

**Caring For those with Dementia: How Can Evidence Based Care Support Healthcare to
Improve Outcomes?**

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Clinical Background

For healthcare professionals, a large percentage of the geriatric population in need of care has a diagnosis related to Alzheimer's disease or dementia. The Centers for Disease Control and Prevention (CDC) (2019) estimate that there will be approximately 14 million individuals living with dementia. This is a significant increase from the present number of individuals with a diagnosis. With this growing number it is apparent that families as well as health care personnel need to be equipped for the unique care of those with these diagnoses. In 2019 the Centers for Disease Control and Prevention reported that the minimal number of three percent or less of medical students choose to electively take geriatric trainings, which in turn proves that a miniscule number of providers are entering the healthcare field with experience to care for these individuals.

Specific healthcare facilities have units tailored to offer safety and appropriate care for these individuals; however, are dementia specific trainings required for all units and facilities that may have to care for individuals with Alzheimer's or dementia? For facilities that are considered to be a long-term care facility, less than half of the United States require that individuals who work in these settings to obtain dementia specific training, with only 14 of those states having laws that require specific units that are for those with Alzheimer's and dementia to have completed training to care for these individuals (Burke & Orlowski, 2015).

Why is it so important to train those health care personnel on the specifics in caring for individuals with Alzheimer's and dementia? Individuals with Dementia face many challenges in regards to their health and well-being. Dementia impacts not only the individuals' physical

abilities to complete activities of everyday life and psychological aspects of life, but the social aspect as well (World Health Organization [WHO], 2021). The treatment and care that is provided to those with dementia is important, specifically the ability for personnel to identify signs and symptoms of physical illness in these individuals as well as understanding how to identify and correct what may be causing the behaviors that occur (WHO, 2021).

One chief concern for these individuals when taking a look at physical health, is that of infections that go un-noticed in the early stages due to the lack of abilities for these individuals to properly express their symptoms or complaints. Urinary tract infections (UTI's) in these individuals are often observed as changes in everyday behaviors before the concrete signs and symptoms of a UTI are detected (Clinton, 2020). This is a leading concern due to the decreased ability for these individuals to either remember to perform hygiene and personal care, or the physical ability for them to do so (Clinton, 2020). A study in 2020 resulted that people living with dementia have two times the chances of being diagnosed with a urinary tract infection in the emergency department, when compared to those without dementia (Yourman et al., 2020). Emergency department admissions are not entirely due to symptoms exhibited to be those of a UTI, but due to cognitive impairment and changes in behaviors the emergency department becomes warranted due to the decreased ability or inability for those caring for these individuals or, the individuals themselves to identify and report urinary symptoms. A visit to the emergency department may further complicate a perplexing diagnosis of Dementia (Yourman et al., 2020).

Behavioral concerns come to the top of concerns with these individuals as well, as this can be a reason for hospitalization, serious illness or injury, or the requirement for a higher level of care. Behaviors are exhibited in several ways, and it is important to know how to manage these changes in behavior as they present. The way caregivers interpret and respond to changes

in behavior can make all of the difference for these individuals. Figuring out what may be causing the change is the key step in the process (Alzheimer's Association, 2022). Some of the behaviors exhibited can be due to physical discomfort, environmental changes, communication frustrations, or even advancing stages of the disease (Alzheimer's Association, 2022).

Identifying what has triggered the behavior can be one of the most effective ways to handle the situation, and then moving on to finding a solution to deescalate or treat is going to be imperative for those caring for the individual. Some of the initial approaches are a medical evaluation, coping mechanisms and supportive care (Alzheimer's Association, 2022). The education held by caregivers, whether it be family or healthcare personnel impacts many outcomes for those with Dementia and Alzheimer's Disease.

Rationale

Caring for those with dementia can be challenging mentally, emotionally and physically. Without proper education and knowledge of the disease and how it affects the way the individuals function as well as their abilities to express their thoughts and feelings plays a large role in the care that they require. It is not enough to give a half-hour long video assignment to staff that are coming into a facility and expect them to feel comfortable giving care to someone with dementia, and it is not adequate to expect that this provides them with the information they need to give safe and appropriate care to those individuals living with the diagnosis. The way individuals with dementia respond to everyday tasks, stimuli, and the environment around them can change drastically based upon the stage as well as the type of dementia for which they have received a diagnosis.

When individuals are hired at the facility where I currently work, questions are asked if they have any experience in not only caring for those of the geriatric population but if they may

have any experience caring for those with dementia. Asking a question does not necessarily allow for completely honest answers. Upon hire, individuals are given the assignment of watching a thirty-minute-long video about caring for those with dementia, and this offers some techniques to help to allow the individuals to maintain some independence with their activities of daily living. This does not offer examples, scenarios or even education regarding how this disease can affect health and acute illness identification, behaviors, or the individual's ability to appropriately respond to care. As a nurse in the facility, I spend a lot of my time educating and reminding direct care staff about the importance of consistent supervision, quick identification and report of behavior and status changes, and managing behavior escalation, as this is not a black and white topic and varies depending on each individual. On-going education is important to the care of the individuals living in the facility as well as the safety of both the individuals and staff.

Research Question

In a geriatric dementia population, how does mandatory dementia-specific staff education compared to standard staff training affect the de-escalation of behavioral outbursts?

Variables

There are several important variables for this research question that has been identified. The geriatric dementia population would be those that live on a dementia unit in a long-term care setting, or an assisted living setting. This could include those who are cared for at home. Importantly these individuals would be ones that require a higher level of care from those who are cared for by their families. The individuals of the geriatric population with dementia, who are cared for by staff hired to do so, are an important part of the variables identified. The intervention of mandatory staff training is identified as a variable that is required for the continued

employment and care of those living with dementia. This includes on-going education for these care givers. Routine education, that is updated as evidence-based practices, is also revised. Comparing the difference in care delivery from those who receive the standard education given upon orientation as well as routine in-services, to those who receive additional and, specific education for those who are a part of the dementia population care team. The outcome identified as de-escalation of behavioral outbursts was identified and more specifically relates to any change in behavior for those living with dementia and the abilities to identify and trouble shoot what may be causing this outburst are important in achieving this outcome. These variables were chosen because there could be a specific change in behavior outcome. Often, behavioral outbursts are exacerbated when there is a lack of knowledge that the outbursts can be directly related to a health concern and the individual's inability to express what they may be experiencing. Identifying the trigger of a situation allows for a proper approach to increase the probability of a positive outcome.

Literature Synthesis

Education specific to the specialties of healthcare is something that can heavily impact care delivery. Caring for the geriatric population is unlike caring for pediatrics and in the same realm of information, caring for individuals living with dementia is different than caring for the geriatric population in general, as a dementia diagnosis is not a normal part of aging. Those living with a diagnosis of dementia is increasing steadily as the years progress, therefore the importance of competent caregivers is vital to the workforce (Parveen et al., 2021; Polacsek et al., 2019). Literature supports the need for dementia specific training and education for those caring for individuals living with dementia, encouraging health care facilities and entities to provide on-going and up-to-date information to assist with the training for the healthcare

personnel employed to care for these individuals (Elpers et al., 2017; Tropea et al., 2022). Several studies identify the impact that specific education and training has on staff attitudes, confidence and, the reported improvement in family satisfaction with care their loved ones are receiving (Polacsek et al., 2019; Tropea et al., 2022; Parveen et al., 2021). Individuals with dementia often experience behavioral changes that present challenges throughout the course of their disease. Research literature supports improved management of these challenges with education and training on techniques to safely care for these individuals (Elpers et al., 2017; Polacsek et al., 2019; Parveen et al., 2021).

Improved Outcomes Reported by Families

Family members are often the preliminary caregivers for those in the early stages of a dementia diagnosis. When considering the management of behavioral outbursts for those living with dementia, families can be a key element. The ability for family members to continue caring for their loved ones correlates directly with the level of care they may need. Keeping individuals in their home remains important for many (Polacsek et al., 2019). As loved ones living with dementia require an increase in care and families may need to place the individual in a facility that is safe for those who experience cognitive impairment due to the disease process, or maybe the family needs to hire outside caregivers to come into the home. The importance of competent caregivers remains of extreme importance to the families of these individuals as they transfer this care to someone that they may not know. Understanding the disease process, how caring for individuals with dementia is unique and, how to communicate with these individuals and their loved ones becomes a key characteristic that families identify in caregivers (Polacsek et al., 2019; Tropea et al., 2022). Person-centered care was identified as a key component that family members believed to have an impact on the care of their loved ones (Polacsek et al., 2019).

Polacsek et al. (2019) brought to attention that “Person-centered care was strengthened when family carers could inform and educate home care workers of the best way to tailor tasks and activities in a way that reflected the individual needs of their loved ones” (p.479). One piece of literature (Tropea et al., 2022) focused on the perceptions that families offered during the end-of-life stages of their loved ones who experienced a dementia diagnosis. Caregivers who attended a training program specific to palliative care of those with dementia had reported improvement in care outcomes. When caring for individuals in the end stages of life, sensitivity to the way their loved ones feel is particularly important as well. Understanding and offering ones-self along with having the knowledge and capability to communicate effectively with the families is pertinent (Tropea et al., 2022).

Staffs Attitudes and Confidence

With experience in caring for those living with dementia, experience and knowledge about the disease process matters. The way care givers use their knowledge, attitudes and confidence to approach each single situation in care delivery, can impact the response received from an individual with dementia. One study (Parveen et al., 2021) supports that variance occurs in care outcomes with difference in years of experience and age of caregivers. Years of experiencing different behaviors, scenarios, complications and outcomes allows for an understanding of what may work in terms of care for those living with dementia and what may exacerbate concerns. Training that focuses on realistic scenarios and simulations correlates with improvement of reported thoughts on dementia care. The focus on simulation-based trainings and face-to-face teaching of modules has been conveyed to improvement in healthcare personnel attitudes and confidence as they relate to communication, person-centered care approach and risk prevention (Tropea et al., 2022; Parveen et al., 2021). Dementia specific training in a protected

environment that allows for safe education as well as both negative and positive feedback allows for personnel to further prepare for real life scenarios. Elpers et al. (2017) discusses the importance of using more simple tasks to center care delivery around each individual which has shown to result in less discomfort for both the caregiver and the individual with dementia.

Behavioral and Care Improvement

The needs of those with dementia can go un-detected by caregivers if they are not adequately trained to understand how different issues may present. Polacsek et al. (2019) discusses that the family members must voice the importance of understanding that an individual may present with behavioral challenges. These behaviors can be directly related to the inability to express their needs and are not necessarily the personality of the individual, but part of the disease process. Understanding that individuals with dementia are still able to make choices about their care, their food, and every day necessities is important for caregivers to acknowledge as individuals begin to lose their abilities to care for themselves independently. Playing part in these decisions still offers autonomy and was reported to improve care outcomes and maximize person-centered care (Polacksek et al., 2019). Another study (Elpers et al., 2017) supports the need for a knowledge base of how to strategically interact with an individual who may be showing signs of agitation or beginning to experience a behavioral challenge, to allow for escalation. Case scenarios used with identified behavior concerns that were facility specific, such as resisting care and, verbal or physical aggressive behaviors were created for training. Allowing staff to put to practice skills learned to manage these behaviors permitted educators to identify mainstream mistakes that caregivers make when managing behaviors (Elpers et al., 2017). Improvement in staff knowledge, confidence and attitudes towards those living with dementia has a significant impact on the outcomes of those they care for. With knowledge about the

disease process and added confidence in caring for these individuals, health outcomes are impacted, which can be directly correlated to behavioral management (Parveen et al., 2021; Elpers et al., 2017).

Literature supports the need for further research on the effects of dementia specific training for healthcare personnel, and how to improve participation and completion of training programs to allow for a more accurate measurement of the impact. Staff participation, allowance of time to participate in trainings as it impacts the work day, and the modes of delivery of content are reported to be limitations from stronger outcomes (Parveen et al., 2021; Elpers et al., 2017; Tropea et al., 2022).

Patient Preferences and Values

For consideration of patient preferences and values with the implementation of change regarding dementia-specific education, several aspects of patient care are affected. Implementation of dementia specific training is not all inclusive. Patients may have specific preferences about how they would prefer to deal with the changes in their cognitive abilities. They may not relate to the information that staff is taught concerning caring for individuals with dementia, therefore care would need to continue to be tailored to each specific individual. For example, often times dementia training encourages caregivers to meet the patient where they are at in their mental abilities and not bring them back to a reality state of mind. This becomes difficult if the individual is in such a state of the past that it becomes upsetting and leads to behavioral concerns. As a caregiver, understanding how the individuals responds to different interventions continues to be key. Many individuals do respond quickly and in a positive manner to being brought back to a present-day reality when they are experiencing heightened feelings about their past, or what they feel is current time.

One of the more difficult things for caregivers may be the ability to understand that although individuals living with dementia have a degree of impairment with their cognition, it is important to remember that their preferences for the care they receive must still be taken seriously. One specific example is their sleep and wake schedule. This is often altered in those with dementia, as a part of the disease process that involves sun-downing. For implementation of dementia-specific education, this is not a topic that can be completely taught to individuals. Allowing the patient to sleep or wake when they would like would need to be a part of on-going education and the implementation plan must make caregivers aware of this.

The implementation of dementia-specific education does not end at training completion and as the individuals head out to the units to care for these patients, it must be on-going and caregivers should understand that the dementia-specific training offers insight into the disease, ways to identify changes in conditions and offers plans for de-escalation of behaviors. Patient preferences do not expire, and with implementation of training, the information learned does not become an end-all, be-all for care.

Recommendations

Implementation change is not easy in a clinical environment. Many become resistant to change and look for ways to avoid any deviations from normal. In addition, changes to clinical practice often require use of resources, both monetary and human. Presenting strong reasons why the change is crucial to care can have significant impact on those who are on board with the recommendations for change. My recommendation for change is that a dementia-specific training program is put into place for any staff that may be a part of the team that delivers care to those living with a dementia diagnosis.

Implementing change in the assisted living setting that I currently hold a position at would require several meetings prior to a decision being made for implementation. This meeting would involve the information found that supports the need for change, as well as information regarding incidents that have occurred in the facility that were related to lack of education or knowledge or that could have been prevented with further information about caring for individuals living with a dementia diagnosis. If the change was to require a large monetary involvement from the facility, the Chief Financial Officer would also be present. Once all of the questions and concerns were answered and if an agreement could be made, then we would escalate the meeting to involve the Medical Director to ensure up-to-date and appropriate practice approval from their perspective. Following approval and meetings, myself and the Resident Care Director would come up with how the training would be presented and at what intervals, as well as who would be required to do so.

A soft introduction would occur with individuals who presently work at the facility to gain feedback and make adjustments as needed. This would allow for individuals with some experience to relate actual care and practice to what was being taught in the training. Prior to, during, and after training information would be collected and adjustments would be made as seen fit. The training would then become a requirement for all employees who would have contact with and care for those living with dementia and would be adjusted as new evidence presented. The training should be included as part of the orientation process for new hire employees. This would allow for them to complete the training without needing to do it outside of hours that they are working on the units. For any employees that are already employed by the facility that require such training, they would be offered compensation to attend sessions outside of their working hours. If this was not feasible for legitimate reasons, the individual would be provided

coverage by a member of the team during working hours so that they can complete such training within a timely manner. Offering feedback not only for the training itself, but also for the learner, is crucial to a successful program.

The program would consist of hands-on and simulation-based training, allowing for scenarios to be role-played and feedback given in a safe environment that would not affect current patient care. Background and videos regarding the education program would need to be presented prior to simulations, but there should be much more hands-on and role play occurring to allow for the most effective and efficient outcomes. The literature supports in-person, simulation-based training, and reports success within these programs (Parveen et al., 2021; Elpers et al., 2017; Tropea et al., 2022; Polacsek et al., 2019).

Aside from staff training, protocols should be updated to match the training procedures that individuals are then taught. The training should align with changes to policy and procedure. For example, an individual experiences a behavior and the staff uses all taught and previously known techniques and is unable to manage the behavior appropriately, there should then be a protocol for a huddle that discusses what the situation may have been and what was done and what could occur in the future to deter this situation from arising again. The feedback loop should occur on a continuum for staff support.

I do not work on a specific unit at this time; however, I am part of each unit in the facility. As the Registered Nurse in the facility, I review all internal and reportable incident reports and this would directly affect my duties with this task. With each incident report a quality assurance audit takes place which allows for a look into what has occurred, how do we prevent the occurrence from happening again, and who can be educated to avert such incident. My duty to change would be to offer a comparison of behavioral incidents from the implementation at

follow-up intervals for evidence that training program has been implemented in a way that is improving the care delivery of the facility.

Change Theory

Use of a theory to guide the implementation of changes can be beneficial. Kurt Lewin developed a three staged theory that assists with implementation of change with focus on an understanding of how the dynamics of the organization effect how change is implemented (Schmidt & Brown, 2022) As Lewin's Change Theory continues to be a key guide to assist with implementing and sustaining change, it also can be used to implement change recommendations discussed above.

The first step to this theory is the identification of change also known as the unfreeze stage and, why it is vital (Schmidt & Brown, 2022). When considering the change, who are the stakeholders? Do they support the change? While reviewing the recommendation to make changes to the education offered regarding dementia-specific staff education in an assisted living facility, first and foremost, why is this needed? The number of preventable incidents shows a very clear increase when the staffing on the unit has a deviation from the staff with previous knowledge of dementia, or previous experience working with these individuals. What stakeholders do we need support from? The top of the pyramid would be the administrator, gaining her insight and approval is crucial. Working collaboratively with the Resident Care Director to educate on the importance of caregivers' education regarding those living with dementia, will permit the approval. The final step to the first stage of the change theory is to convince the organization that there is a need for change (Schmidt & Brown, 2022). Delivering information with projections as to the improved outcomes that the change would allow will be fundamental in this step. The why remains a question throughout implementation of change so

setting forth an answer to the why from the first stage of implementation can allow for an early understanding by stakeholders and personnel responsible for implementing the change. This stage of the change theory would be anticipated to last a month or so, depending on the availability of the Resident Care Director and Administrator to discuss the changes that are identified as needing to occur.

The second stage of Lewin's stages of change is the change stage itself. This is where the implementation begins. After appropriate approval and support from stakeholders has taken place, this stage can be initiated (Schmidt & Brown, 2022). This is one of the more important steps to initiate the change, the who, what, when, where and how of the change. Communication remains vital (Schmidt & Brown, 2022). This is when the plan should be introduced to staff. In recommending dementia-specific training for care staff, it is important that the staff understand that this change is not a punishment, but a way to improve care outcomes for those living with dementia. Staff will have questions; this stage is when those questions should be answered the best that they can be (Schmidt & Brown, 2022). This is when a trial run could occur, or a mock training to allow for any questions and feedback. This would offer the benefits to the change as well as clear instructions on how this would take place. With any occurrences in the work place, often times there are rumors to follow. Clearing up these rumors and clarifying where the truth remains would be important during this time, as previously mentioned some may believe this is due to staff mistakes or as a punishment, and this stage is a time to educate the staff on the importance of evidence-based practice changes and implementing them to care (Schmidt & Brown, 2022). Support for those involved in the change must continue. Those who are a part of management that may also be struggling not only encourage other staff to attend trainings but also to receive encouragement themselves, may need extra support at this time. Staff

involvement will remain a key component of implementing change (Schmidt & Brown, 2022). I would anticipate this stage to last approximately six months at the facility due to hesitation, questions, and support required by staff as there is much resistance to change identified.

The third stage of change theory is known as the Refreeze Stage. This stage is where it all comes together. The organization adapts the change to their existing culture (Schmidt & Brown, 2022). This would mark the implementation of the training program as a successful part of the training process at the assisted living facility and would be a successful program that has shown to increase staff confidence, attitudes, and abilities when caring for those living with dementia. During this time, any barriers to the change would be identified and plans would be set into place to overcome these barriers (Schmidt & Brown, 2022). Perhaps a large portion of staff is unable to complete the training program outside of normally scheduled hours. However, the organization plans to utilize as needed employees, or offer an incentive program for those willing to cover a portion of their co-workers shift to allow adequate training time. This would be an example of overcoming a barrier. Continuing to receive support from all tiers of the organization and, ensuring that feedback is considered and utilized with the continuance of change implementation allows for sustaining change in an organization (Schmidt & Brown, 2022). Statistical reports as well as subjective reports from individuals as well as care staff can be vital in offering feedback on the training program success in an Assisted Living Facility. Ensuring that success is communicated throughout the organization can assist with further implementation of evidence-based practice changes, as most feel empowered through success. This stage would continue throughout a longer-term such as a twelve-month period. I feel as this is an on-going stage at some capacity due to evolution of evidence.

Conclusion

There is evidence that supports the assumption made that dementia-specific staff education can assist in appropriate management of dementia behavioral outbursts when compared to general staff education. When beginning research, I believed that there would be much research regarding this in long-term care settings, and that the statistical outcome would be significant enough that there would be no question whether the outcome was apparent or not. This however, was not the case. The studies found offer data that does support the need for dementia-specific staff education to improve care outcomes, but there is lack of significant data. Further research is required because of several factors. The lack of participation from facilities and staff due to many barriers that are common to healthcare, such as time, were one of the primary issues. Throughout the process of searching for studies and identifying those that I would use to support my PICO question, I learned that focusing on key words that are used in more than one article is important, as support from one source is not enough to recommend change. I took the time to read through the summaries of the background, methods, and outcomes of the articles I was interested in to make sense of what the overall study was going to tell me. This seemed to help when focusing on supportive research. If I were included in research in the future, utilizing the research databases in their entirety will be a focus of mine. This is a key decision because I was able to experience a minuscule amount of the databases throughout this project, and I did not use them in their entirety when filtering them by certain results. I specifically used year and full text. I believe that if used to their complete capability, there would be many options that can be generated to describe the topics of interest. Overall, research can be intimidating to read, but learning how to dissect and appraise evidence assisted in the ability to understand what was being discussed at a simpler level.

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