Demystifying Dementia in Primary Care: A stepwise approach to the diagnosis and care for people living with dementia

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DTA GP clinical education team

Dementia Training Australia

Just to clarify before we start….

We are from **Dementia Training Australia (DTA)**

not to be confused with

Dementia Australia (DA), formerly Alzheimer's Australia

or

Dementia Support Australia (DSA), formerly DBMAS

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Acknowledgements

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By the end of this session participants will be able to:

- Recognise features other than memory loss in people with dementia by applying the Domains Framework
- Explain the trajectory of dementia by applying the Stages Framework
- Apply the Inclusion and Exclusion Criteria Frameworks in assessing patients for a possible diagnosis of Alzheimer’s Dementia
- Implement an effective management plan for people living with dementia based on the stages and domains of dementia
- Appreciate the impacts of caring for someone living with dementia

To begin with the end in mind

1. **Dementia is more than a memory problem**
2. MMSE and other cognitive assessment tools are not validated as population screening tools or as diagnostic tests
3. It is often appropriate for a person to have dementia diagnosed and for post-diagnostic care to be initiated in general practice (with support)

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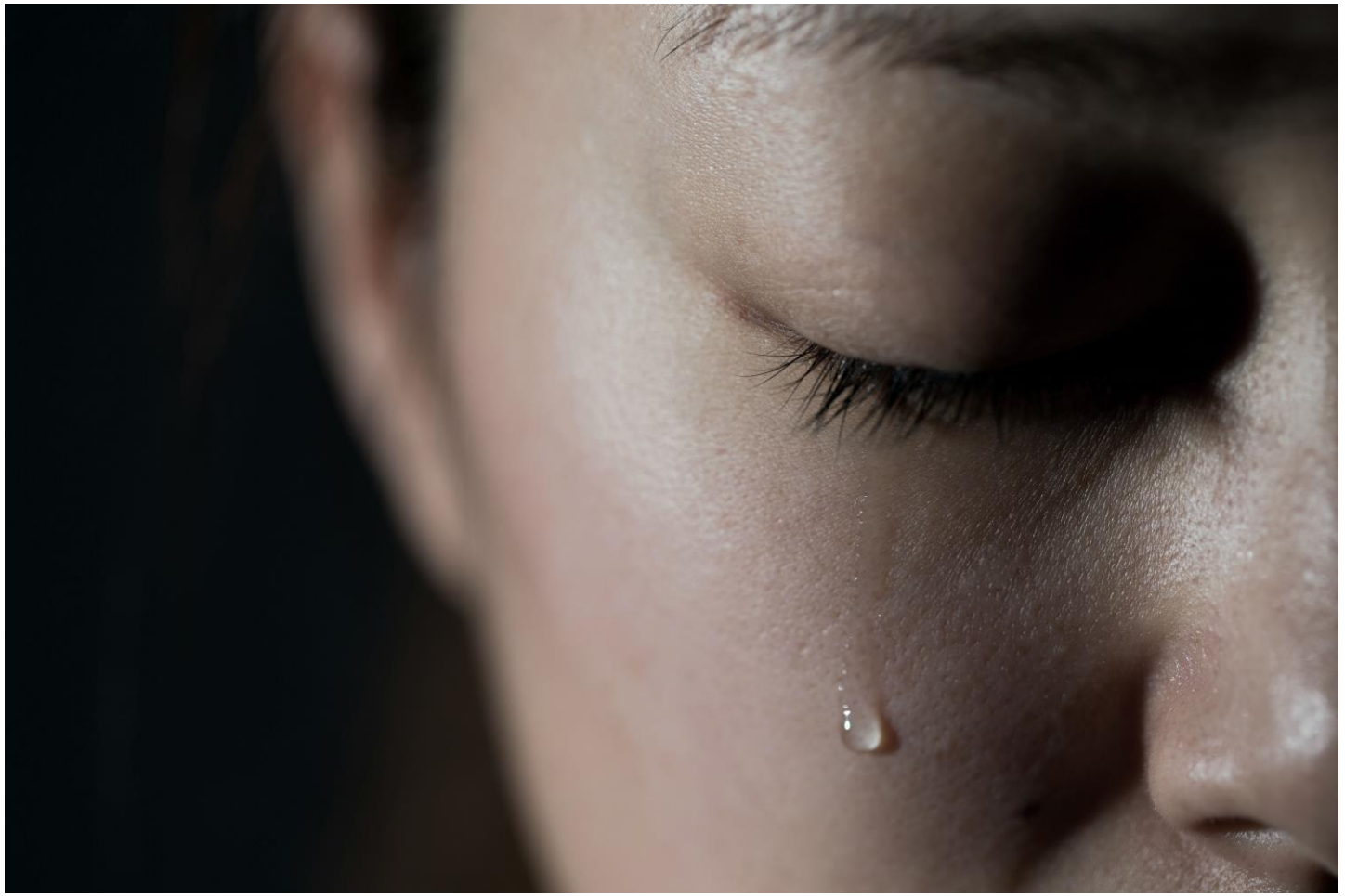
Trigger warning



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Language

Appropriate language must be:

- Accurate
- Respectful
- Inclusive
- Empowering
- Non-stigmatizing

https://www.dementia.org.au/resources/dementia-language-guidelines

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The leading causes of death in women?

1. **Dementia**
2. Ischaemic heart disease
3. Cerebrovascular disease
4. Chronic lung disease (COPD)
5. Lung cancer
6. Breast cancer
7. Bowel cancer
8. Influenza and pneumonia
9. Diabetes
10. Heart failure

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The overall leading causes of death?

1. Ischaemic heart disease
2. **Dementia**
3. Cerebrovascular disease
4. Chronic lung disease (COPD)
5. Lung cancer
6. Bowel cancer
7. Diabetes
8. Leukaemia/lymphoma
9. Influenza and pneumonia
10. Heart failure

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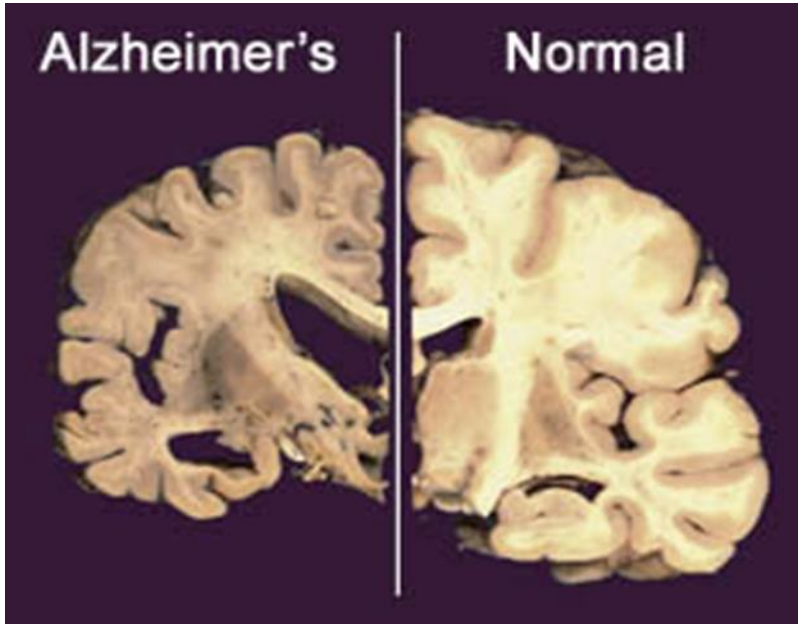
Demystifying Dementia: Building Understanding

Defining Dementia

A progressive, global, life-limiting condition that involves generalised brain degeneration which effects people in different ways and has many different forms.



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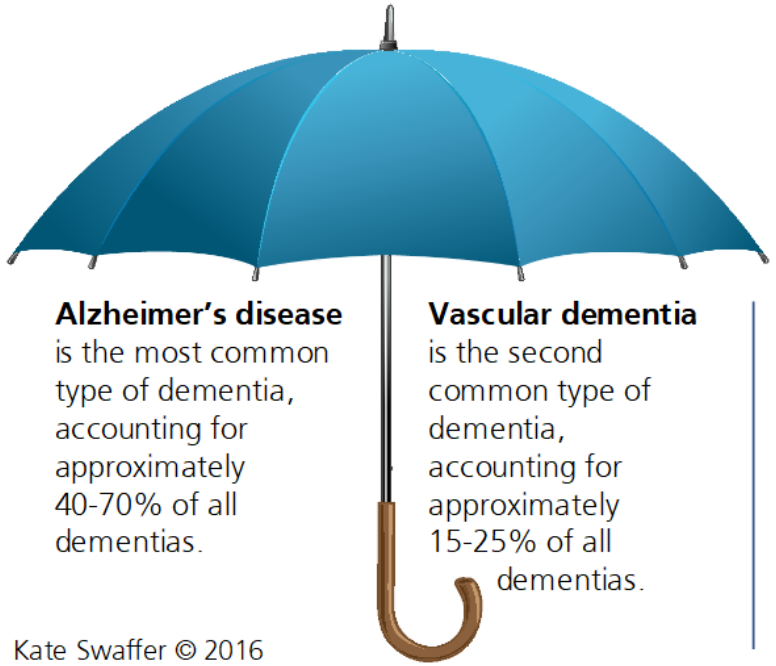
People **die** from dementia due to loss of brain function, which impacts body functions necessary to sustain life.

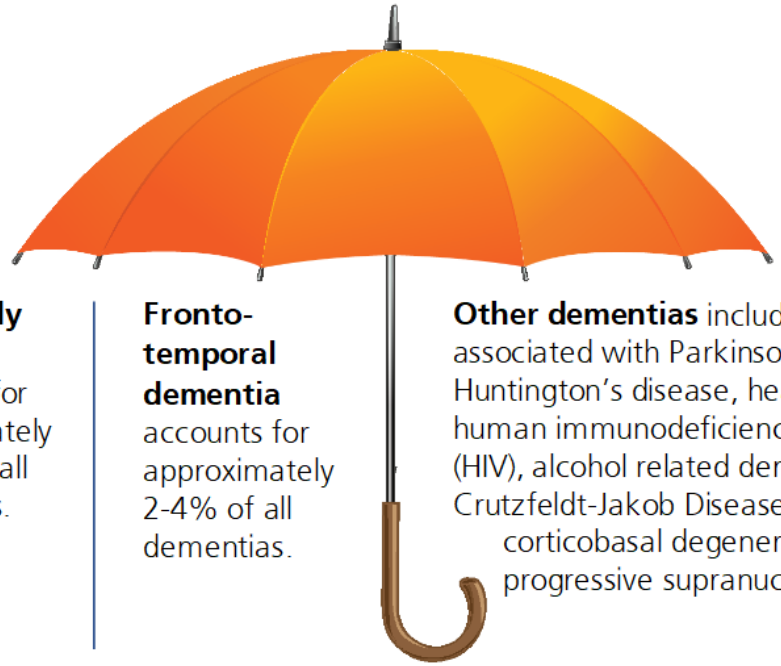
Defining Dementia

Dementia is an umbrella term that describes a collection of symptoms that are caused by disorders affecting the brain. It is not one specific disease. Dementia affects thinking, behaviour and the ability to perform every day tasks, and brain function is affected enough to interfere with the person's normal social or working life. The most common type of dementia is Alzheimer's disease.



Alzheimer's disease is the most common type of dementia, accounting for approximately 40-70% of all dementias.

Vascular dementia is the second common type of dementia, accounting for approximately 15-25% of all dementias.



Lewy body dementia accounts for approximately 2-20% of all dementias.

Fronto-temporal dementia accounts for approximately 2-4% of all dementias.

Other dementias include dementia associated with Parkinson's disease, Huntington's disease, head trauma, human immunodeficiency virus (HIV), alcohol related dementia, Crutzfeldt-Jakob Disease, corticobasal degeneration and progressive supranuclear palsy.

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Mild Cognitive Impairment

- significant memory loss compared with peers
- could be another cognitive domain such as executive function or language
- no loss of function

"Cognition for monitoring" as up to 10 - 15% may progress to dementia each year

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Alzheimer's Association. 2022 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2022;18

Impact of dementia

2023 - **more than 400,000 Australians** living with dementia.

2058 - ≈ **800,000 Australians** living with dementia

2nd leading cause of death overall 2018-19 - $3 billion Cost to Australia directly for dementia

≈ **1 million** people care for a relative or friend with dementia

Younger onset and higher rates of diagnosis in our indigenous population

2nd leading cause of burden of disease in Australia BUT leading cause of burden **for women** as well as for **Australians aged 65 and over**

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Australian Institute of Health and Welfare (2022) Dementia in Australia, AIHW, Australian Government, accessed 20 January 2023.

Impact of dementia on women

- Women are twice as likely to be diagnosed with dementia than men
- Women often diagnosed later and have a faster decline
- Leading cause of death and disability for women
- Women do most of the care of people with dementia

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Why talk about dementia ?

Dementia is:

- Under diagnosed
- Poorly understood
- Not just one person’s disease
- A social and medical issue
- Has a trajectory that can assist better understanding and management
- Is a terminal illness

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Demystifying Dementia: Introducing the Domains and Stages

Domains of Dementia Framework

1. Cognitive decline
    - gradual onset
    - worsening STM
    - decline in attention, concentration, insight
2. Functional decline
    - loss of ADLs, hobbies and responsibilities (cooking, banking)
    - look for change over time
3. Psychiatric symptoms
    - depression and/or anxiety
    - delusions: money and infidelity
    - hallucinations
4. Behaviour changes
    - short tempered
    - withdrawal
    - vagueness
5. Physical decline
    - often late
    - decline in walking, swallowing, continence

Stages of dementia

Stage 1: Still at home

- Short-term memory loss with repetitive questions
- Loss of interest in hobbies and previously enjoyable activities
- Impaired instrumental functions

Stage 2: Escalating care needs, transitioning to 24 hour care

- Progression of cognitive deficits
- Declining function
- Behaviour changes

Stage 3: Diminishing quality of life

- Increasing loss of independence: dressing, feeding, bathing
- Responsive behaviours
- Physical decline

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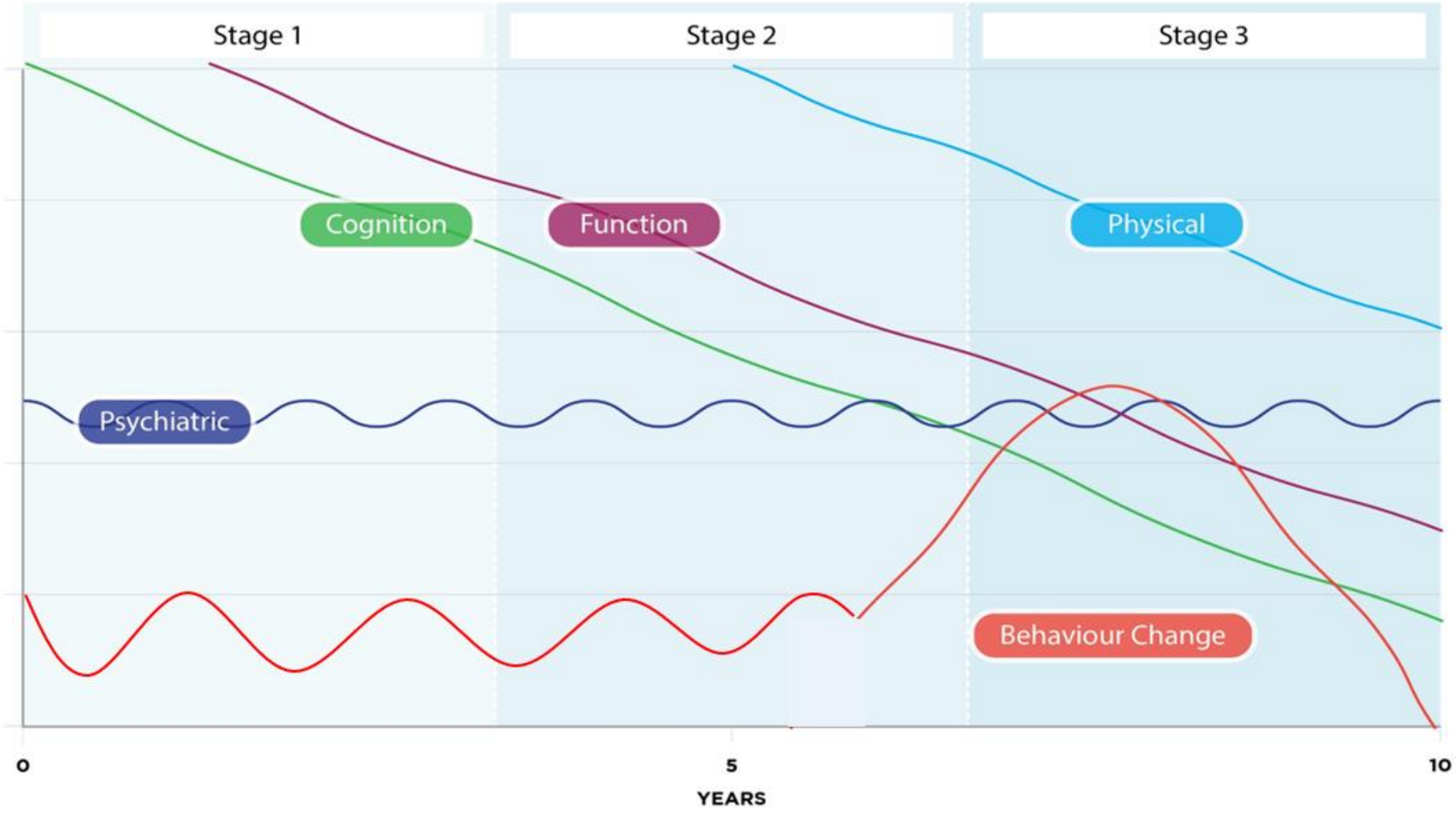
Stages and domains of Alzheimer's dementia



How might a person with dementia be identified in primary care ?

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Barriers to a diagnosis ?

People living with Dementia and their carers

Lack of Information

Stigma

Lack of diagnostic test

Lack of access to healthcare

Clinicians

Lack of post diagnostic support

Lack of education on Dementia

Lack of diagnostic pathway

Professional Nihilism – what's the point?

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Consequences of not making a diagnosis

- Failure to intervene symptomatically
- Failure to provide assistance for functional problems
- Missed opportunities
  - Medications and other interventions to slow progression
  - Power of Attorney
  - Will
  - Substitute decision maker
  - Advance Care Planning
- Dangerous decision making
- Struggling families, misunderstanding

Demystifying Dementia: Risk Reducation

Brain health

"Contributions to the risk and mitigation of dementia begin early and continue throughout life, so it is never too early or too late" Lancet Commission 2020

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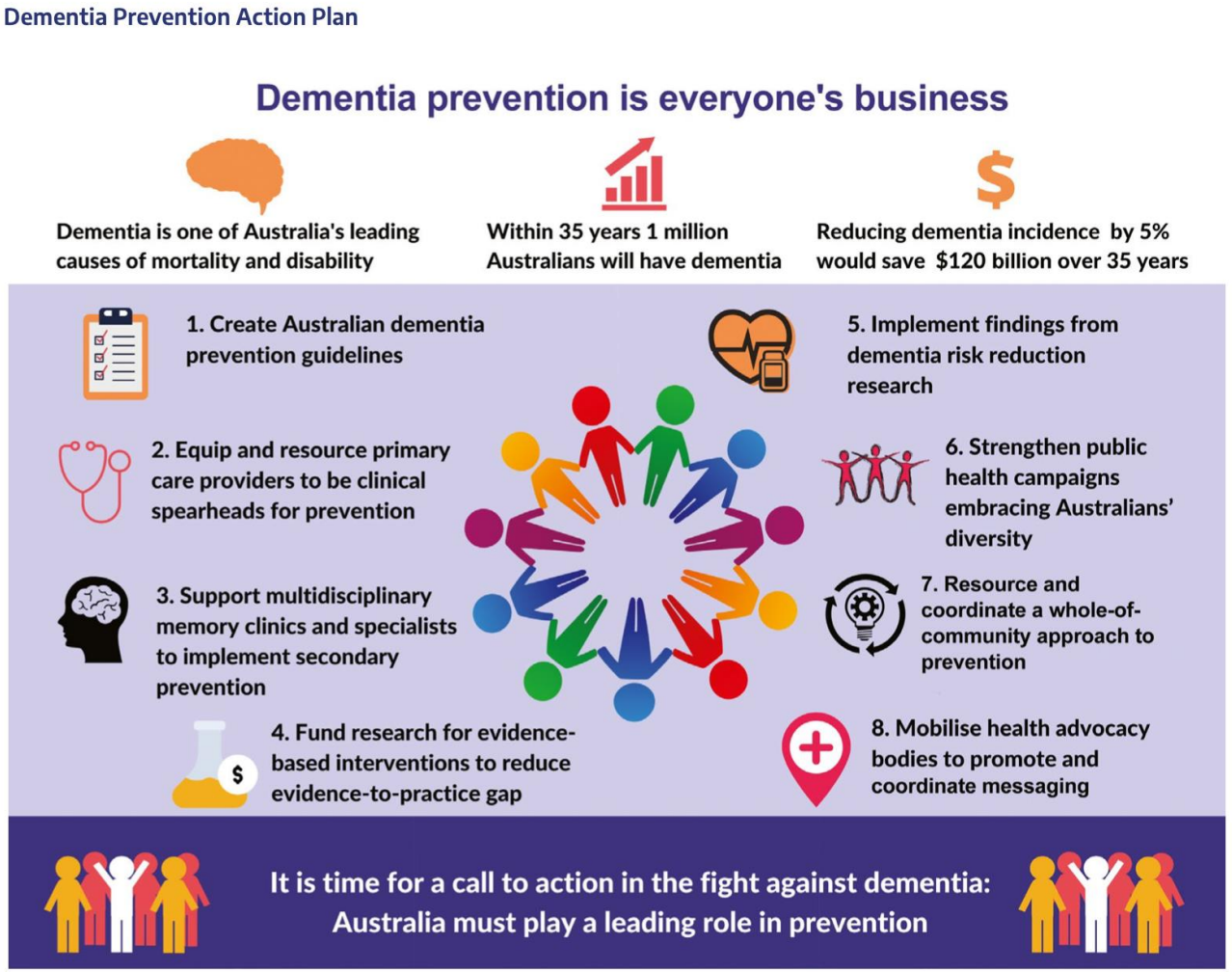
MJA - Dementia Prevention Action Plan



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What is a brain health check ?

Any opportunity to:

- promote and optimise an individual's brain health at any age
- identify patients at risk of dementia, specifically in midlife
- utilize an evidence-based tool to establish any personal risk factors that can be modified to reduce overall risk of, or delay the onset of dementia
- engage in motivational interviewing/shared decision making to assist an individual to reduce their risk of dementia

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Opportunities within MBS

- No specific MBS item numbers
- >30 years: Heart Health Checks
- **45-49 year: can provide an opportunity to perform a brain health check**
- 40-49 year: Individuals, if at high risk of Diabetes type 2 ,may undergo risk evaluation
- >75 year: Annual health assessments
- Annual health assessments
  - Aboriginal and Torres Strait Islander
  - RACF
  - Living with an intellectual disability

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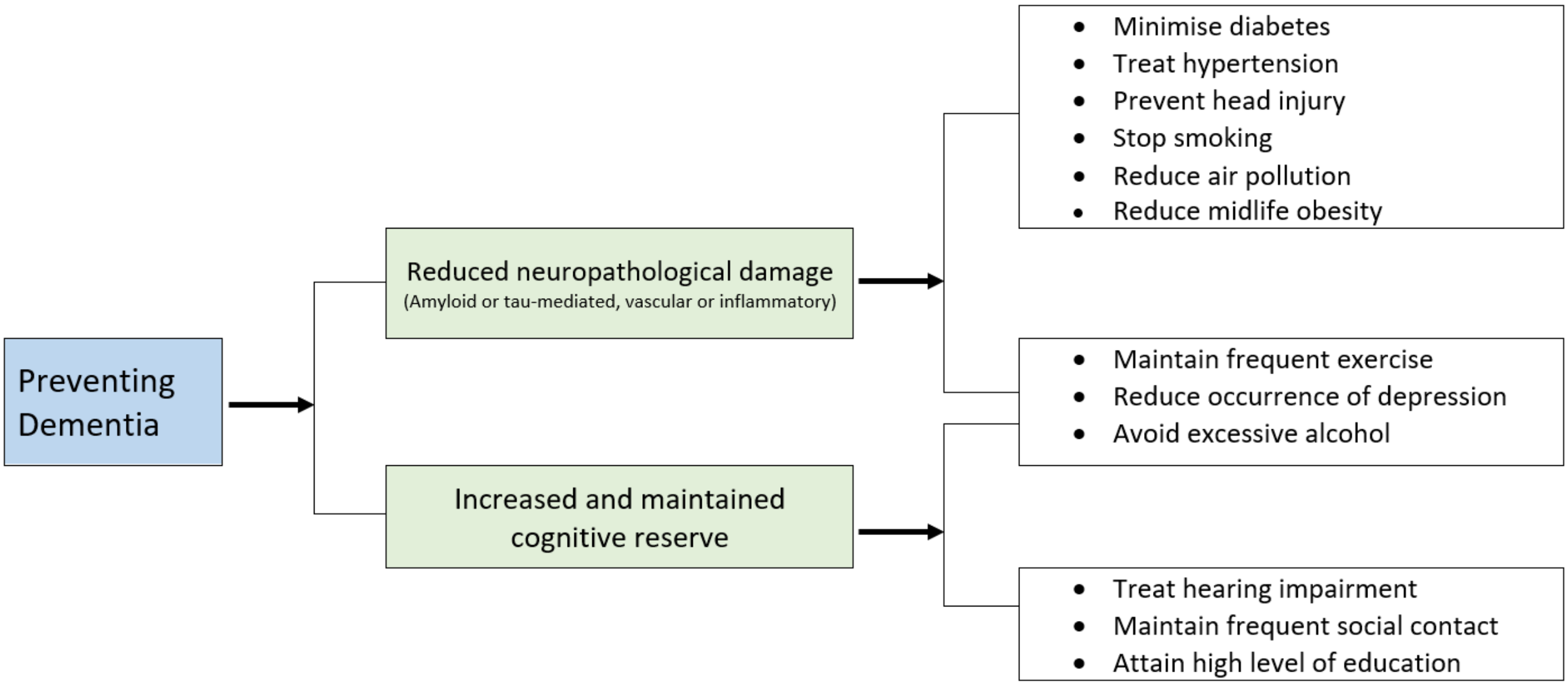
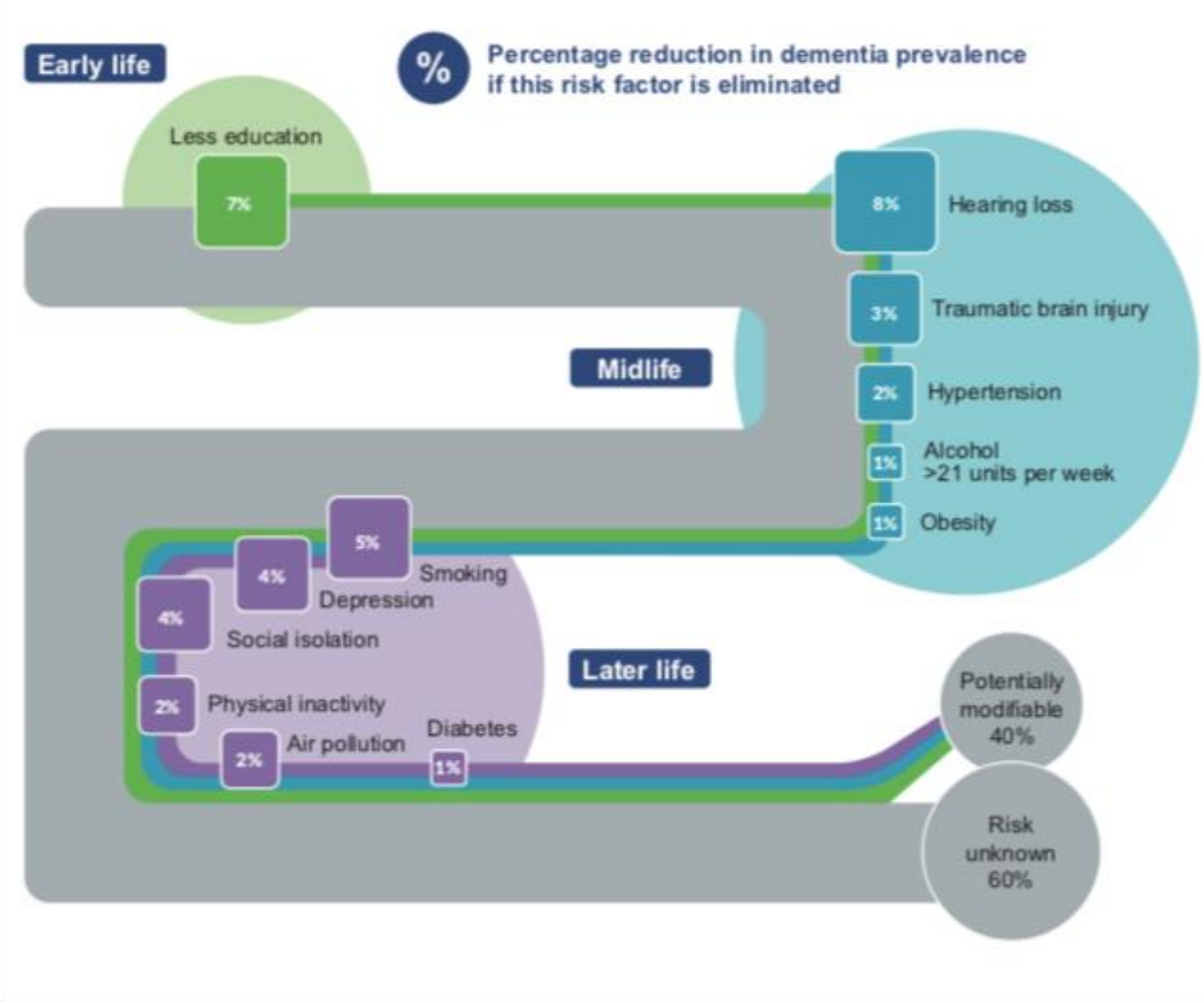
45 – 49 year health assessment

- A patient at risk of developing a chronic disease, is a clinical judgement made by the GP
- At least one risk factor must be identified
- Risk factors may include, but are not limited to:
  - lifestyle risk factors - smoking, physical inactivity, poor nutrition and/or alcohol use
  - biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight (blood biomarkers?)
  - a family history of a chronic disease.


Preventing Dementia
Reduced neuropathological damage
(Amyloid or tau-mediated, vascular or inflammatory)
Increased and maintained cognitive reserve
Minimise diabetes
Treat hypertension
Prevent head injury
Stop smoking
Reduce air pollution
Reduce midlife obesity
Maintain frequent exercise
Reduce occurrence of depression
Avoid excessive alcohol
Treat hearing impairment
Maintain frequent social contact
Attain high level of education

12 modifiable risk factors



- Early life <45
- Mid life 45-65
- Later life >65
- 40% cases worldwide

- Non-Modifiable: Family history/genetics
- (sex and gender)

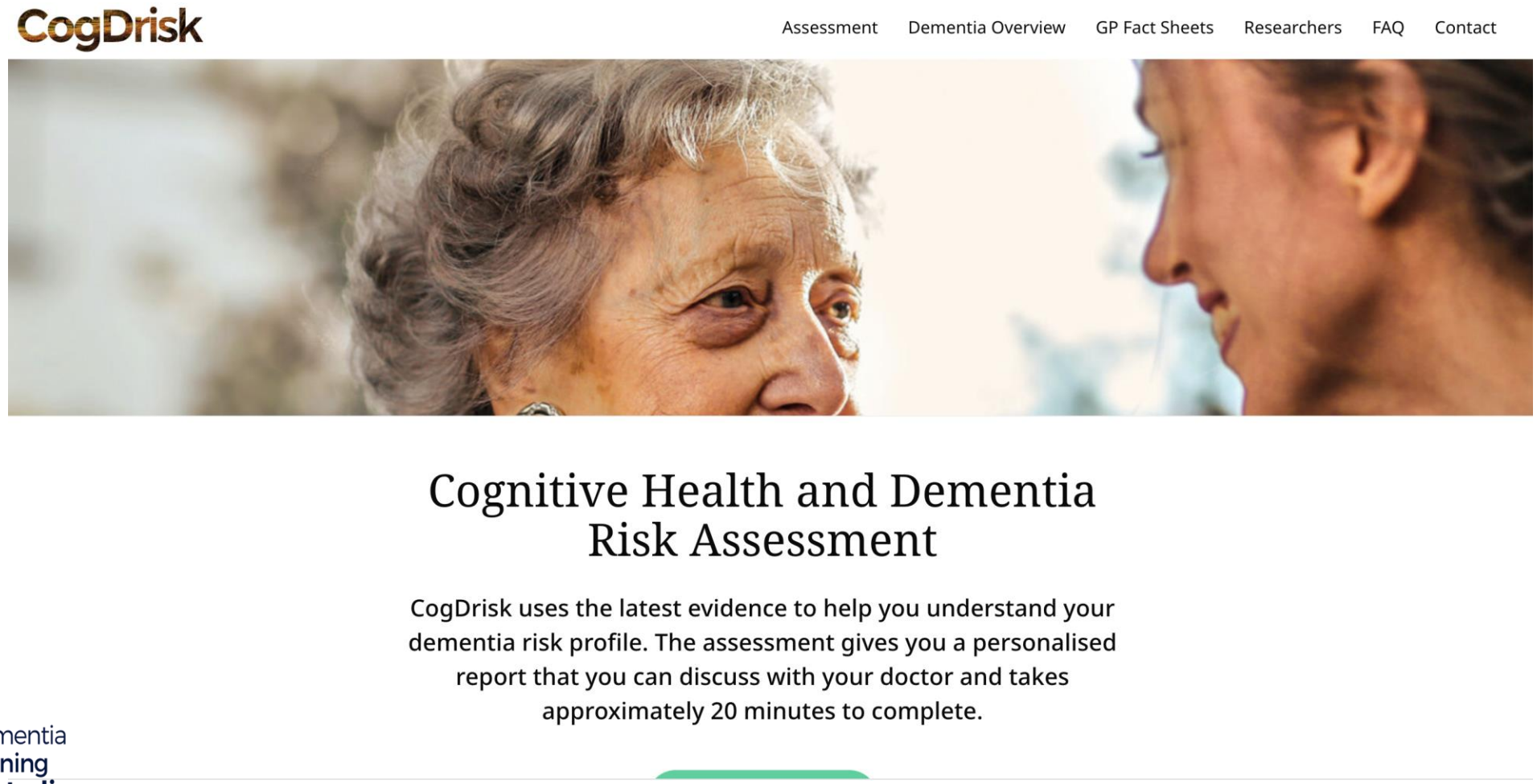
Brain health check in 45-49Health Assessment

- Opportunity to talk about dementia prevention
- Early education
- Hearing loss
- Hypertension
- Traumatic Brain Injury
- **Obesity**
- Alcohol
- Diabetes
- Depression
- Air pollution
- Social isolation
- Smoking
- **Physical activity**
- Sleep, Diet

Dementia risk reduction strategies target:

- Population
- Individual

If you identify anyone at risk ?



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Personalised Risk Profile

Here is your personalised risk profile based on your answers from the assessment. Factors in bold are your identified risk factors. Click on each risk factor to see recommended strategies to reduce your risk of developing dementia. You can also click on the other factors (no risk) to learn how to maintain good health and continue your healthy lifestyle habits.

Demographics & Environment

Education

Pesticides

Lifestyle habits & diet

Alcohol Intake

Cognitive Engagement

Fish Intake

Physical Activity

Smoking

Social Engagement

Medical

Atrial Fibrillation

Body Mass Index

Cholesterol

Depression

Diabetes

Hypertension

Insomnia

Stroke

Traumatic Brain Injury

PREVIOUS

EXIT

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CogDrisk

PERSONALISED DEMENTIA RISK ASSESSMENT

Date of Assessment: 2023-05-20

Congratulations on completing the dementia risk assessment!

Your CogDrisk dementia score is 15.25

The risk score has been developed using an evidence-based approach (see notes). The risk score ranges from 0 to 36.25, with a higher score indicating higher risk.

Below is your personalised report based on your current health and lifestyle factors.

	Keep up the good work! You reported:	Room for improvement You reported:
Demographic factor		✗ Your highest qualification was secondary education
Medical risk factors	✓ Normal cholesterol level	✗ Your weight is in the overweight range
	✓ No diabetes	✗ Having hypertension
	✓ No brain injury	✗ Having depressive symptoms
	✓ No prior stroke	
	✓ No atrial fibrillation	
	✓ Good levels of sleep	
Lifestyle habits and diet	✓ High levels of cognitive engagement	✗ Low levels of physical activity
	✓ High levels of social engagement	✗ Eating fish less than once a week
	✓ You do not smoke	✗ Being a heavy drinker

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Helpful fact sheets

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Demystifying Dementia: Diagnosis

Framework for diagnosis of Alzheimer's & Vascular Dementia

Four Inclusion Criteria:

1. Gradual onset of poor memory
2. Worsening of memory problem
3. Failure of function
   - Look for change in function over time (driving, banking, use of tools)
   - Ask about ADLs (cooking, gardening, hobbies)
4. Cortical dysfunction – dysphasia, agnosia, dyspraxia
   - Dysphasia: impairment in language fluency (naming animals, or words starting with letter P)
   - Agnosia: inability to name a person or object
   - Dyspraxia: a disorder of motor skills, coordination and planning (ask patient to brush teeth, brush hair, test for Dysdiadochokinesia, draw a clock face)

(for vascular dementia, add neuro sign or CT evidence of vascular incidents)

Framework for diagnosis of Alzheimer's & Vascular Dementia

Three Exclusion Criteria

1. Delirium:
   - acute onset that resolves, consider reduced cognitive reserve
2. Other organic cause:
   - metabolic, endocrine and brain
   - use Ix to help exclude
   - don't forget AOD and medications
3. Psychiatric illness:
   - depression
   - anxiety
   - Psychotic

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Based on work of Dr Jane Tolman, geriatrician, Hobart

Diagnosing Dementia

- History – 80%
- Examination- 10%
- Investigations- 10%

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Let’s meet Anna

Anna is 75

She lives alone

Attends with daughter, Sophie, for her fluvax

PMH - Hypertension, OA knee

Meds - Perindopril, Panadol osteo

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Anna visits her GP for a flu vaccine

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Taking a history and consent for collaborative history

- Which Inclusion Criteria were demonstrated
- What techniques did the doctor use to help identify these issues?
- What else do you think the doctor did well?
- What could he have done differently?
- Why did doctor ask for consent to speak with daughter?

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Taking a collaborative history

- What extra information was discovered through taking the collaborative history?
- What did the doctor do to help gather this information?
- Who was working harder, the doctor or the carer ?

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Physical examination and office tests

- Weight
- Temperature
- BP/Pulse
- Focused neurological examination
- Urinalysis
- Consider ECG
- Cognitive assessment

Cognitive assessment tools

- Who does this in your practice?
- What tools do you use ?
- Why do you use particular tools ?

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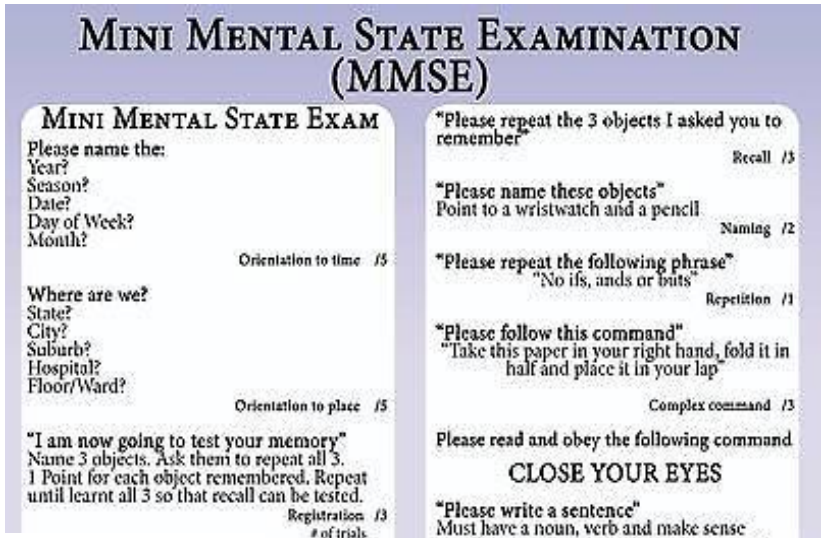
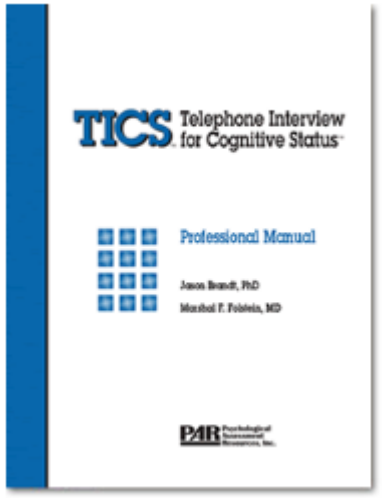
Cognitive assessment tools for dementia





GPCOG

MoCA
MONTREAL
COGNITIVE ASSESSMENT

Investigations

Routine investigations

- Haematology – FBC/ESR/CRP
- Biochemistry- EUC, LFT, Calcium, Glucose
- TFT
- Vit B12, folate
- CT Brain without contrast

Recommended or if indicated investigations

- Fasting lipids
- Urine MCS
- ECG
- CXR
- Syphilis
- HIV

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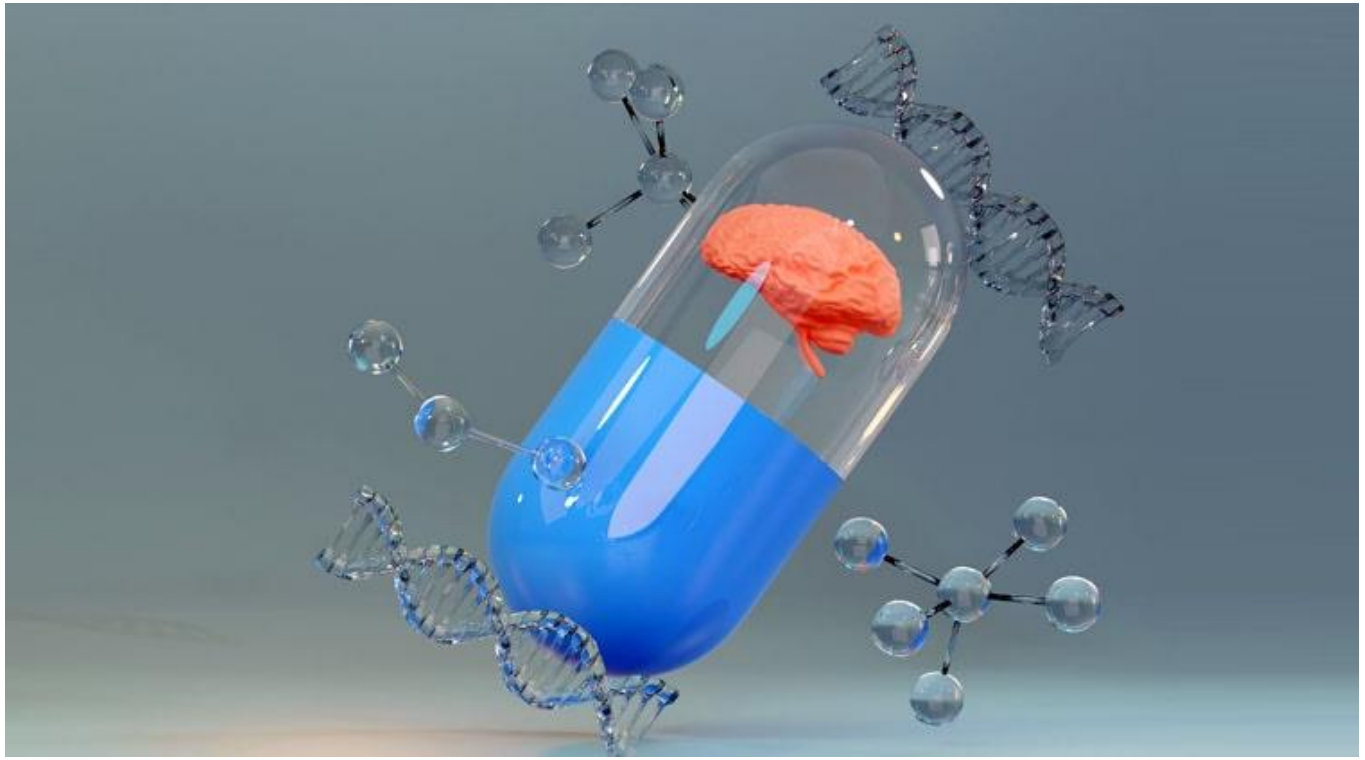
What about newer diagnostic tests ?

- Blood Biomarkers
- MRI
- Pet scans



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Anna and Sophie return for results

- Examination normal for age
- Blood tests and CT brain normal for age
- MMSE score 23
- Dysphasia and agnosia present
- Geriatric depression score normal

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Anna met the Four Inclusion Criteria for a diagnosis of Alzheimer's Dementia

Four Inclusion Criteria:

1. Gradual onset of poor memory – **memory poorer than previously**
2. Worsening of memory problem **– increasingly forgetful, getting worse**
3. Failure of function **– gardening, cooking, socialising**
4. Cortical dysfunction – **dysphasia**, **agnosia**, **dyspraxia**

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Anna had none of the Exclusion Criteria

Three Exclusion Criteria:

1. Delirium
2. Other organic cause and /or drugs
3. Psychiatric illness

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Offering the (gift of a) diagnosis

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Offering the (gift of a) diagnosis

- What do you think Dr George did well ?
- What do you think he could have done differently ?
- What would you have done differently ?

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Demystifying Dementia: Post Diagnostic Support

Importance of a post diagnostic pathway

"A dementia diagnosis often leaves the individual and their family carers devoid of information, specifically about how it may progress, and how to manage its related everyday challenges "

World Alzheimer's report 2022, p. 29

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Stages of dementia – Goals of care

Stage 1: Still at home - Goal of care

- Dignity through maintaining independence and enjoyment

Stage 2: Escalating care needs - Goal of care

- Dignity through keeping safe

Stage 3: Diminishing quality of life - Goal of care

- Dignity through providing comfort

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Stage 1 Management: Maintain dignity through independence and enjoyment

1. Cognition
2. Function
3. Psychiatric illnesses
4. Behaviour
5. Physical decline

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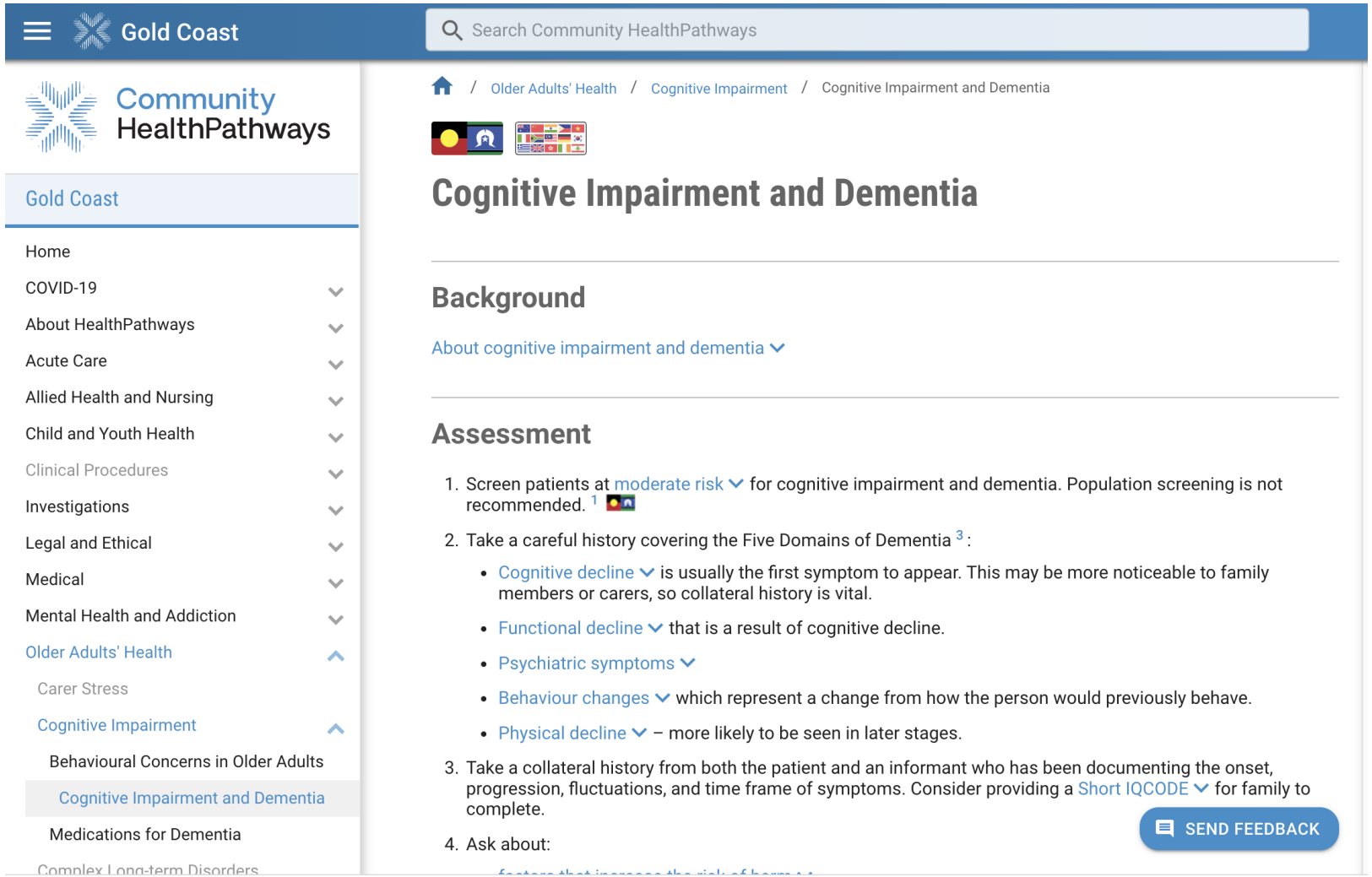
Gold Coast HealthPathways



Anna has just been diagnosed with Dementia

Anna is 75

She lives alone

Attends with daughter, Sophie, for her fluvax

PMH - Hypertension, OA knee

Meds - Perindopril, Panadol osteo

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Anna met the Four Inclusion Criteria for a diagnosis of Alzheimer's Dementia

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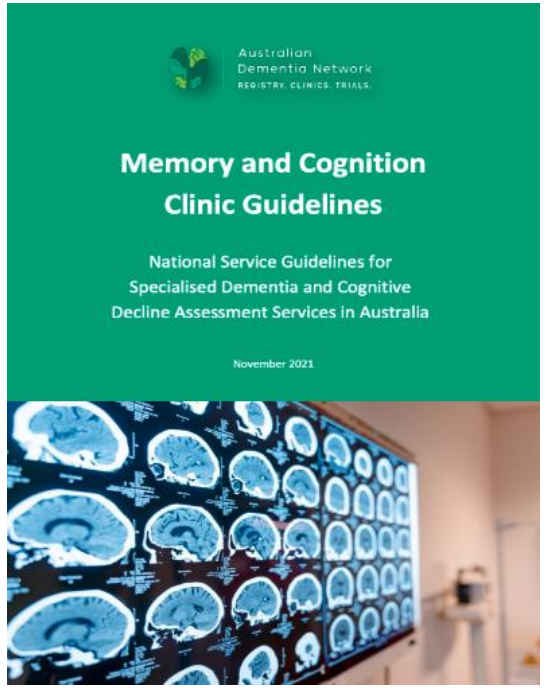
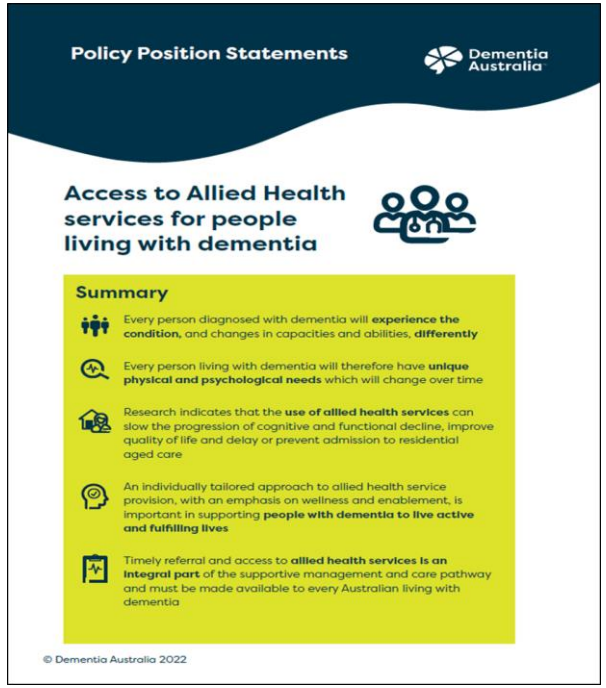
The right to rehabilitation

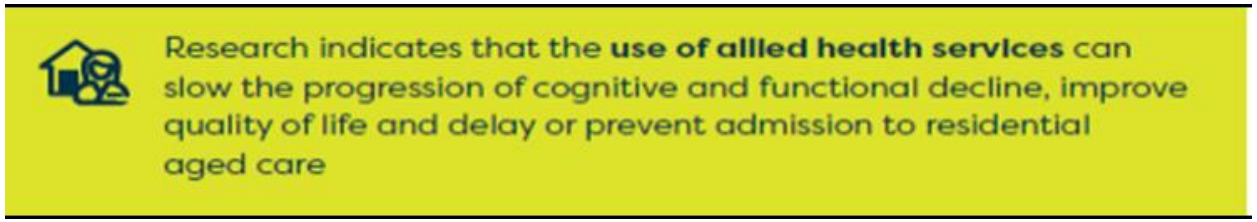
Rehabilitation: “a set of interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment” (World Health Organisation)





- Improve, maintain or slow loss of function
- Maintain independence and safety
- Maintain meaningful activities and relationship

“as much as possible continue to do - rather than do for”

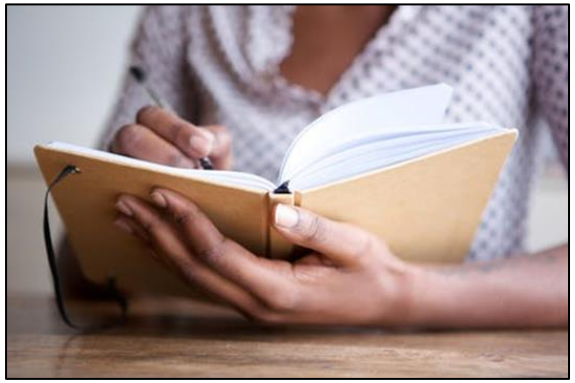


What does this look like?

- Being mentally, socially and physically active
- Cognitive training/stimulation
- Therapies to maintain meaningful activities and relationships
    - Strategies to support cognition, communication and function
    - Aides, technology and modifications to the environment
    - Supporting families and care partners

REFERALS

- Person-centred and goal based
- Private, NDIS, MyAged care, community health, community rehab
- HealthPathways, Allied health professional association websites



Group Activity- Anna Stage 1

- 5 groups
- 1 Domain each
- Discuss what you would/could offer for Anna in each of the domains
- Feedback to group

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What can be done to help support Anna's cognition?

Problems	Actions
• Forgetfulness • Short term memory loss • Repetitive questioning • Mild word finding issues • Difficulty with planning and sequencing	• Medication review • Cholinesterase Inhibitors • CVS risk reduction • Education (including carers) • Legal affairs • Advance Care Planning Occupational Therapist • understand interests, support mentally stimulating activities, skill training and memory strategies Physiotherapy/Exercise Physiology • risk reduction and social connection Speech Pathology • communication skills and strategies

Medications for dementia

Cholinesterase Inhibitors

- Donepezil (Aricept), Rivastigmine (Exelon), Galantamine (Reminyl)
- PBS criteria: MMSE ≥10, in consultation with or specialist confirmed diagnosis
- May provide modest benefit in cognitive function, apathy, behaviour
- SE: GI upset (10%), heart block, asthma

Medications for dementia

NMDA receptor antagonist - Memantine (Ebixa)

MMSE 10-14

Provides modest benefit in:

- reducing carer requirements,
- may delay going to a NH
- limited benefit in cognition

Side effects: confusion, dizziness, drowsiness, headache, insomnia, agitation, hallucinations

Can be used in combination with Cholinesterase Inhibitors (1x private script)

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Medication review and Anticholinergic load

ACUTE	CHANGE	IN	M(ental) S(tate)
Antiparkinsonian **C**orticosteroids **U**rologic (antispasmodics)[1] Theophylline **E**mesis (antiemetics)	**C**ardiac (antiarrhythmics) **H**2 blockers (cimetidine) **A**nticholinergics **N**SAIDs **G**eropsychotropic **E**toh	**I**nsomnia medications **N**arcotics	**M**uscle relaxants **S**eizure medications

[1]**U**rologic (antispasmodics) such as oxybutynin or tolterodine

[2]**G**eropsychotropic medications (such as antidepressants, antipsychotics, sedatives)

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STOPP START Toolkit
Supporting
Medication Review

An evidence based approach to prescribing in the elderly

STOPP:
Screening Tool of Older People's
Potentially
Inappropriate Prescriptions

START:
Screening Tool to Alert Doctors to
Right
(i.e. appropriate, indicated)
Treatments

Colour Key

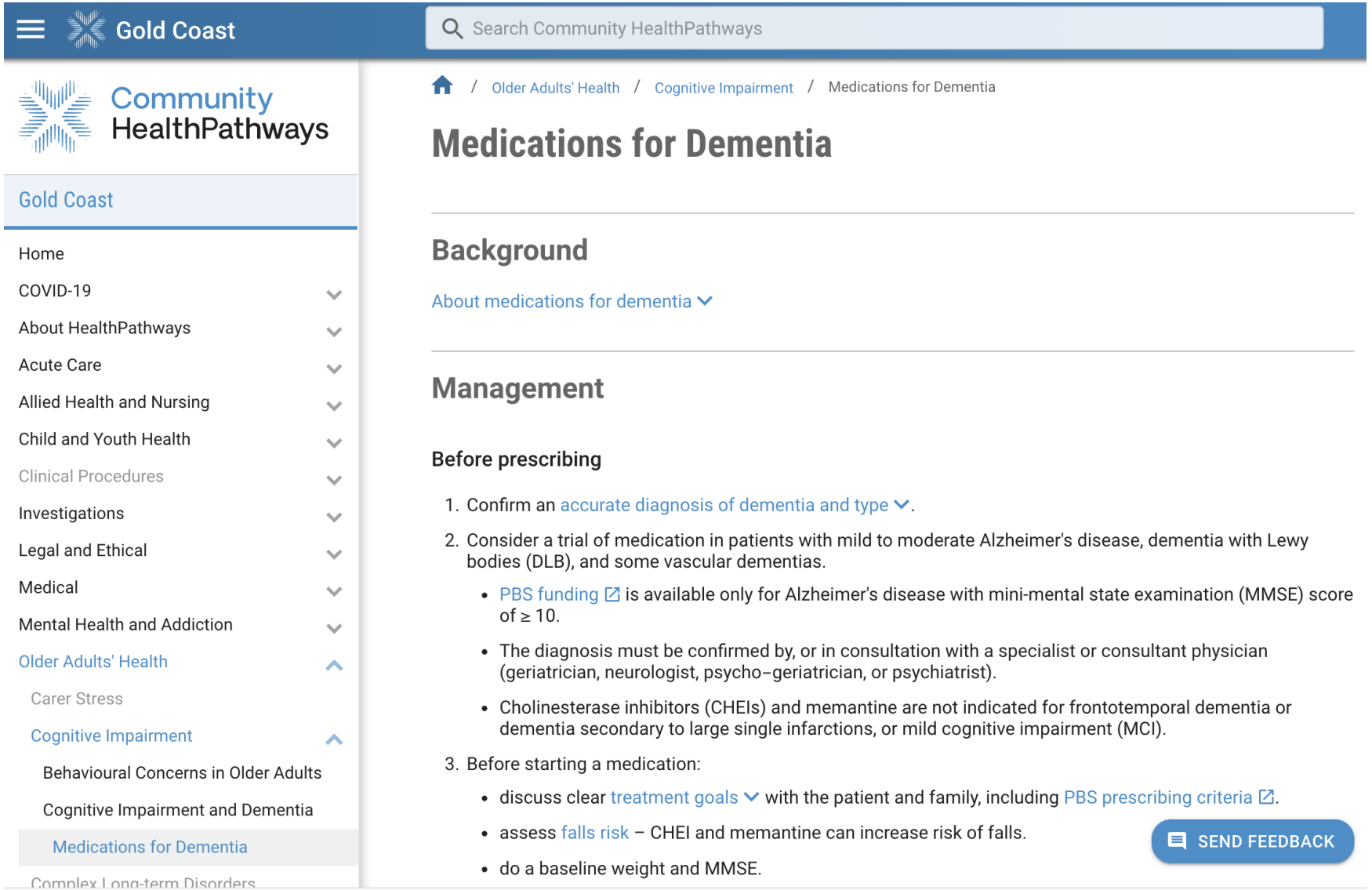
Medication to consider stopping in patients over 65 from the STOPP Tool[1]

Medication to consider starting in patients over 65 from the START Tool [1]

National and local guidance e.g. NICE Guidelines[5]

https://geri-em.com/wp-content/uploads/2013/05/STOPP_START-criteria.pdf

Gold Coast Health Pathways



How can we help with reduced function?

Problems	Actions
• Trouble with cooking • Reduced activity in garden • Missing pills • Safety in the house • Driving? • Socially withdrawn	**OT** to help with: • Adaptation of environment – reduce clutter, group ingredients, contrasting plates/cups, labelling cupboards • Task break down and simplification • Safety – safety cut of switch on stove • Assistive technologies and strategies – pill dispenser, reminders, calendars, google home pod • Carer education to provide support but facilitate to maintain independence • Support and strategies to return to social activities • Driving assessment **Physio/OT**: Raised garden beds; **physio** for OA knee and mobility; gardener for larger jobs

Driving and dementia

- It’s complicated!
- Have the conversation early
- Minimum: conditional license as per Australian Fitness to Drive guidelines
- Get advice if needed

(reporting state based)

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Driving and dementia

MMSE not a good predictor of driving

- However if MMSE <20 then generally should not be driving

Evidence based tests:

- Trail Making Tests A and B
  - *Tests processing speed, visuospatial and executive assessment*
- Clock drawing test
  - *Tests visuospatial and executive function*
- Intersecting pentagons
  - *Tests visuospatial function*

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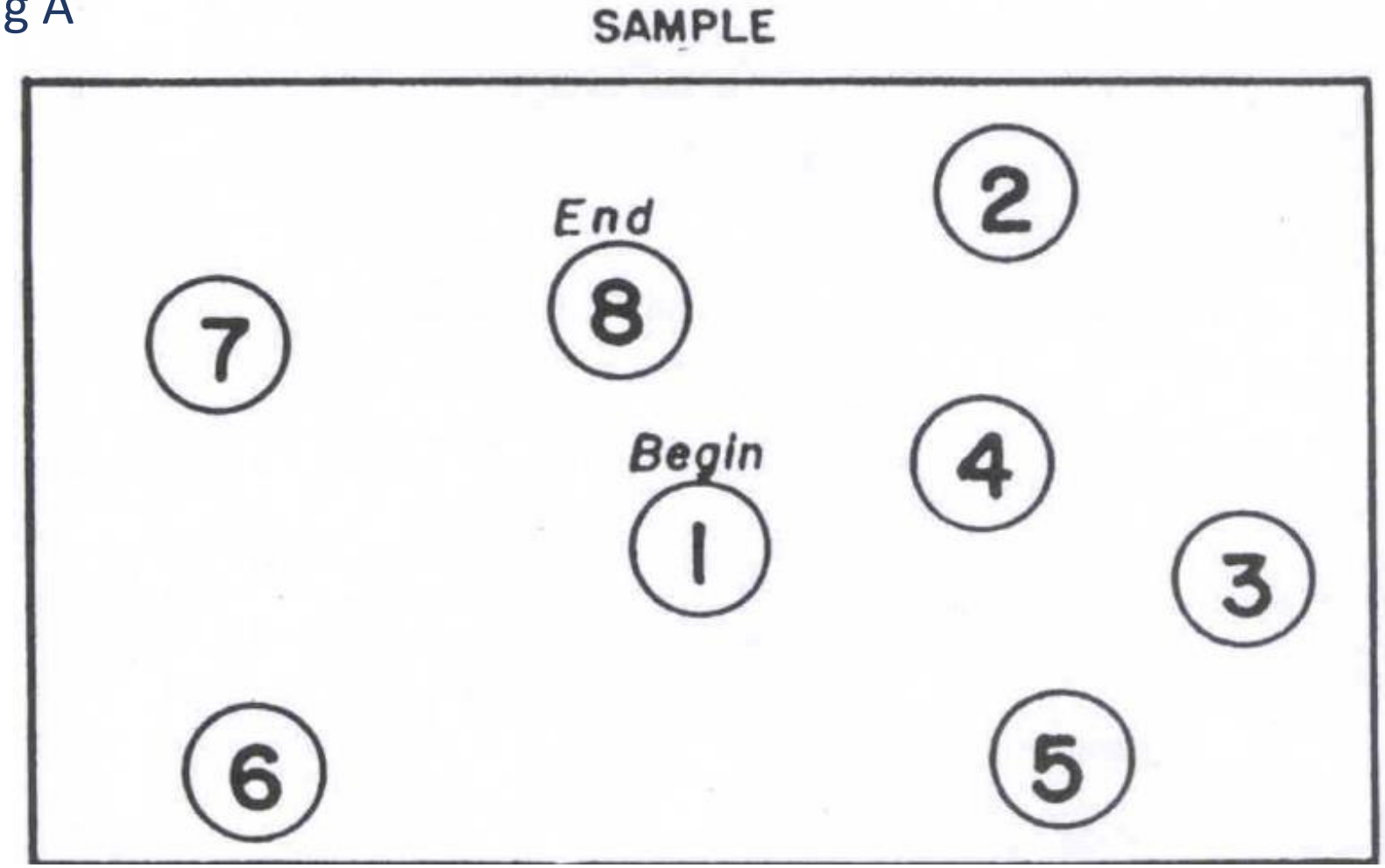
Driving and Dementia

Trail Making A



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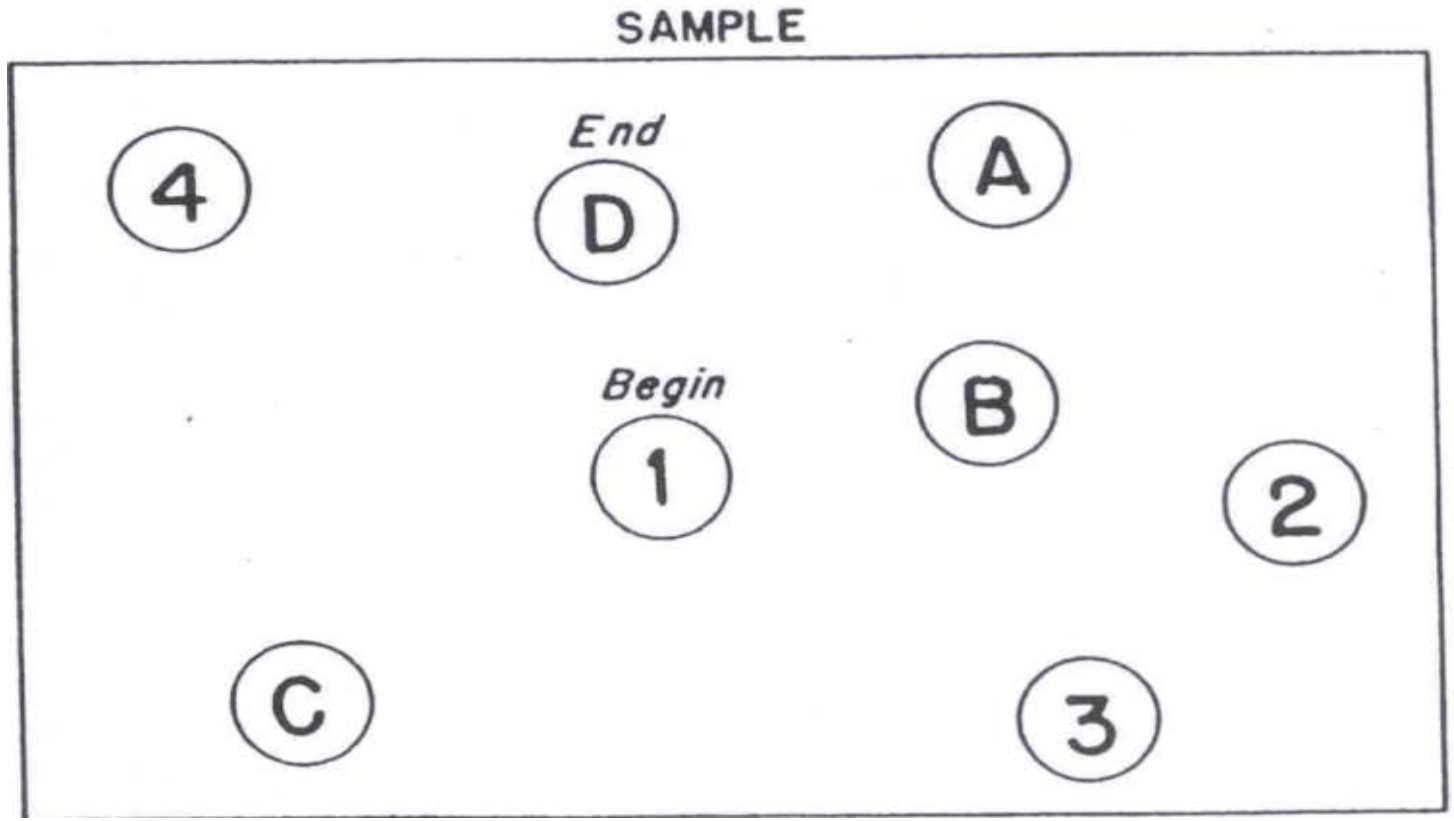
Driving and Dementia

Trail Making B



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Driving OT assessment

- Rehabilitation opportunity
- Comprehensive
- Off road assessment initially- safer
- Car safety

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Drive Safe Drive Aware

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What about the psychiatric domain?

Problems	Actions

• Depression
• Anxiety
• Hallucinations
• Delusions
	• Mental Health Screening: for person living with dementia and carers
	• Consider MHCP for both PLWD and Carer
	• Treat any coexisting psychiatric conditions and re-evaluate
	  ▪ Psychologist/Counsellor – for adjustment disorder/depression anxiety – via a MHCP
	  ▪ Prescribing antidepressants
	• Delirium action plan
	• Ongoing family education
	• Support to engage in social/stimulating activities

Mid & North Coast HealthPathways

Delirium action plan

Delirium is a sudden inability to think clearly and pay attention. It is common among older people. Delirium can be a sign of a serious underlying medical problem. **If you notice any sudden changes, think of a delirium episode.** Prompt medical attention may help to prevent a hospital admission.

What to look out for

Delirium can develop quickly, usually over hours or days. A person with delirium may:

- [ ] become confused and forgetful
- [ ] become unable to pay attention
- [ ] become different from their normal selves
- [ ] become either very agitated or quiet and withdrawn
- [ ] become unsure of the time of day or where they are
- [ ] have garbled or confused speech
- [ ] have difficulty following a conversation
- [ ] have changes to their sleeping habits, such as staying awake at night and being drowsy during the day
- [ ] see or hear things that are not there, but which are very real to them
- [ ] lose control of their bladder or bowels

What causes delirium?

Delirium can have many causes. Most commonly it is caused by:

- infection
- constipation
- dehydration
- strong pain
- medicines

Further advice?

healthdirect 1800 022 222

Speak to a registered nurse or doctor 24 hours a day, 7 days a week to get health advice you can trust. This is a free service.

What can family and carers do?

If you notice signs of delirium call the patient's GP immediately and tell the practice you suspect delirium and request an urgent appointment that day.

Patient contacts

GP name

GP practice

Phone

Local hospital

Other family/contacts

Once the person has appropriate medical care, you can still help care for them.

- Encourage and assist someone with delirium to have enough food and fluids.
- Knowing the time of day can reduce confusion. Remind the person where they are, and what day and time it is.
- It is reassuring for people with delirium to see familiar people. Visit as often as you can and try to be available to help with their care.

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How can we help with behaviours?

Problems	Actions

• Agitation
• Frustration
• Apathy
• Social isolation
	• Occupational Therapist
	  ▪ Problem solving why and working with care partner on skill training and strategies
	  ▪ Meaningful activities/social engagement
	  ▪ Maintaining a routine
	• Speech Pathology
	  ▪ communication tools & aids
	• Day respite
	• Education- person living with dementia & carers

Anna's physical decline?

Problems	Actions

• Changes to mobility, balance, coordination	Physiotherapist/Exercise Physiologist
	• Mobility changes can occur early (can be predictive)
	• In stage 1 can build reserve, prevent falls and frailty and maintain ADL's
	• Additional benefits include maintain cognition, mood and sleep
	GP
	• Health assessment (over 75)
	  ○ Medication review
	  ○ Optimise CVS risk factors
	  ○ Vision
	  ○ Hearing
	  ○ Dental check

GP Management Plan: Stage 1 Dementia

DOMAIN	PATIENT PROBLEM	TREATMENT/SERVICES/PATIENT & FAMILY ACTION	ARRANGEMENTS FOR TREATMENTS/SERVICES
Cognition	Forgetfulness Short-term memory loss Repetitive questions	Cardiovascular Risk assessment and management Medication Acetylcholinesterase inhibitors Legal issues such as POA Advance Care Directive Family Education	Dementia Australia Forward with Dementia Practice Nurse – education on dementia General Practitioner Speech Pathologist – language issues Consider use of practice recall/reminder system
Function	Impaired instrumental functions	Family education Encourage maintenance of skills Support with cooking/meal prep Support to attend usual activities Maintain social interaction Driving assessment Home hazards assessment	Dementia Australia Practice Nurse General Practitioner My Aged Care/Care package Dementia outreach service Occupational therapist / OT driving assessment
Psychiatric	Depression Anxiety Hallucinations Delusions Paranoia	Screening of mental health in patient Screening for mental health issues in carers Family education	Practice Nurse General Practitioner Psychologist MHCP Social worker Carer support groups Dementia Australia Dementia Support Australia
Behavioural	Social withdrawal Frustration	Increased social engagement Family education	Practice Nurse General Practitioner Consider family meeting: 3 – 6 monthly Dementia outreach service Dementia Australia – online resources Dementia Support Australia
Physical	Failure to maintain physical health care needs	Home medication review Reduction in cardiovascular risks, as appropriate Exercise assessment Hearing assessment Dental review Continence assessment Falls assessment Immunisation – influenza, pneumococcus, herpes, zoster Family education	Practice Nurse General Practitioner - Consider use of practice recall Pharmacist Community dietician Podiatrist Optometrist Audiologist Exercise physiologist Physiotherapist Occupational Therapist

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Stage 2 - Dignity through safety

1. Cognition
2. **Function**
3. Psychiatric illnesses
4. **Behaviour**
5. Physical decline

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Stage 2 - Further reduced function?

Problems	Actions	Resources
Impaired instrumental functions Impaired functions of daily living	Home hazards assessment Hobbies/Community involvement Addressing basic needs – clothing, food, hygiene Communication strategies and aides Family/care partner education Facilitation of transition in to care Collaboration between care staff/family/GP	Dementia Australia Practice Nurse General Practitioner My Aged Care/Care package- level of support Occupational Therapist Community physiotherapy/OT/SP/Social Work Personal Alarm/GPS tracking support Home help Meals Service Travel assistance - taxi voucher Respite Care arrangements

Stage 2 - More complex behaviours?

Could it be delirium or a biological cause?
Could it be depression or a psychiatric cause?
Could it be an environmental trigger?

Or could it be a combination of the above?

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Stage 2 - More complex behaviours?

Problems	Actions	Resources
Social withdrawal Apathy Repetitive questioning shadowing Frustration Sleep disturbance Wandering Hoarding	Carer education and increased support Routine Increased social engagement Facilitation of transition in to care Collaboration between care staff/family/GP	Practice Nurse General Practitioner Family meeting – 3 monthly Dementia outreach service Dementia Australia Dementia Support Australia Respite Care arrangements

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COVID-19
About HealthPathways
Acute Care
Allied Health and Nursing
Child and Youth Health
Clinical Procedures
Investigations
Legal and Ethical
Medical
Mental Health and Addiction
Older Adults' Health
Carer Stress
Cognitive Impairment
Behavioural Concerns in Older Adults
Cognitive Impairment and Dementia
Medications for Dementia
Complex Long-term Disorders
Depression in Older Adults
Elder Abuse and Neglect
Falls Prevention in Older Adults
Frailty in Older Adults
Unexpected Deterioration in an Older Adult

Background

About behavioural concerns in older adults

Assessment

1. Take a history from the patient, their family, and/or carers if appropriate. Ask about:
   - behaviours of concern.
   - psychological issues.
   - medical issues.
   - impact of symptoms on the patient, family, and carers. Consider using The Neuropsychiatric Inventory Questionnaire.
   - the patient's social, cultural, and religious norms.
2. Identify social and environmental factors.
3. Perform examination:
   - Check vital signs – temperature, pulse, respiration, blood pressure, and oxygen saturation.
   - Perform thorough physical examination.
   - Assess for pain.
   - Do a urine dipstick.
   - Perform neurological exam, including speech assessment.
   - Perform a Standardised Mini-Mental State Examination (SMMSE) if possible.
4. Consider investigations, but do not delay initial management while waiting for results:
   - FBC, E/LFTs, BSL, vitamin B_{12}, folate, calcium, thyroid stimulating hormone (TSH).
   - Urinalysis and urine microscopy, culture, and sensitivities (MCS). Use caution when interpreting results, as asymptomatic bacteriuria is prevalent in older patients.
5. Consider differential diagnoses:
   - Delirium
   - Anxiety and/or depression – see Depression in Older Adults
6. Assess risk of harm to patient by self or others, and risk of harm to others.
7. Explore the carer's expectations. A reasonable treatment goal is reducing, rather than eliminating, the behaviour.

Get help from Dementia Support Australia

If a person with dementia in your care is experiencing changes to their behaviour that might impact their wellbeing – refer them to us today.

Get help, day or night

Dementia doesn't follow a set schedule – and neither do we. You can contact us 24-hours a day, 365 days a year.

1800 699 799

Make a referral

Sophie needs a break

- Anna’s cognition and function is deteriorating
- Sophie needs to go into hospital for knee surgery
- Dr George does a home visit at Sophie’s request to arrange respite care for Anna

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Carers as patients

- 30% of carers develop depression
- Physical, social and financial burdens
- Behavioural problems the most stressful
- Spouse the most distressed

- Home | Carer Gateway
- Dementia Australia

Dementia Training Australia

Carers as patients

Carers may require

- Education – of the illness, trajectory, impact
- Screening – mental & physical health
- Assistance - respite or transition to RACF
- Strategies – to manage behavioural or cognitive problems

CBT for carer

- Reduces burden of care
- Delays RACF
- Improves skills in managing patient behavioural problems

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Dementia specific support services

Alzheimer's Queensland – Carer Support Programs

Provides information and support for people caring for a friend or family member living with dementia. Available as in-person group program, or telephone support group.

1. Telephone support group – advise the carer to contact the service – 24 hour dementia help line **1800-639-331**.
2. In-person program – advise the carer of program details:
   - Held fortnightly at Southport, Club Musgrave, 104 Musgrave Avenue
   - Bookings are essential – phone **(07) 5613-1844**
   - No cost
   - Only carers can attend. Contact the Multi Service Centre on **(07) 5613-1844** to arrange day respite if required for the care recipient
3. For more information, see Alzheimer's Queensland – Carer Support

Dementia Australia

Provides education sessions and group programs for carers, family members and friends of people living with dementia.

1. Advise the carer to contact the National Dementia Helpline – phone **1800-100-500** (24 hours, 7 days)
2. See information for families and carers:
   - support programs and groups
   - information and ideas
   - education
3. Consider:
   - Help sheets – Caring for Someone with Dementia
   - Counselling support – for people to talk about their feelings and experiences with dementia
   - Dementia Australia Library – print and digital resources about dementia (includes books, articles, audio books, e-books and subject guides.

Dementia Support Australia

Provides help 24/7, 365 days, to carers of people living with dementia, where behaviours are impacting on care.

1. Advise the carer to contact the service:
   - Phone **1800-699-799**
   - Email dsa@dementia.com.au
   - Chat online at www.dementia.com.au

Stage 3 Dignity through comfort

1. Cognition
2. Function
3. Psychiatric illnesses
4. Behaviour
5. **Physical decline**

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Stage 3 – Physical decline

What is affected?

- Eating
- Swallowing
- Continence
- Falls

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Stage 3 - further physical decline

Problems	Actions	Resources
Continence Falls Swallowing Pain Comfort/Warmth Thirst Constipation Urinary Retention	Cease all medications other than those for comfort Nutritional, continence, falls and pain assessments Family education Clear outline for dealing with problems as they arise Plans in place for avoiding transfer to hospital if possible Review advance care plan to reach agreement for end of life care including in the terminal phase	RACF/home care Staff General Practitioner Pharmacist Physiotherapist/OT Family Meeting – 6 weekly or as needed

End of life planning

- Signpost that it will come – gradual decline vs acute event
- Clarify goals of care and document well
- Advanced care planning - consider:
  - Quality of life rather than quantity
  - Remaining in a familiar environment with staff who know the resident
  - Futility of hospital transfer/CPR
  - Capacity of staff/RACF/doctor for palliative care
  - Whether anticipatory prescribing may be appropriate

One thing you have learnt today ?

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To end with the beginning in mind

1. **Dementia is more than a memory problem**
2. MMSE and other cognitive assessment tools are not validated as population screening tools or as diagnostic tests
3. It is often appropriate for a person to have dementia diagnosed and for post-diagnostic care to be initiated in general practice (with support)

GP dementia resource hub

Easy access to dementia courses, resources and links

Includes:

- Dementia in Practice podcast episodes
- Online courses for GPs – from 40mins to 4hrs
- Downloadable GP resources – Management plans and Supervisor teaching plans
- GP related events
- GP workshops
- Links to other helpful websites

Visit https://dta.com.au/general-practitioners/

Dementia Training Australia

- A **podcast** made by GPs for GPs and others interested in learning more about dementia

Selection of Season One & Two episodes:

- Life with dementia: A first-hand account
- Healthy ageing and dementia: How to recognise the difference
- Diagnosing dementia in general practice: A stepwise approach
- A carer's story: When dementia comes home
- The healthy brain check: Reducing risk factors for dementia
- Dementia and multicultural communities: Dementia doesn't discriminate
- Dementia at the end of life: A person centred approach
- Driving and dementia: Who's in the driver's seat
- Looking at residential aged care: Living the best life possible
- Sleep Matters

New series coming soon

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Dementia Training Australia

https://dta.com.au/gp/#podcast