The purpose of this section is to help the learner understand Parkinson’s disease and what to consider when screening a potential resident with Parkinson’s disease. Additionally, this section will review accommodations an adult foster home provider needs to make when caring for a resident with Parkinson’s disease.

**KEY TERMS:**
- Anticholinergic effects
- Bradykinesia
- Delusions
- Hallucinations
- Rigidity
- Tremors

**OBJECTIVES:**
After completing this section the learner will be able to:
- Define what Parkinson’s disease is and symptoms associated with Parkinson’s disease;
- List key questions to ask when screening potential residents with a diagnosis of Parkinson’s disease;
- Describe care guidelines for residents with Parkinson's disease including common treatment and drug side effects;
- Give examples of mobility and communication interventions for residents with Parkinson’s disease;
- Explore your own physical and emotional limits regarding the type of care required for residents.
INTRODUCTION

Parkinson’s disease is a slow, progressive disease affecting brain centers controlling movement, balance, posture and walking. This disorder is caused by the loss of cells in the part of the midbrain called the substantia nigra. These cells manufacture dopamine, a chemical that acts upon the brain’s nerve cells to begin, coordinate and maintain movement.

People in the later stages of Parkinson’s disease cannot be sure what they will be able to do from one moment to the next. The unpredictably or major fluctuations in mobility creates anxiety and adds uncertainty to daily life. A simple movement, such as turning over in bed, may require major effort and concentration.

Parkinson’s disease is not fatal, although health complications may occur due to problems with immobility, falls, coexisting illness or drug therapy.

MAJOR SYMPTOMS

The major symptoms of Parkinson’s disease are muscle rigidity (muscle stiffness), tremor and bradykinesia (slowness of voluntary movement). Other causes mimic Parkinson’s disease symptoms (i.e., side effects of antipsychotic drugs, tumors, etc.) so it is important a qualified medical professional diagnoses the resident.

- **Rigidity** involves muscles on one side, or both sides, of the body. Involvement of facial muscles causes a fixed or mask-like facial expression and slurred speech. Stooped posture occurs, in part, from rigidity of neck and back muscles. Shuffling gait and the head turned downward are characteristic signs of the disease.
• **Tremors** may appear in the hands and sometimes in the feet. They may involve the head, neck, face and jaw, and be worse on one side of the body. Stress, fatigue and emotions cause tremors to worsen. They disappear with full relaxation and sleep. Major tremors are severe, constant and physically exhausting.

• **Bradykinesia** is one of the more disabling symptoms of Parkinson’s disease. It is characterized by delayed movement initiation, reduction of movement and sudden inability to move. It contributes to trouble with balance, legs “freezing,” difficulty walking or turning, and lack of facial expression (sometimes called a “poker face”).

Bradykinesia makes it difficult to get in and out of a chair or car or to finish self-care activities (such as dressing). The person begins the activity, then slows down and wavers before completing it. It is as if the person’s “battery has run down.” Weakness or fatigue is commonly experienced. Beginning an action or movement, stopping one activity to begin another, or trying to do two things at once is stressful. Because of these problems, people with Parkinson’s disease tend to withdraw from activities.

**COMMON PROBLEMS**

It takes careful observation and knowledge of a person’s health history to distinguish the differences between age-related changes and problems commonly associated with Parkinson’s disease. Problems with balance and walking, for instance, may be mistakenly attributed to “old age.”

**Mobility problems**

• **Loss of automatic movement.** Action or movement requires thought and work. The effort exerted is mentally and physically exhausting. For example, to swing the arms while walking, the person must concentrate on moving the arms and feet as well as keeping the torso and head upright.
- **Balance.** The person’s reaction to an impending fall comes too late, too slowly, and with movements that are too small to regain balance.

- **Unnatural gait.** Gait is short-stepped and shuffling. The person tends to break into a run or trot, especially when starting to walk after getting up from a chair, which may increase risk of falling.

- **Fluctuations in mobility.** The person may be able to carry out an action or movement on one occasion, but not on another. Such fluctuations can occur throughout the day. Mobility is also affected by changing energy levels. The person may need more assistance at different times with different activities.

- **Reduced ability to start an activity.** Persons who have Parkinson’s disease know what they want to do, but they have trouble getting into gear to make the initial movement.

- **Leg freezing.** This problem occurs later in the course of the disease. While walking, the person suddenly cannot move. It seems as though one of the person’s feet has “stuck to the floor.” Moments later the foot frees itself. This often occurs in doorways, at the edge of rugs, while crossing streets, and when turning. Freezing is frustrating and can lead to falling.

**Cognitive changes**

- **Depression.** Depression can be a natural occurrence or a side effect of levodopa, the drug treatment of choice for Parkinson’s disease. Many people who have Parkinson’s disease benefit from treatment for depression.

- **Personality changes.** Irritability, suspiciousness and a lack of motivation are common problems.

- **Intellectual changes.** Cognitive abilities are usually not impaired by the disease. However, dementia occurs in 10 to 20 percent of the people who have Parkinson’s disease. Mental changes resemble symptoms of Alzheimer’s disease.
Speech and communication problems

- **Low speech volume and monotone voice.** In Parkinson’s disease, the muscles that control breathing are weakened. This condition affects speech rhythm, tone, rate and word pronunciation. The person must use considerable energy to be heard and understood. The person with Parkinson’s disease may speak more softly, or begin speaking loudly and then fade. There may be little variety in voice tones. The voice is monotonous, lacking variety and feeling.

- **Decreased facial expression.** As mentioned previously, the face of a person who has Parkinson’s disease is less mobile and expressive because of loss of muscle control. Lack of facial expression and abnormal facial movements sometimes interfere with the person being understood. The person’s smile may spread and disappear slowly, giving others the mistaken impression that the person is “slow-minded.” Emotions are less apparent. However, behind the mask-like face may be a “hurting” person who is mentally aware and longing to be treated the same as before the disease struck.

- **Decreased use of gestures.** People who have Parkinson’s disease may not be able to use their hands and body to communicate nonverbally.

Physical and functional problems

- **Minor aches and pains.** These include soreness in the arm or leg due to tremors or rigidity, foot cramps during the night or when getting out of bed in the morning, chest pain from rigid chest and shoulder muscles and backaches caused by stooping. A doctor may prescribe exercise, massage or medications to help relieve cramps, or heat or massage to reduce pain associated with sustained muscle contraction.

- **Swelling (edema) of the feet and ankles.** Reduced movement of the legs can cause swelling. Edema generally increases during the day and declines at night. A doctor may prescribe support stockings or water pills (diuretics) to help control this problem.
• **Extreme sweating.** This is a common but unpredictable problem in Parkinson’s disease. Sweat glands appear to overreact to normal stimuli.

• **Oily or dry scaly skin (seborrhea).** Seborrhea is caused by overactive oil glands of the skin, especially on the scalp, forehead and sides of the nose. Dandruff shampoos and low-potency (1 percent) hydrocortisone cream may relieve this minor but annoying problem.

• **Itching or burning of the eyes (conjunctivitis).** Decreased frequency of eye blinking results in dust particles, smoke and other irritants remaining on the eye longer, which causes itching or burning. The white of the eye appears bloodshot and crusts form on the edges of the eyelid. Artificial tears (not medicated eye drops) may be used to rinse and refresh the eyes.

• **Visual problems.** The muscles of the eye no longer work together properly. Blurred and double vision and irregular eye movements make reading and other activities difficult for persons with longstanding Parkinson’s disease.

• **Unusual sensations.** Feelings of warmth, burning or – less often -- cold are sometimes experienced externally (e.g., in a hand or foot) or internally (e.g., in the stomach, rectum or throat). Some people complain of inner restlessness, nervousness and trouble sleeping at night.

• **Sleep disturbances.** Difficulty falling and remaining asleep at night is experienced. Frequent nighttime wakening leaves the person exhausted in the morning. Some individuals reverse sleeping patterns; they take frequent daytime naps and stay awake at night. Other sleep problems include vivid dreams, talking during sleep and involuntary jerking limb movements.

• **Dizziness upon standing.** This may occur due to a drop in blood pressure caused by medications used to treat Parkinson’s disease or other health problems (such as diabetes). Frequent dizziness should be reported to the resident’s health care professional.

• **Breathing problems.** Rigidity or extreme slowness (bradykinesia) of the chest wall muscles keeps the lungs from expanding. Shortness of breath after
minor exertion may be experienced. Sometimes an adjustment in medications will help relieve this problem.

- **Difficulty swallowing (dysphagia).** Swallowing problems usually arise from the inability of the throat muscles to contract. Food or pills may stick in the throat. Contact a health care professional if this happens.

- **Drooling.** This results from the person’s inability to swallow saliva. Certain medications (e.g., anticholinergics, as discussed later in this section) may be prescribed to help reduce the problem by decreasing saliva production.

- **Weight loss.** A drop in weight of 10 to 30 pounds is common in people with Parkinson’s disease because of swallowing problems and energy (calories) used by tremors and involuntary movements.

- **Reduced bowel activity.** Parkinson’s disease slows down bowel activity. Constipation may be a problem. The condition is worsened by medications taken for the disease, especially anticholinergic drugs.

- **Bladder problems.** These include a strong desire to urinate (urgency), increased frequency, hesitancy in starting to urinate, and incomplete urination with dribbling. These problems occur because the muscles of the bladder become rigid, sluggish and less able to contract and excrete urine.

**MEDICAL TREATMENT**

There is no specific diagnostic test or cure for Parkinson’s disease. The diagnosis primarily is based on signs and symptoms associated with the disease (i.e., rigidity, tremors and/or bradykinesia).

Medical treatment focuses on reducing symptoms of the disease as it progresses and involves the use of several types of drugs. Anti-Parkinson drugs, such as levodopa or Sinemet®, are used to replace the depleted supply of dopamine. Other drugs, called dopamine agonists, imitate the action of dopamine. These include Parlodel® (bromocriptine) and Permax® (pergolide).
Symmetryl (amantadine) encourages the surviving nigra cells to release more dopamine. Eldepryl (seligiline) discourages the destruction of dopamine by suppressing an enzyme that breaks it down. These two drugs act to increase dopamine in the brain.

**Side effects of drugs**

Drugs used to treat Parkinson’s disease have the potential for serious drug reactions and interactions. If a side effect or adverse drug reaction is observed, contact a health care professional.

**Levodopa.** The most common side effect of levodopa treatment is the development of involuntary movement called “dyskinesia.” The drug-induced movements take the form of involuntary movements such as twitches, jerks, nods, gestures, twisting or writhing of the body, lip smacking, head rolling or simple restlessness.

Serious side effects are **hallucinations** (seeing or hearing things that are not there), delusions (false beliefs that cannot be reasoned away with facts) and depression. Other side effects of treatment include:

- Loss of appetite, nausea and vomiting
- Nervousness and agitation
- Sleep problems, including bad dreams
- Confusion and agitation

**Dietary protein/levodopa interactions:** Dietary protein affects the action of levodopa or Sinemet. High protein meals can hinder the availability of drug to the brain. Because protein is an important part of the diet, consult a dietitian about lowering the amount of protein in a resident’s diet. Timing of medication and meals is also important in effective treatment. Follow these basic guidelines:

- **Coordinate timing of medications and meals.** Resident should take Sinemet 15-30 minutes before meals for predictable absorption. A low
protein snack (e.g., fruit or crackers) may be eaten if nausea is a problem.

- **Monitor fluctuations in mobility.** If the resident experiences moderate fluctuations, spread dietary protein intake throughout the day. If major fluctuations are experienced, provide protein at the evening meal, but restrict it during the day. This approach enhances predictability of movement during the day, but lessens mobility in the evening. Be sure to consult the resident’s health care practitioner before doing this. If improvement does not occur within a week, contact the health care practitioner again.

**Anticholinergic effect:** Medications with an anticholinergic effect include antihistamines (e.g., Benadryl®, Chlor-Trimeton® and most cold pills), anti-Parkinson agents (e.g., Artane®, Cogentin®, Parlodel®), antipsychotic agents (e.g., Haldol®, Prolixin®, Mellaril® and Risperdal®) and antidepressants (e.g., amitriptyline, Prozac®, Paxil® and Zoloft®). Older persons have an increased sensitivity to anticholinergics. Anticholinergic effects include:

- ✔ Decreased memory
- ✔ Delirium and hallucinations
- ✔ Restlessness
- ✔ Blurred vision
- ✔ Dry mouth
- ✔ Trouble starting to urinate or inability to urinate (urine retention)
- ✔ Dizziness
- ✔ Headache
- ✔ Confusion
- ✔ Agitation
- ✔ Sweating
- ✔ Low blood pressure
- ✔ Constipation
MANAGEMENT

Your role in the management of Parkinson’s disease is directed toward helping afflicted persons cope with the disease, preventing accidents and complications, and monitoring diet and exercise. You may work with a physical therapist whose role is to help the person maintain independence and functional abilities. A speech therapist may work with the person to correct speech, communication, and swallowing problems. You, the resident and health care professionals need to understand and accept the importance of this team approach in providing physical therapy and care.

Your general responsibilities are to:

- **Understand and follow the medical treatment plan.** Be sure drugs for Parkinson’s disease are taken as prescribed. Careful timing helps maintain a therapeutic level of the drug. Never abruptly stop medications.

- **Be alert to functional changes.** Consult the resident’s health care practitioner if you are not sure whether recent physical or mental changes are caused by drug side effects of under- or over-medication. For example, uncontrolled muscular movements (such as writhing or grimacing), dizziness or mental confusion can be caused by too much medication. Have the resident’s chart and medication records handy for quick reference whenever you contact care team members.

- **Ensure proper medical management of all coexisting chronic diseases.** The presence of glaucoma, heart disease and high blood pressure complicate treatment of Parkinson’s disease.

- **Be alert to changes and problems related to disease progression.** Because of the progressive nature of the disease, individuals may require increasingly higher doses of medication to relieve symptoms. The drug occasionally wears off early or suddenly loses its effectiveness. An adjustment in the dosage may be required. Consult the appropriate health care professional.
In doing an assessment of a prospective resident, be sure to learn if medications ever wear off before the next scheduled dose or if on-off periods have been experienced.

GUIDELINES FOR CARE

To ensure that the resident who has Parkinson’s disease remains as independent, comfortable and safe as possible, follow these recommendations:

- ** Maintain the resident’s sense of control.** Identify what personal tasks the resident wants to do alone. The person’s limited energy can be used in those areas. For example, your resident has had Parkinson’s disease for 12 years. He hated being helped to bathe. The provider and resident agreed that assisted baths would be alternated with wash ups at the sink, which could be done by himself. On assisted bath days, a towel would cover the resident while sitting in the bath chair, and the provider would wait outside while the resident finished bathing. The schedule would be flexible.

- ** Allow the resident plenty of time.** Rushing increases stress and the possibility of freezing or falls.

- ** Encourage daily exercise of muscles most affected.** Pay special attention to the knees, hands, fingers, wrists, elbows and neck. There are also exercises to aid swallowing and speech.

- ** Plan activities when their medications are at the most effective levels.**

- ** Encourage self-care.** Be prepared to help when needed, especially in starting a task. Slowness and limited energy make planning and streamlining tasks important. Limit activities to one task at a time. This allows the person time to concentrate and reduces feelings of frustration and anxiety. Remember that what the person is able to do alone may vary from moment to moment. Be patient; stress undermines self-care. Consult the care team about special adaptive wearing apparel and equipment.
Bathing and grooming

The bathroom is especially hazardous for people who have impaired balance, difficulty walking or tremors. Take these steps to enhance safety:

- Place non-skid strips in tubs and showers.
- Remove glass doors from around tubs and showers.
- Provide a bath bench or shower chair.
- Install grab bars and a hand-held shower.

The independence of a resident may be increased by providing mittens instead of washcloths and suction brush for nail care attached to the inside of the tub, shower or sink.

Dressing

Dressing and undressing is made easier if clothing is a size larger than the person usually would wear. Energy-saving features include:

- Non-cling, stretchy or tightly woven fabrics that do not stick to the body
- Raglan or loose-fitting sleeves
- Non-tapered pant legs
- Roomy waistline (suspenders, instead of belts, can be used to hold pants)
- Sleeve cuff buttons sewn on with elastic thread (remind the resident to make a fist before putting the hand through the sleeve)
- Elastic inserts in neckties that make it possible to slip them over the head
- Elastic shoe laces that allow shoes to be slipped on while tied (a long-handed shoe horn reduces stooping and the risk of losing balance when putting shoes on)
- Garments that fasten in front, slip over the head and have large buttons or Velcro closures
• String loops, yarn or leather loops for zipper pulls (these help when a weak grip or poor coordination limits use of the hands)
• Gloves and mittens with leather palms (for people using crutches or wheelchairs)
• Large pockets in shirts, blouses and jackets to keep tissues handy in case of drooling

If dressing is difficult, suggest that the resident:
• Place the stiffer limb in the garment first and remove it last when undressing.
• Begin with the bottom button when buttoning a garment. This lines up the other buttons and makes each button easier to see.
• Sit in a firm chair with arm rests, if balance is a problem.
• Rest the elbows on a table while fastening upper garments if arms are too weak.

Diet and mealtime

People who have Parkinson’s disease often feel isolated because messy eating, choking and drooling interfere with eating and upsets others at the table. Because chewing and swallowing require conscious thought, they need to eat slowly. Food tends to collect in the mouth and at the back of the throat. Eating too fast causes coughing and choking. Rushing them through meals can lead to malnutrition.

Follow these guidelines to help ensure the resident who has Parkinson’s disease obtains adequate calories and nutritional intake:

• **Monitor positioning.** The person should hold the head upright so saliva collects at the back of the mouth. This helps automatic swallowing and reduces drooling.

• **Persons with Parkinson’s disease are at high risk for aspirating (choking) on food or fluids.** Know the Heimlich maneuver. Being prepared may save a resident’s life.
• **Provide a quiet, non-distracting surrounding.** This will help the person concentrate on eating.

• **Correct eating procedure, if needed.** Remind the person to think through steps of swallowing:
  » Close the lips.
  » Close the teeth together.
  » With the food on the tongue, lift the tongue up, move the tongue back and swallow (up, back, swallow).
  » Swallow two or three times for each bite.
  » Move the food from one side of the mouth to the other side and wait until the mouth is empty before taking another bite.
  » Alternate food and liquid to aid swallowing.
  » Take small bites of food and small sips of liquid.

• **Provide thick liquids.** They are easier to swallow than thin liquids. Thick milk shakes, creamy soups, thinned cooked cereals and purees are appropriate.

• **Monitor dietary protein and sugar intake.** Too much protein interferes with the action of levodopa (refer to discussion on side effects of drugs in this chapter). Sugar tends to increase saliva. Be sure the resident and family understand the reasons for these dietary restrictions.

• **Discourage skipping meals or overeating.** Eating four to six small meals a day reduces exhaustion and improves self-feeding.

• **Provide a warming tray if needed.** Persons with Parkinson’s disease eat very slowly. Food often cools before they finish a meal.

• **Provide assistive eating equipment.** For example, attach rubber-like material under dishes to keep them from sliding; provide large-handled eating utensils and lightweight mugs for easy grasping. Wide, flexible straws
make drinking easier; shorten straws to conserve energy required to suck thick liquids. An occupational therapist is a valuable resource in this area.

- **Consult their health care practioner about vitamin, iron and other food supplements.** If a well-balanced diet is provided, and dietary intake is good, supplements should not be required by the resident.

**Toileting**

Two common bladder problems experienced by persons who have Parkinson’s disease are overfilling and overflowing and spastic bladder. These problems lead to frequent trips to the bathroom and bladder infections. Urgency is a special problem for someone who is unable to move quickly. Incontinence adds to the list of insults to self-esteem. Follow these guidelines:

- **Encourage fluid intake.** Fluids keep the bladder flushed out; the urine is clear and less irritating to the bladder wall. People who experience incontinence usually resist drinking fluids. Help from other care team members may be needed to convince a resident to drink more fluids.

- **Understand potential drug interactions.** Drugs used to treat urinary infections may weaken or strengthen medications prescribed for Parkinson’s disease. If necessary, consult with a specialist such as an urologist to obtain information.

- **Provide special devices, if needed.** Having a urinal or commode may aid the resident, especially at night. Protective garments (e.g., Depends®) may be worn day or night.

- **Encourage scheduled trips to bathroom.** Regular trips to the bathroom before and after meals may help the resident remain continent.

- **Allow plenty of time and privacy in the bathroom.**

Parkinson’s disease slows bowel activity. Constipation is common; 80–90 percent of the persons who have Parkinson’s disease experience the problem.
Sleep and rest

Sleep may be disturbed by vivid dreams, mental confusion from the dreams, and the need to use the bathroom. Weakness and fatigue result from performing activities of daily living. A balance of rest, relaxation, activity and exercise is essential. Consider these suggestions:

- Encourage the resident to take an hour nap rather than frequent catnaps. Observe whether this approach to rest reduces nighttime wakening.
- Discourage use of drugs for sleep including over-the-counter brands. Consult the resident’s doctor if sleeping is a problem.
- Keep special events calm and within the daily schedule. Plan special activities for quiet days and keep holiday activities within the daily schedule to avoid overtaxing the resident.
- Suggest assistive devices for bed use. A trapeze installed over the head of the bed helps a person change position. Bed “pulls” installed at the end or sides of the bed aid the person in lying down, sitting up and turning over. A sturdy cardboard box or a foot board under the covers at the foot of the bed frees the feet of bedding while turning. A physical therapist can be a great resource regarding assistive devices.

Special bedding or sleepwear may be helpful. For example, synthetic fleece sheepskin may reduce friction of turning in bed; satin sheets and pajamas may also aid in turning (but they may make it easier to slip off the bed). Discuss these ideas with the resident and care team.

Adjusting the resident’s bed so it is easy to get in and out of promotes safety and self-care. The bed should not be lower than knee-high.

If stiffness or rigidity is a problem, suggest the resident follow this procedure for getting out of bed:

- Turn on the side close to the edge of the bed.
• Drop the legs while pushing down with the elbow that is on the bed and with the opposite hand.
• Tuck in the chin and lift the head.

**Special caregiving concerns**

Mobility and communication are areas of major concern in providing care for the resident who has Parkinson’s disease. The resident who has Parkinson’s disease may resist activities or exercise because their legs feel stiff and heavy, and they need extra energy just to pick up their feet. The following suggestions can help you help the resident who freezes, walks with a shuffle, or has difficulty with balance or coordination.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Suggestion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feet become glued</strong></td>
<td>Remind the person to:</td>
</tr>
<tr>
<td></td>
<td>• Stand still.</td>
</tr>
<tr>
<td></td>
<td>• Lift the toes to break the muscle spasm.</td>
</tr>
<tr>
<td></td>
<td>• Place heels on the floor.</td>
</tr>
<tr>
<td></td>
<td>• Raising arms at the same time as lifting toes often helps to get moving again.</td>
</tr>
<tr>
<td></td>
<td>• Lightly rock from side to side.</td>
</tr>
<tr>
<td></td>
<td>• Try marching in place and then step forward on the heels.</td>
</tr>
<tr>
<td></td>
<td>• Visualize kicking a ball or stepping over a line.</td>
</tr>
</tbody>
</table>

**Note:** Freezing is made worse if using arms or hands to carry something while walking.
<table>
<thead>
<tr>
<th>Problem</th>
<th>Suggestion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shuffling</strong></td>
<td>Remind the person to:</td>
</tr>
<tr>
<td></td>
<td>• Place feet eight inches apart.</td>
</tr>
<tr>
<td></td>
<td>• Stand up straight.</td>
</tr>
<tr>
<td></td>
<td>• Think, “Take a big step.”</td>
</tr>
<tr>
<td></td>
<td>• Lift their toes; place their heel down.</td>
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<tr>
<td></td>
<td>• Walk as though marching.</td>
</tr>
<tr>
<td></td>
<td>• Swing the opposite arm forward when taking a step.</td>
</tr>
<tr>
<td><strong>Turning</strong></td>
<td>Remind the person to:</td>
</tr>
<tr>
<td></td>
<td>• Walk through the turn; do not pivot.</td>
</tr>
<tr>
<td></td>
<td>• Turn in a forward direction.</td>
</tr>
<tr>
<td></td>
<td>• Keep legs parallel (don’t cross one leg over the other when turning).</td>
</tr>
<tr>
<td><strong>Tilts to one side (when walking)</strong></td>
<td>Suggest, when walking, that the person carry a weighted shoulder bag on the other side.</td>
</tr>
<tr>
<td><strong>Balance</strong></td>
<td>Canes or a walker may stabilize the person and reduce the problem. Some people have difficulty using such devices. Walkers lend to increased stooping. Consult the care team.</td>
</tr>
</tbody>
</table>
If maneuvering through your home is a problem for the resident, ask the person what gets in the way. An occupational therapist can recommend ways to make your home barrier-free. The following are general suggestions:

- **Allow adequate space around furniture.** Rearrange crowded areas if passage to chair or through room is blocked.

- **Keep routes to key rooms clear of obstacles.** Provide something to hold on to for support along the route to and through such rooms.

- **Provide appropriate seating.** For example, a heavy rocking chair or a straight-backed chair makes sitting and rising easier. Help may be needed to sit down and get up from low overstuffed couches and chairs.

- **Avoid the use of scatter rugs** — if they must be used, tape them to the floor even if they have rubber backing.

**Communication**

A person with Parkinson’s disease may have some or all of the following speech problems to overcome:

- Difficulty starting to speak;
- Low voice volume;
- Voice that fades;
- Little expression or change in tone of voice;
- Change in voice quality: breathy, shaky, higher pitched and piercing, or hoarse;
- Slurred speech; word endings omitted (e.g., “k” in “book”)
- Rapid speech and words crowded together with increasing speed near the end of a sentence;
- Uncontrollable repetition of words or phrases;
- Drooling; the person must swallow before speaking;
• Lack of facial expression or use of gestures.

There are many different exercises to improve speaking skills. Consult a speech therapist or the American Parkinson’s Disease Association. You can help the resident if you:

• **Give the resident your complete attention.** Face the person so you can lip read.

• **Give the resident feedback.** Repeat what you understood and ask the resident to continue.

• **Ask the resident to spell words you cannot understand.** Repeat each letter.

• **Be patient.** Give the person adequate time to respond or react. Avoid speaking or filling in words for the person.

• **Encourage the use of a speaking aid.** Examples include a microphone to help voice volume, alphabet charts (resident points to letters), a printed word communication chart (resident points to words) and a picture communication chart (resident points to pictures). Communication charts can be made to fit the individual’s needs. A speech therapist could offer individualized information.

**You can help the resident by offering these suggestions:**

» Take a breath before starting to speak.

» Use short sentences or speak in phrases. Speak after breathing, not at the same time. For example:

  (Breathe in -- talk) “We need (breathe in -- talk) more bread.”

  (Breathe in) “Pease get (breathe in -- talk) my coat.”

» Concentrate on speaking loudly.

» Enunciate each word. Finish the final consonant of each word before starting to say the next word. Exaggerate each sound.
» Practice speaking (and using facial expressions) in front of a mirror.

• **Written communication.** Change in handwriting style is common. Handwriting often becomes smaller. Words at the end of a sentence may be in smaller script than those at the beginning. To help the resident write legibly, offer these suggestions:
  » Use paper with dark or raised lines.
  » Use a different shade of ink than the color of the lines.
  » Try medium-tipped felt pens. These may reduce the effects of the tremor and require less pressure to use.
  » Use print instead of cursive letters.
  » Say each word as it is written. This technique may aid in controlling the motion and speed of the pen.

Use an electronic typewriter or computer if the person knows how to type (or wants to learn). Using a computer or typewriter may be helpful when trying to communicate. Keyboards on most electronic equipment require less pressure and are almost silent in operation.

• **Reading.** Irregular, jerky movements and failure of the eyes to return to the left side of the page after finishing a line make reading difficult for people with long-standing Parkinson’s disease. The following suggestions may assist the resident who enjoys reading:
  » Use a colored line guide to isolate one line of reading at a time.
  » Use written cues on the line guide for left-to-right scanning, if needed.
  » Use finger tracking; point to each word across the line.
  » Read aloud.
  » Try large print books. Use magnifiers, if suitable.
ADDITIONAL RESOURCES

Parkinson’s Resources of Oregon
www.parkinsonsresources.org

National Parkinson’s Foundation
www.parkinson.org