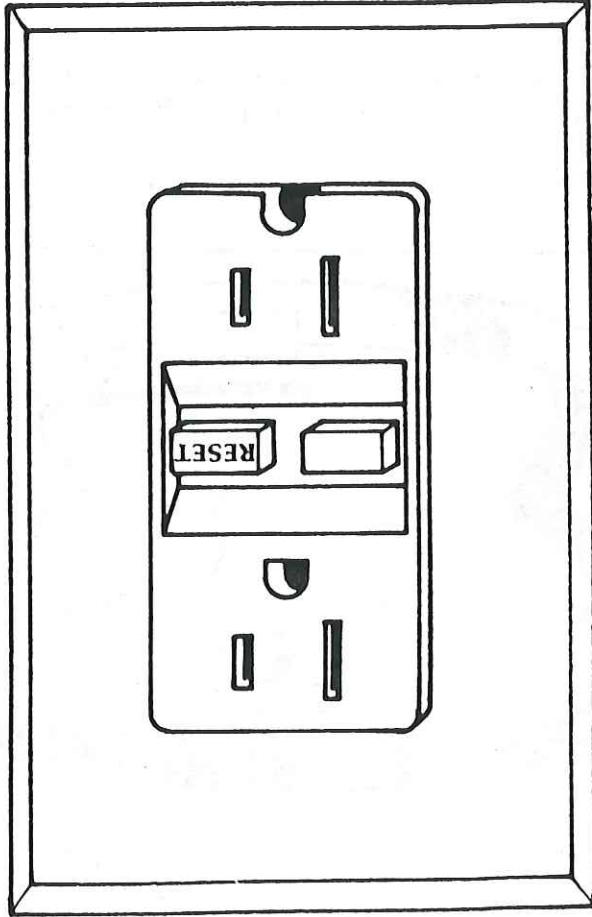
\* For more information on cords, refer to the beginning of the checklist (pages 1 and 2).

## QUESTIONS

Are all extension cords and appliance cords located away from the sink or range areas?

☐ yes

☐ no



A ground fault circuit interrupter (shock protection device) protects against electric shock.



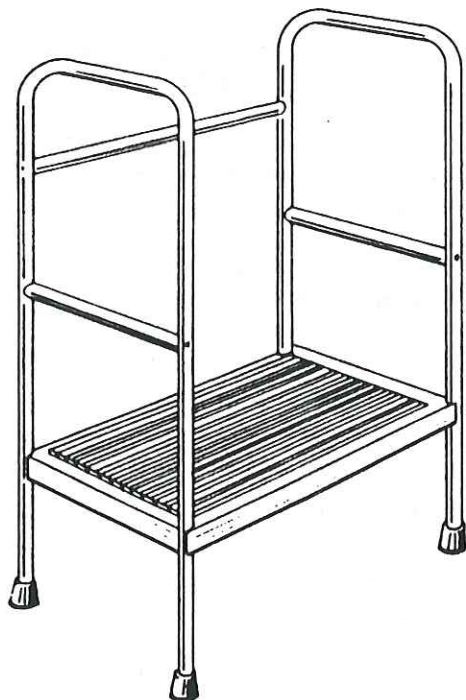
# CHECK STEP STOOL

## QUESTIONS

Do you have a step stool which is stable and in good repair?

☐  
yes

☐  
no



Use a step stool with a handrail that you can hold onto while standing on the top step.

## RECOMMENDATIONS

Standing on chairs, boxes, or other makeshift items to reach high shelves can result in falls. CPSC estimates that in 1982, 1500 people over 65 were treated in hospital emergency rooms when they fell from chairs on which they were standing.

- If you don't have a step stool, consider buying one. Choose one with a handrail that you can hold onto while standing on the top step.
- Before climbing on any step stool, make sure it is fully opened and stable.
- Tighten screws and braces on the step stool.
- Discard step stools with broken parts.

\*Remember: Check all of the product areas mentioned at the beginning of the checklist.

## LIVING ROOM/FAMILY ROOM

In the living room/family room, check all rugs and runners, electrical and telephone cords, lighting, the fireplace and chimney, the telephone area, and all passageways.

## CHECK PASSAGEWAYS (Continued)

- Consider using additional lamps or light fixtures. Make sure that the bulbs you use are the right type and wattage for the light fixture.

Are exits and passageways kept clear?

yes ☐ no ☐

Furniture, boxes, or other items could be an obstruction or tripping hazard, especially in the event of an emergency or fire.

- Rearrange furniture to open passageways and walkways.
- Remove boxes and clutter.

Remember: Check all of the product areas mentioned at the beginning of the checklist.

## BATHROOM

In the bathroom, check bathtub and shower areas, water temperature, rugs and mats, lighting, small electrical appliances, and storage areas for medications.

## CHECK BATHTUB AND SHOWER AREAS

### QUESTIONS

### RECOMMENDATIONS

Are bathtubs and showers equipped with non-skid mats, abrasive strips, or surfaces that are not slippery?

yes ☐ no ☐

- Wet, soapy tile or porcelain surfaces are especially slippery and may contribute to falls.
- Apply textured strips or appliques on the floors of tubs and showers.



# CHECK THE WATER TEMPERATURE

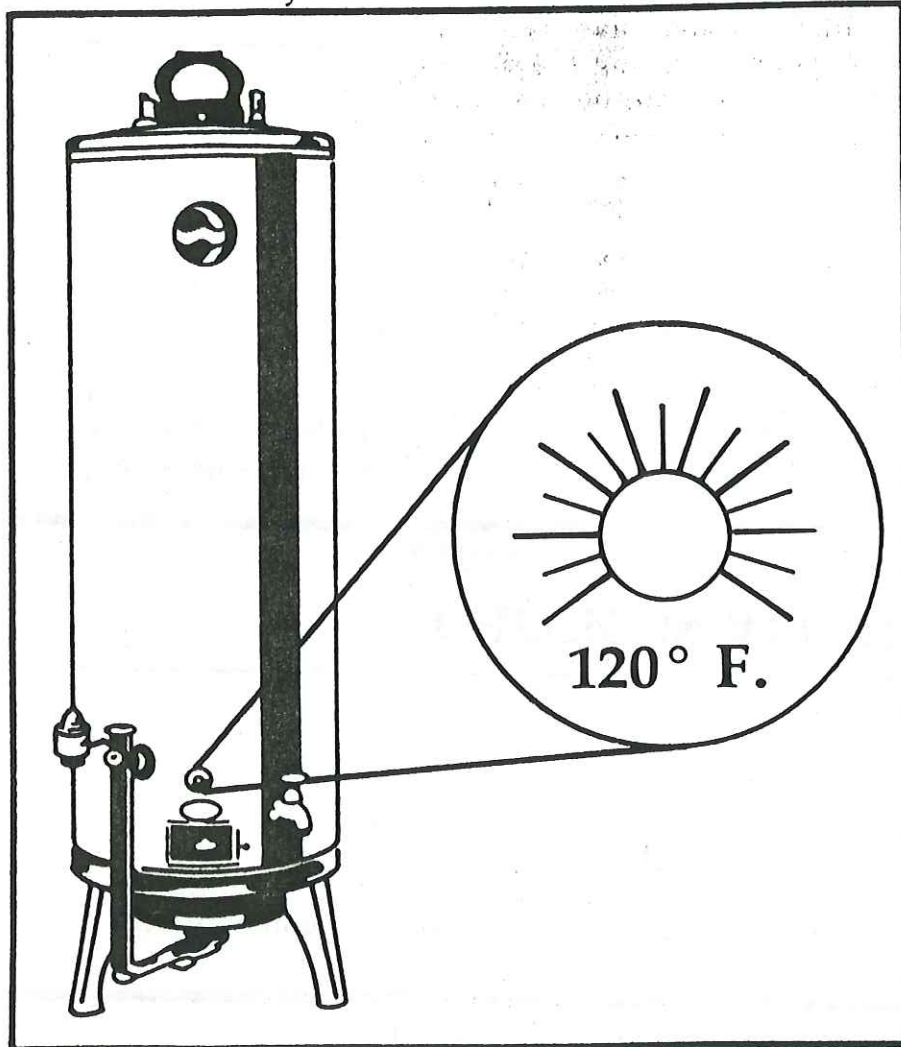
## QUESTIONS

## RECOMMENDATIONS

Is the water temperature 120 degrees or lower?

☐  
yes

☐  
no



Water temperature above 120 degrees can cause tap water scalds.

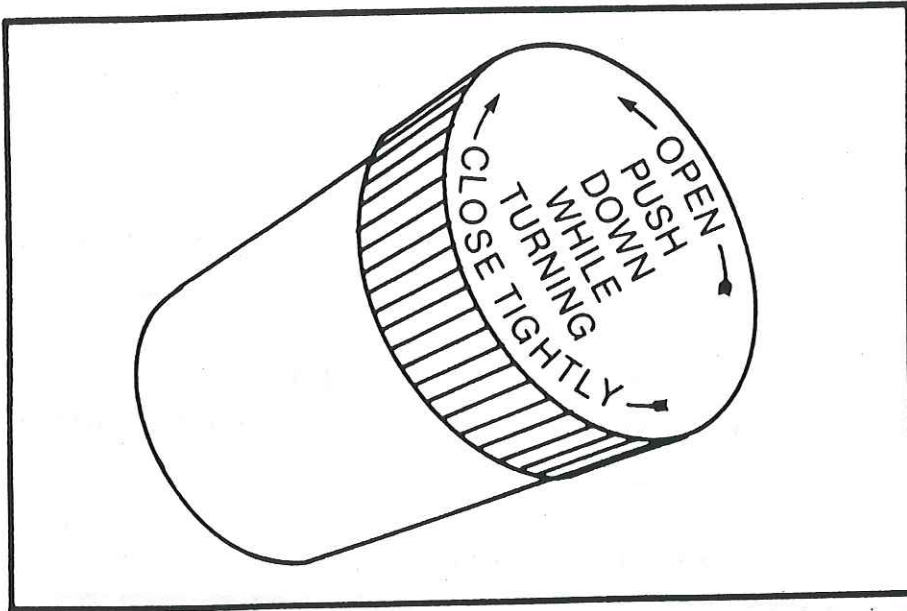
- Lower the setting on your hot water heater to "Low" or 120 degrees. If you are unfamiliar with the controls of your water heater, ask a qualified person to adjust it for you. If your hot water system is controlled by your landlords, ask them to consider lowering the setting.

NOTE: If the water heater does not have a temperature setting, you can use a thermometer to check the temperature of the water at the tap.

- Always check water temperature by hand before entering bath or shower.
- Taking baths, rather than showers, reduces the risk of a scald from suddenly changing water temperatures.

Lower the setting on your hot water heater to "low" or 120° F.

## CHECK MEDICATIONS (Continued)



Re-close child-resistant caps tightly, and put medicines out of reach of children.

- Be sure that all containers are clearly marked with the contents, doctor's instructions, expiration date, and patient's name.
- Dispose of outdated medicines properly.
- Request non-child-resistant closures from your pharmacist only when you cannot use child-resistant closures.

NOTE: Many poisonings occur when children visiting grandparents go through the medicine cabinet or grandmother's purse. In homes where grandchildren or other youngsters are frequent visitors, medicines should be purchased in containers with child-resistant caps, and the caps properly closed after each use. Store medicines beyond the reach of children.

\* Remember: Check all of the product areas mentioned at the beginning of the checklist.

## BEDROOMS

In the bedroom, check all rugs and runners, electrical and telephone cords, and areas around beds.

### CHECK AREAS AROUND BEDS

#### QUESTIONS

Are lamps or light switches within reach of each bed?

☐ yes

☐ no

#### RECOMMENDATIONS

Lamps or switches located close to each bed will enable people getting up at night to see where they are going.

- Rearrange furniture closer to switches or move lamps closer to beds.
- Install night lights.



## CHECK AREAS AROUND BEDS (Continued)

Are ash trays, smoking materials, or other fire sources (heaters, hot plates, teapots, etc.) located away from beds or bedding?

☐ yes

☐ no

Burns are a leading cause of accidental death among seniors. Smoking in bed is a major contributor to this problem. Among mattress and bedding fire related deaths in a recent year, 42% were to persons 65 or older.

- Remove sources of heat or flame from areas around beds.
- Don't smoke in bed.



Do not smoke in bed or have hot liquids or other heat sources near the bed.

Is anything covering your electric blanket when in use?

☐ no

☐ yes

"Tucking in" electric blankets, or placing additional coverings on top of them can cause excessive heat buildup which can start a fire.

Do you avoid "tucking in" the sides or ends of your electric blanket?

☐ yes

☐ no

- Use electric blankets according to the manufacturer's instructions.
- Don't allow anything on top of the blanket while it is in use. (This includes other blankets or comforters, even pets sleeping on top of the blanket.)
- Don't set electric blankets so high that they could burn someone who falls asleep while they are on.

## CHECK AREAS AROUND BEDS (Continued)

Do you ever go to sleep with a heating pad which is turned on?

☐  
no

☐  
yes

Never go to sleep with a heating pad if it is turned on because it can cause serious burns even at relatively low settings.

Is there a telephone close to your bed?

☐  
yes

☐  
no

In case of an emergency, it is important to be able to reach the telephone without getting out of bed.

Remember: Check all of the product areas mentioned at the beginning of the checklist.

## BASEMENT/GARAGE/WORKSHOP/STORAGE AREAS

In the basement, garage, workshop, and storage areas, check lighting, fuse boxes or circuit breakers, appliances and power tools, electrical cords, and flammable liquids.

### CHECK LIGHTING

#### QUESTIONS

Are work areas, especially areas where power tools are used, well lit?

☐  
yes

☐  
no

Power tools were involved in over 5200 injuries treated in hospital emergency rooms to people 65 and over in 1982. Three fourths of these were finger injuries. Good lighting can reduce the chance that you will accidentally cut your finger.

- Either install additional light, or avoid working with power tools in the area.

Can you turn on the lights without first having to walk through a dark area?

☐  
yes

☐  
no

Basements, garages, and storage areas can contain many tripping hazards and sharp or pointed tools that can make a fall even more hazardous.

- Keep an operating flashlight handy.
- Have an electrician install switches at each entrance to a dark area.



## CHECK THE FUSE BOX OR CIRCUIT BREAKERS

### QUESTIONS

If fuses are used, are they the correct size for the circuit?

☐  
yes

☐  
no

### RECOMMENDATIONS

Replacing a correct size fuse with a larger size fuse can present a serious fire hazard. If the fuse in the box is rated higher than that intended for the circuit, excessive current will be allowed to flow and possibly overload the outlet and house wiring to the point that a fire can begin.

- Be certain that correct-size fuses are used. (If you do not know the correct sizes, consider having an electrician identify and label the sizes to be used.)

NOTE: If all, or nearly all, fuses used are 30-amp fuses, there is a chance that some of the fuses are rated too high for the circuit.

## CHECK APPLIANCES AND POWER TOOLS

### QUESTIONS

Are power tools equipped with a 3-prong plug or marked to show that they are double insulated?

☐  
yes

☐  
no

### RECOMMENDATIONS

These safety features reduce the risk of an electric shock.

- Use a properly connected 3-prong adapter for connecting a 3-prong plug to a 2-hole receptacle.
- Consider replacing old tools that have neither a 3-prong plug nor are double insulated.

Are power tool guards in place?

☐  
yes

☐  
no

Power tools used with guards removed pose a serious risk of injury from sharp edges or moving parts.

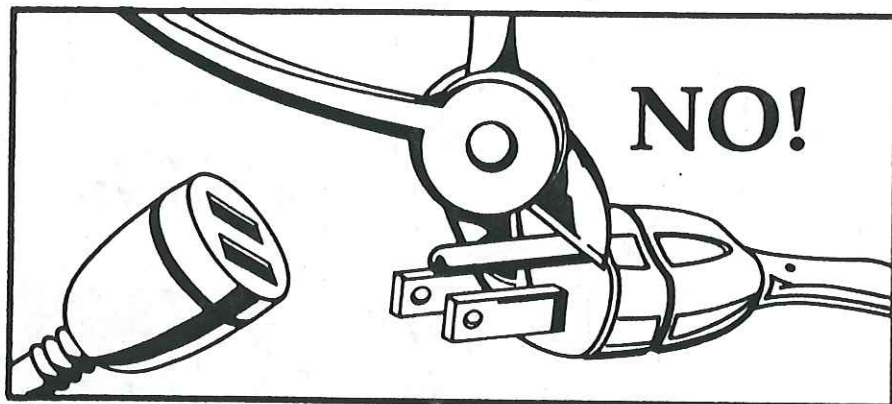
- Replace guards that have been removed from power tools.

## CHECK APPLIANCES AND POWER TOOLS (Continued)

Has the grounding feature on any 3-prong plug been defeated by removal of the grounding pin or by improperly using an adapter?

☐  
no

☐  
yes



Don't do it! The third prong is there because the appliance must be grounded to avoid electric shock.

Improperly grounded appliances can lead to electric shock.

- Check with your service person or an electrician if you are in doubt.

## CHECK FLAMMABLE AND VOLATILE LIQUIDS

### QUESTIONS

### RECOMMENDATIONS

Are containers of volatile liquids tightly capped?

☐  
yes

☐  
no

If not tightly closed, vapors may escape that may be toxic when inhaled.

- Check containers periodically to make sure they are tightly closed.

NOTE: CPSC has reports of several cases in which gasoline, stored as much as 10 feet from a gas water heater, exploded. Many people are unaware that gas fumes can travel that far.



## CHECK FLAMMABLE AND VOLATILE LIQUIDS (Continued)

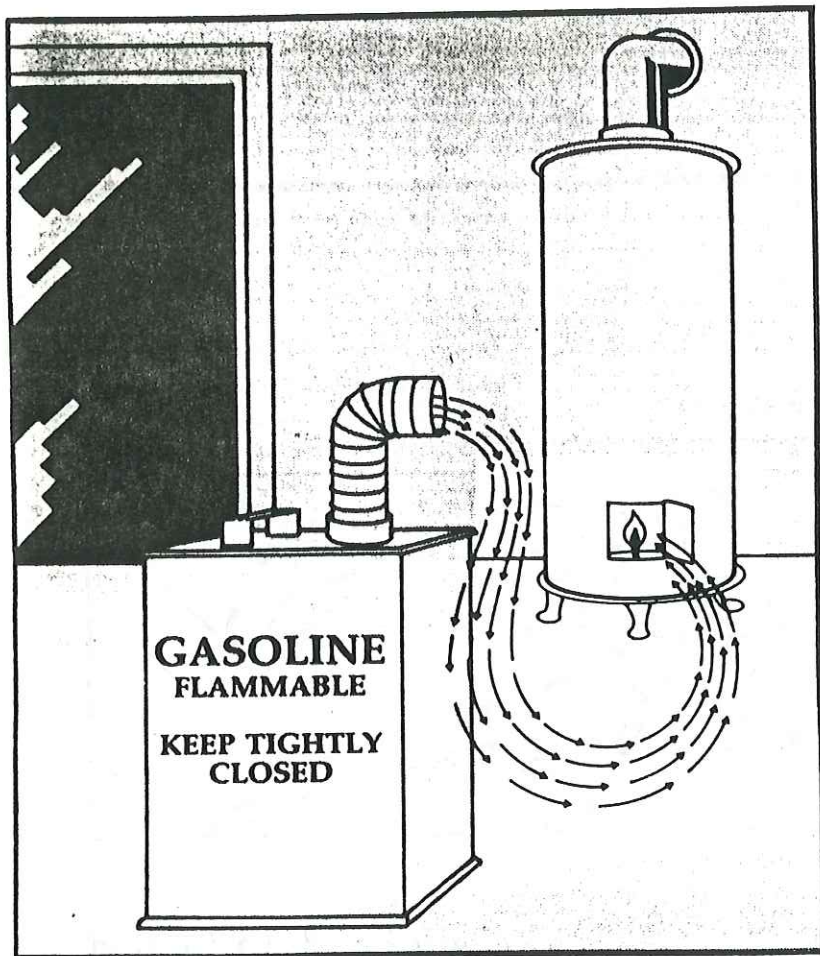
Are gasoline, paints, solvents, or other products that give off vapors or fumes stored away from ignition sources?

☐  
yes

☐  
no

Gasoline, kerosene, and other flammable liquids should be stored out of living areas in properly labeled, non-glass safety containers.

- Remove these products from the areas near heat or flame such as heaters, furnaces, water heaters, ranges, and other gas appliances.



Never store gasoline in the home. The vapor from gasoline can be ignited by pilot lights or arcs caused by activating electric switches.

# STAIRS

For all stairways, check lighting, handrails, and the condition of the steps and coverings.

## CHECK LIGHTING

### QUESTIONS

### RECOMMENDATIONS

Are stairs well lighted?

☐  
yes

☐  
no

Stairs should be lighted so that each step, particularly the step edges, can be clearly seen while going up and down stairs. The lighting should not produce glare or shadows along the stairway.

- Use the maximum wattage bulb allowed by the light fixture. (If you do not know the correct wattage, use a bulb no larger than 60 watts.)
- Reduce glare by using frosted bulbs, indirect lighting, shades or globes on light fixtures, or partially closing blinds and curtains.
- Have a qualified person add additional light fixtures. Make sure that the bulbs you use are the right type and wattage for the light fixture.

Are light switches located at both the top and bottom of inside stairs?

☐  
yes

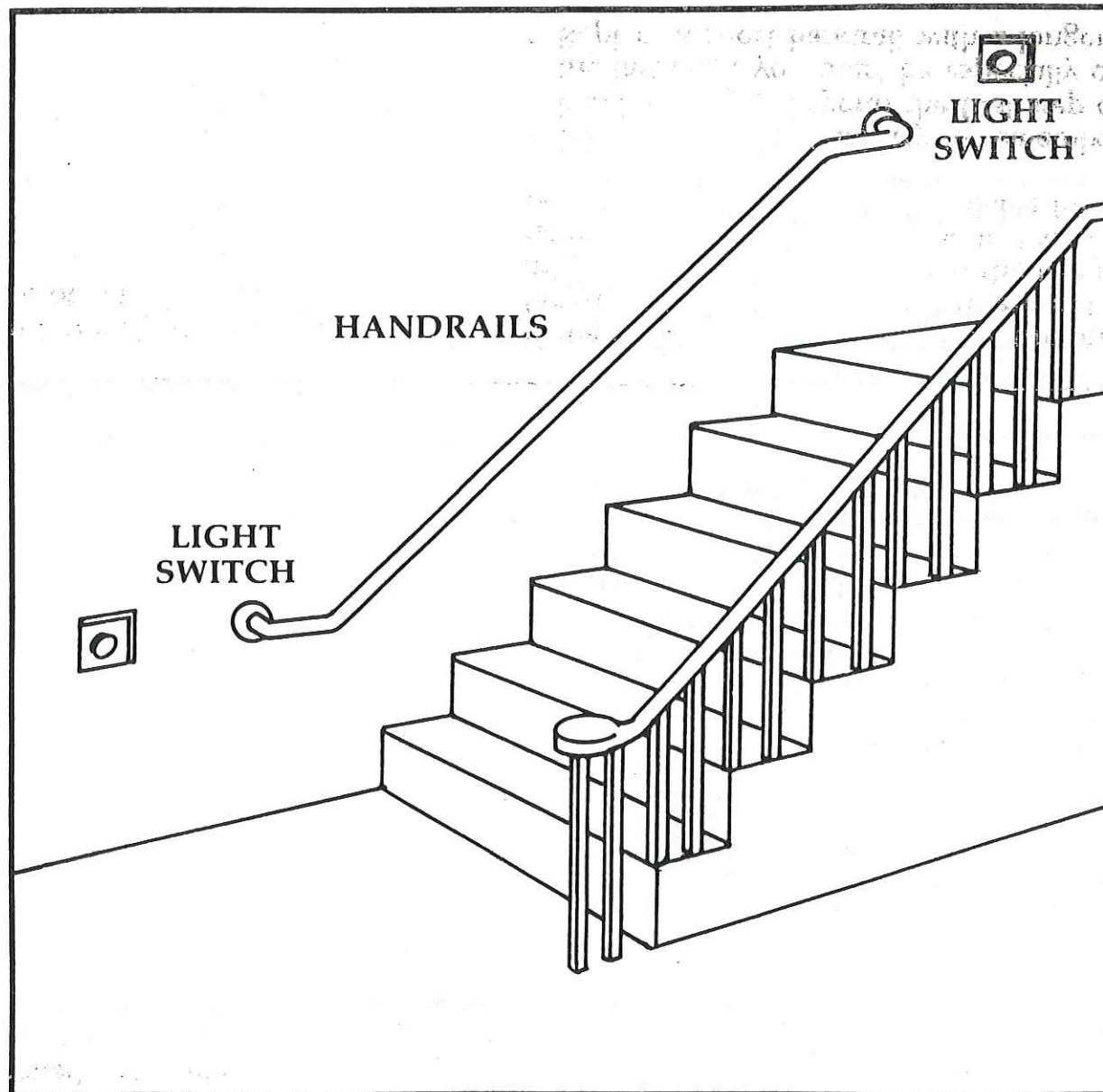
☐  
no

Even if you are very familiar with the stairs, lighting is an important factor in preventing falls. You should be able to turn on the lights before you use the stairway from either end.

- If no other light is available, keep an operating flashlight in a convenient location at the top and bottom of the stairs.
- Install night lights at nearby outlets.
- Consider installing switches at the top and bottom of the stairs.



## CHECK LIGHTING (Continued)



Stairs should have light switches at top and bottom and handrails on both sides.

# CHECK THE HANDRAILS

## QUESTIONS

## RECOMMENDATIONS

Are sturdy handrails fastened securely on both sides of the stairway?

☐  
yes

☐  
no

The handrail should provide a comfortable grip and should always be used when climbing up or going down the steps.

- Repair broken handrails.
- Tighten fixtures that hold handrails to the wall.
- If no handrails are present, install at least one handrail (on the right side as you face down the stairs).

Do the handrails run continuously from the top to the bottom of the entire flight of stairs?

☐  
yes

☐  
no

If the handrail doesn't extend continuously the full length of the stairs, people who are not aware of this might think they have come to the last step when the handrail stops. Misjudging the last step can cause a fall. A handgrip should be available for even one step.

- While using the stairs, try to remember that if the handrail begins beyond the first step or ends before the last step, you must be especially careful.
- Replace a short handrail with a longer one.



# CHECK THE CONDITION OF THE STEPS

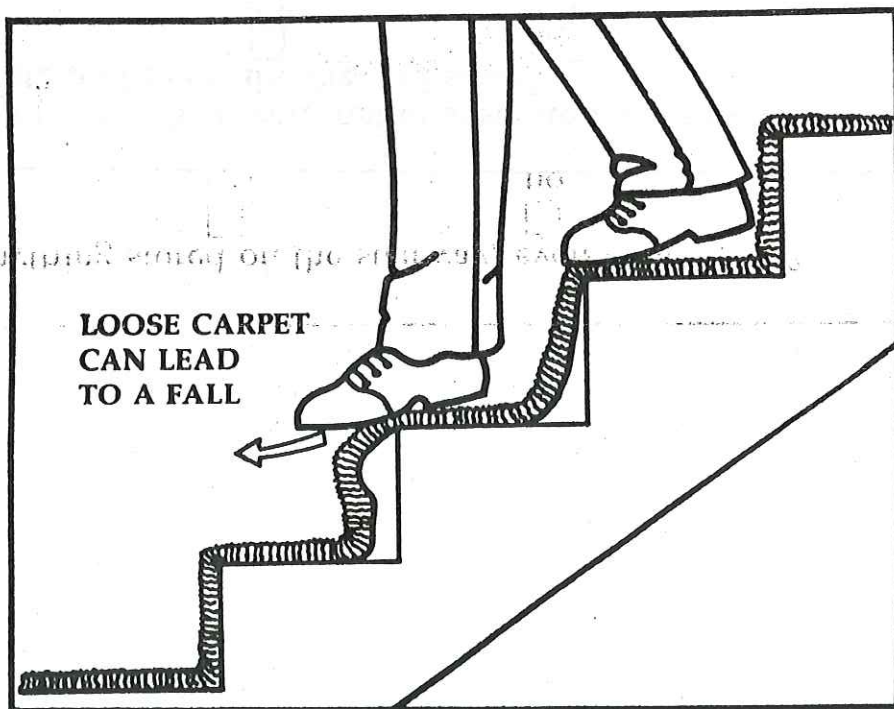
## QUESTIONS

## RECOMMENDATIONS

Do the steps allow secure footing?

☐ yes

☐ no



Carpet should be firmly attached to steps all along the stairs.

Worn treads or worn or loose carpeting can lead to insecure footing, resulting in slips or falls.

- Try to avoid wearing only socks or smooth-soled shoes or slippers when using stairs.
- Make certain the carpet is firmly attached to the steps all along the stairs.
- Consider refinishing or replacing worn treads, or replacing worn carpeting.
- Paint outside steps with paint that has a rough texture, or use abrasive strips.

Are steps even and of the same size and height?

☐ yes

☐ no

Even a small difference in step surfaces or riser heights can lead to falls.

- Mark any steps which are especially narrow or have risers that are higher or lower than the others. Be especially careful of these steps when using the stairs.

## CHECK THE CONDITION OF THE STEPS (Continued)

Are the coverings on the steps in good condition?

☐  
yes

☐  
no

Worn or torn coverings or nails sticking out from coverings could snag your foot or cause you to trip.

- Repair coverings.
- Remove coverings.
- Replace coverings.

Can you clearly see the edges of the steps?

☐  
yes

☐  
no

Falls may occur if the edges of the steps are blurred or hard to see.

- Paint edges of outdoor steps white to see them better at night.
- Add extra lighting.
- If you plan to carpet your stairs, avoid deep pile carpeting or patterned or dark colored carpeting that can make it difficult to see the edges of the steps clearly.

Is anything stored on the stairway, even temporarily?

☐  
yes

☐  
no

People can trip over objects left on stairs, particularly in the event of an emergency or fire.

- Remove all objects from the stairway.

**Remember periodically to re-check your home.**

QUESTIONS

RECOMMENDATIONS

CHECK THE CONDITION OF THE STEPS



For further information, write:

**U.S. Consumer Product Safety  
Commission  
Washington, D.C. 20207**

To report a product hazard or a product-related injury, write to the U.S. Consumer Product Safety Commission, Washington, D.C. 20207, or call the toll-free hotline: 800-638-CPSC. A tele-typewriter for the deaf is available on the following numbers: National 800-638-8270, Maryland only 800-492-8104.

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6 World Trade Center  
Vesey Street, 3rd Floor  
New York, New York 10048

**CENTRAL REGIONAL CENTER**  
230 South Dearborn Street, Rm. 2944  
Chicago, Illinois 60604

**WESTERN REGIONAL CENTER**  
555 Battery Street, Rm. 415  
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