WELCOME

Dementia in Residential Aged Care: Untangling the intricacies

Hosted in partnership with GCHHS and GCPHN

FRIDAY 7 FEBRUARY 2025

Jingeri.
We acknowledge the Traditional Custodians of the land in which we work, live and grow, the Kombumerri, Wangerriburra, Bullongin, Minjungbal and Birinburra peoples, of the Yugambeh Language speaking nation. We also pay our respects to Elders past, present and emerging. We also acknowledge other Aboriginal and Torres Strait Islander people present today.

Housekeeping

- Please switch phones to silent or off completely
- In an emergency…
- Toilet locations
- Breaks
- Please ensure you have your ticket for parking (and parked in a 2HR spot)
- Please ensure you EVALUATE at the end of the day

PHN Team

- Here today
- Chat with them!
- They would love to do some profiling about you and your role in your homes
- This will be included in the PHN's upcoming bulletins
- They will be present during breaks
- Leave your info at the registration table if you are happy to be contacted after todays event

Recap and overview of today

- After Hours Project has been running since March 2023
- Most of you in the room are familiar with what this project is trying to achieve
- Ultimately, it is about improving/ refining skill and confidence in aged care nurses
- To ensure presentations to the Emergency Department after hours are potentially avoidable
- Available resources are used and updated to improve and enhance care.
- Empowering development or refinement of succinct action plans that translate in the after hours to support and strengthen care to residents
- Untangling the intricacies of people living with dementia in aged care homes.
- “Magic cure” “perfect worlds”
- Information, and insights that will shape care provision now and into the future

Q&A Panel

- Presenters will be present for the day. They are experts in their fields and are available for chats/comments
- Network with your fellow colleagues
- Throughout the morning and early afternoon, please think about the following

Active participation IS REQUIRED

- What are your challenges caring for those living with dementia in the after hours space?
- What assistance or resources do you feel you need to support you in the after hours space?
- Tell us things that work for you and your organisation when caring for people living with dementia
- Tell us things that just don't seem to work at the moment when caring for people living with dementia but you would like advice on what to do
- Tell us what you might be thinking you want to achieve caring for people living with dementia, improvements, simple or major?

Post It Notes

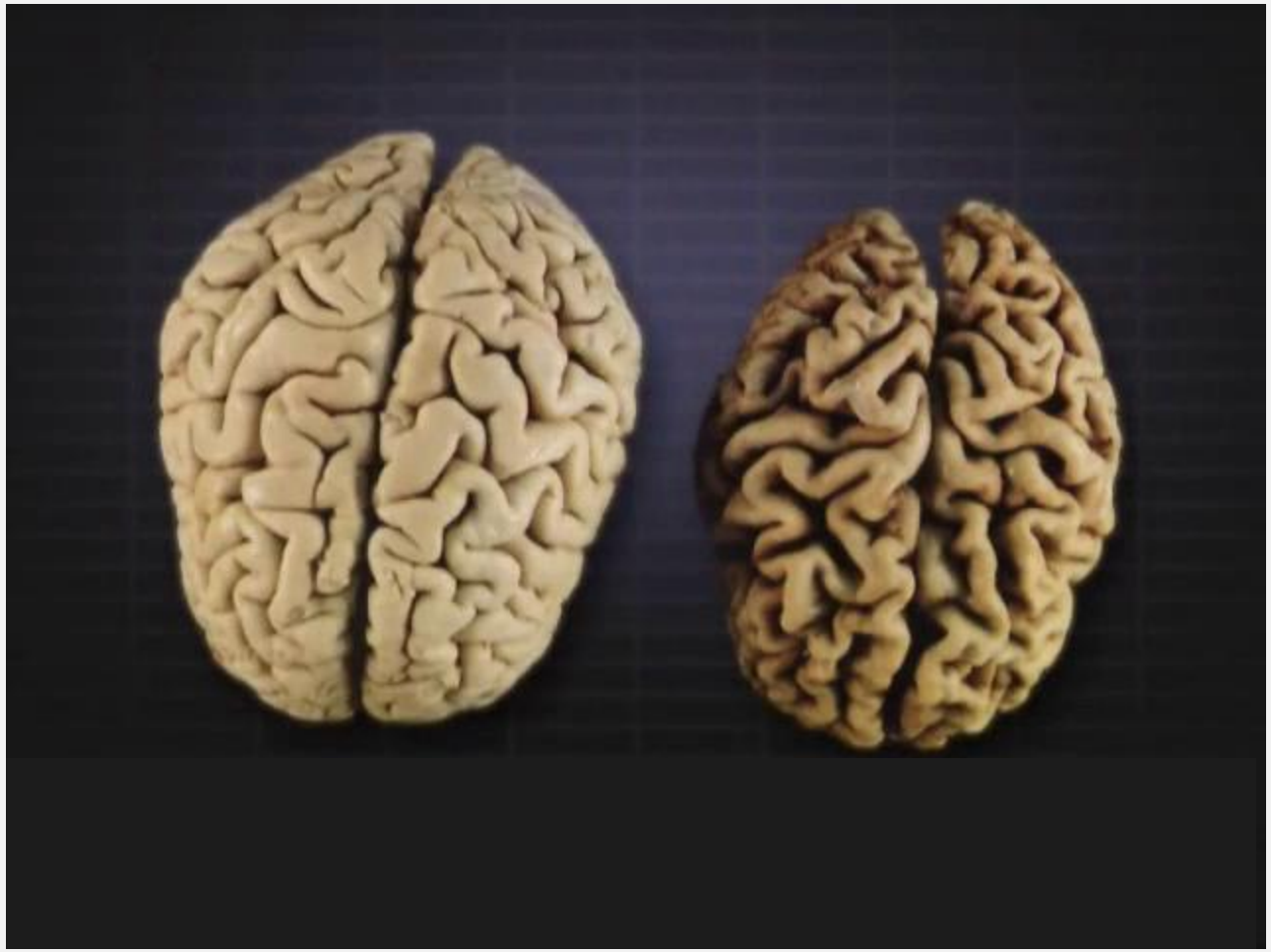
- On your desk are post it notes
- Jot down thoughts and questions as they come to mind- collectively or individually, they can be anonymous or tell us who you are
- If we run out of question time post presentation, save the question or comment for the **Q&A panel**
- Themes

Introducing our first presenter…

Dementia the Brain & Communication

Dr. Jo-Anne Todd BPsych (*Honl*) PhD
Cognitive Ageing Specialist
Adjunct Lecturer, Menzies Health Institute Queensland

Maree Krug RN
Nurse Unit Manager SMU Robina



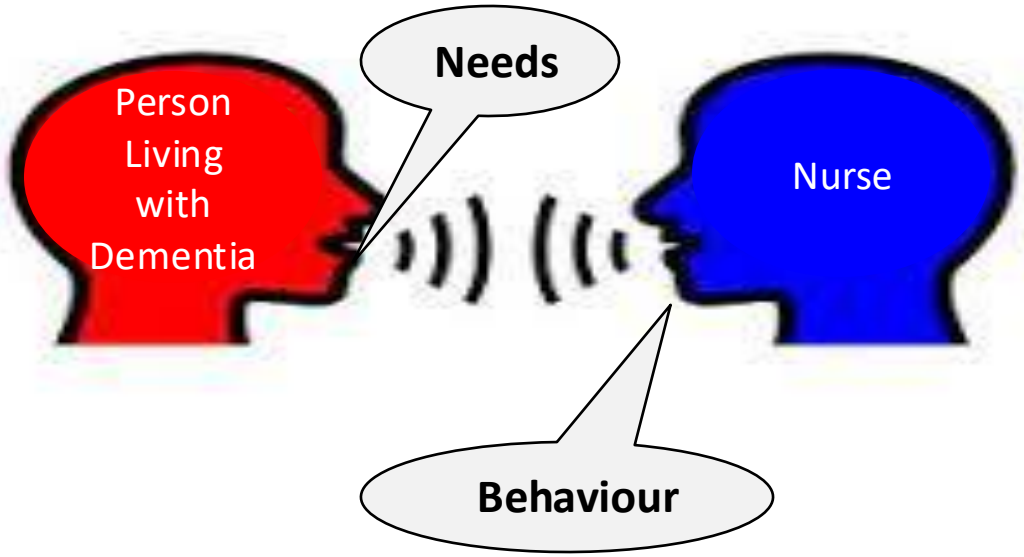
OVERVIEW

- Behaviour as ‘altered communication’
- Contributing Factors BPSD
- Strategies to communicate care
- The Challenge

Behaviour as altered communication

Interaction between two (or more) parties, reversibly the sender or receiver of information.
Consists of verbal aspects
tone and speech
And non-verbal aspects
body language and touch

(Machiels, Metzelthin, Hamers & Zwakhalen, 2017, p 38).

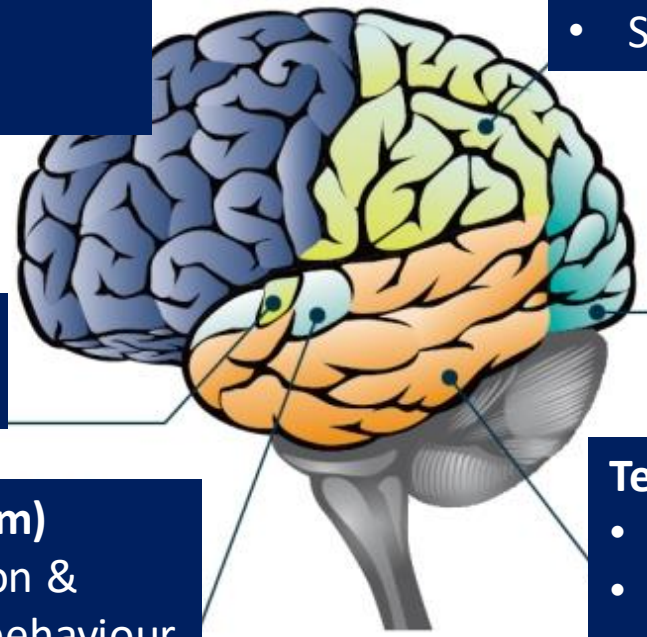


Warren A (2022) Behavioural and Psychological Symptoms of Dementia as a Means of Communication: Considerations for Reducing Stigma and Promoting Person-Centred Care. *Frontiers in Psychology, 13:875246*. doi: 10.3389/fpsyg.2022.875246

Behaviour as altered communication

Frontal Lobes
- Planning & problem-solving
- Judgement & Inhibition
- Language production
- Self-regulation

Parietal lobe
- Positioning and Recognition
- Reading, Writing, Number processing
- Sensitivity to sound, taste, touch, temperature



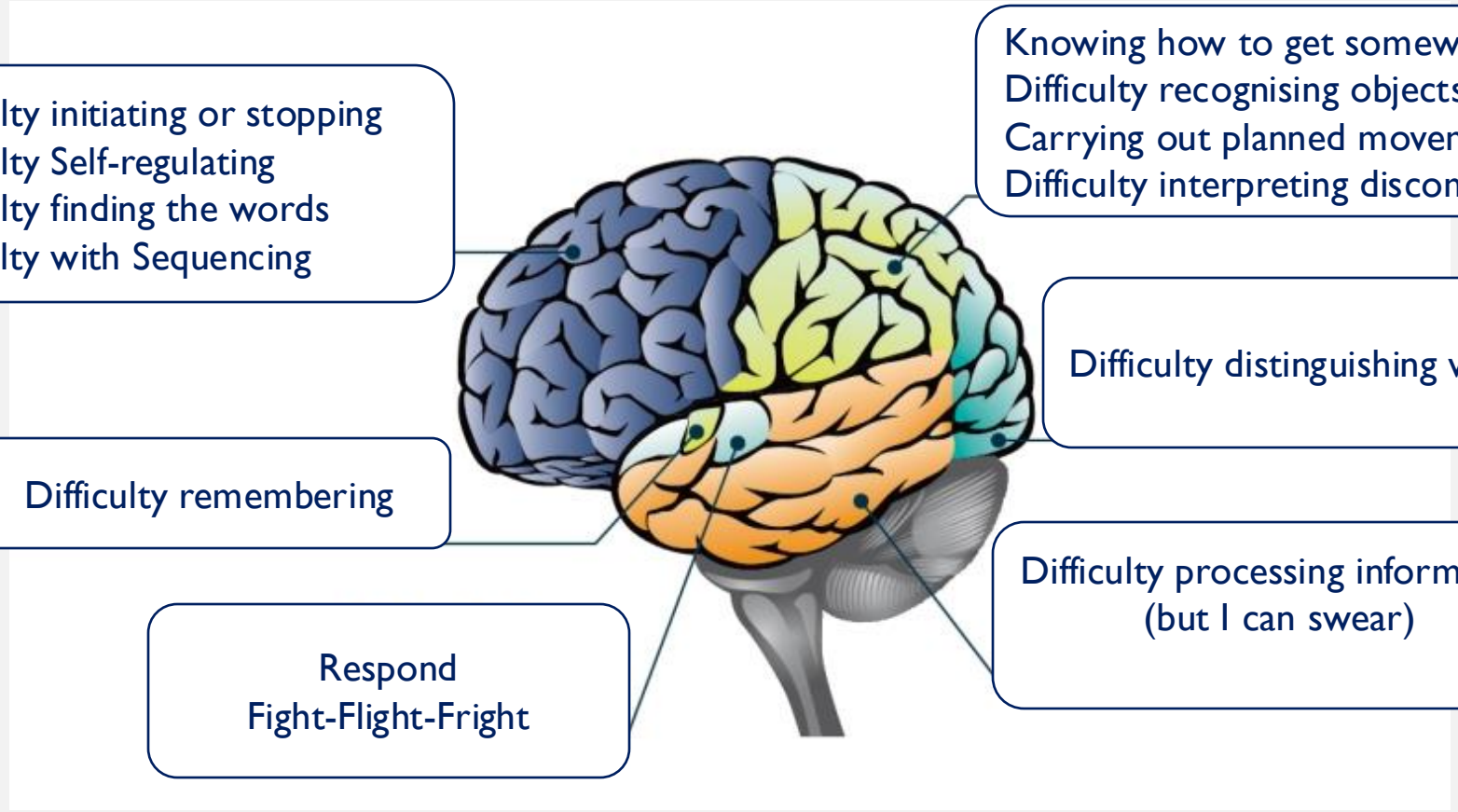
Occipital Lobes
- Vision
- Difficulty distinguishing what is seen

Hippocampus
- Memory

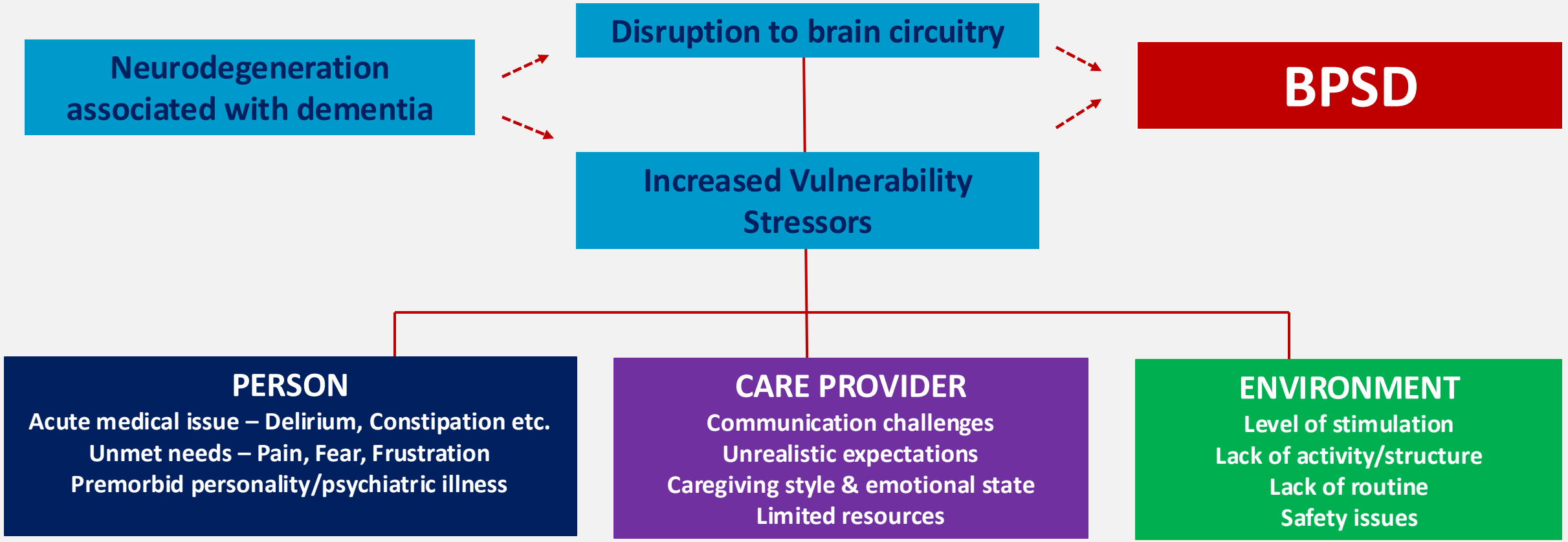
Amygdala (within limbic system)
- Connect and process emotion & memories associated with behaviour
- **Fight-Fright-Flight**

Temporal Lobe
- Memory
- Comprehension & auditory processing
- Music, rhythm, swear words

Behaviour as altered communication



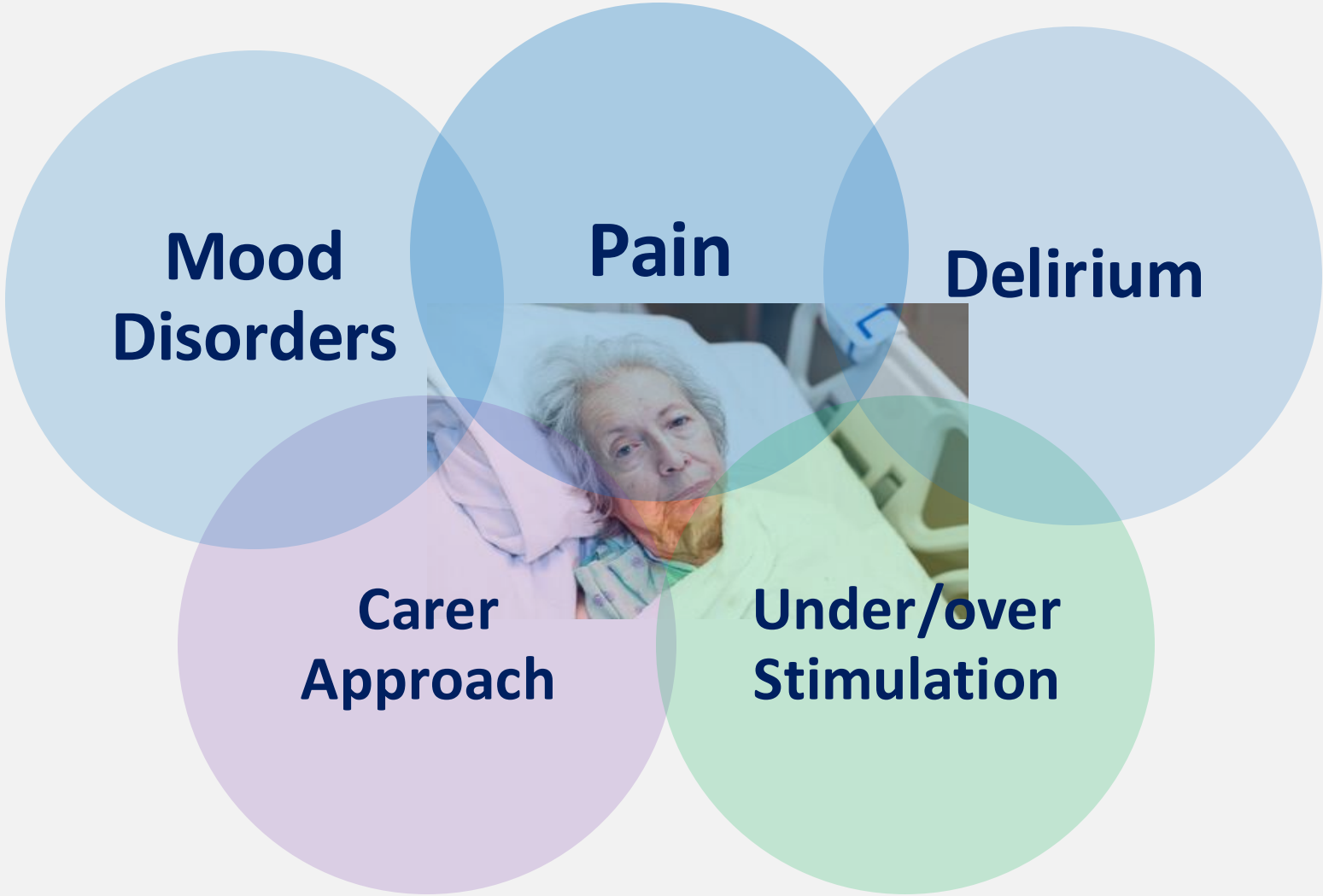
Factors associated with BPSD



Kales, H.C., Gitlin, L.N., & Lyketsos, C.G. (2015). Assessment and management of behavioural and psychological symptoms of dementia. *BMJ 350*, h369. DOI: 10.1136/bmj.h369.

Kales, 2024. The Dice Model. In *Geriatrics Models of Care*. M.L. Malone et al. (Eds.). Springer Nature: Switzerland.

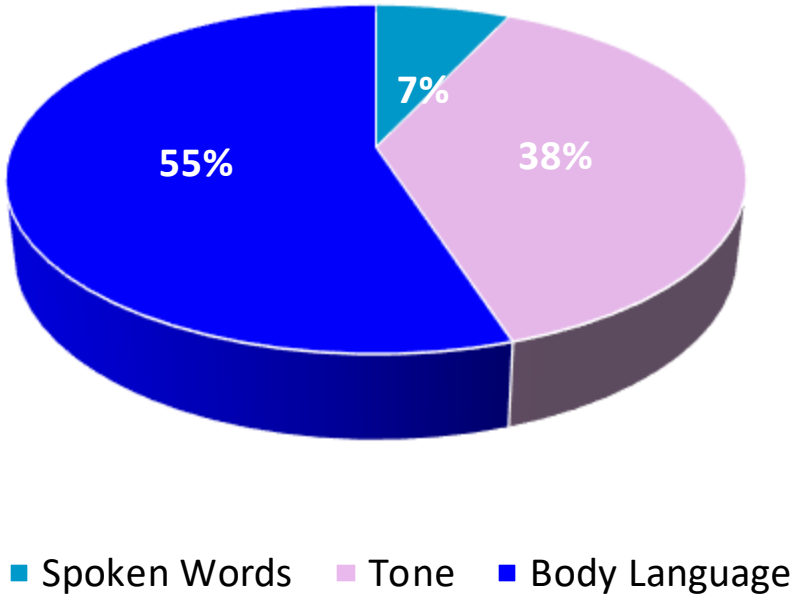
Evidence: Contributing Factors of BPSD



Atee et al. (2021). Novel models of dementia care: Evidence from national dementia behaviour support programs in Australia. *Alzheimer's Dementia.* 17 (Suppl. 8):e050463

Communicating Care

Communicating emotions and feelings



Mehrabian (1981)

Motives & Expectations profoundly affect our perceptual experience.

Dynamic interplay between

- what we know (or think we know)
- what we are looking at and/or hearing
- what we expect to see and/or hear

(Swets, Tanner, Jr., & Birdsall, (1961).

Powerful impact on how we understand the actions of people living with dementia

Communicating Care

People living with dementia

- **Perceive**
- **Interpret**
- **Respond**

interaction between changes in brain and environment

What to do…

M Maximise attention

E Expression & Body Language

S Simple

S Support Conversation

A Assist with Visual Aids

G Get their message

E Encourage & Engage

The Challenge

- 10–15% aged care beds
    - moderate-to-severe BPSD (Brodarty Tier 4/5)
- BPSD complex, heterogeneous, multidimensional
    - Time & resource intensive
    - Poor and costly health and care outcomes
    - Overreliance on psychopharmacotherapy

Macfarlane et al., (2021) Evaluating the Clinical Impact of National Dementia Behaviour Support Programs on Neuropsychiatric Outcomes in Australia. *Frontiers in Psychiatry 12:652254*. doi: 10.3389/fpsyt.2021.652254

Be the Change

- Be proactive not reactive
- Promote a culture of empathy, patience, person-centred care to ensure the health and wellbeing of <u>both</u> people living with dementia & staff

"What people living with dementia need from Us is Us"

Michael Verde

QUESTIONS

Jo-anne.todd@health.qld.gov.au

PallConsult

Support for clinicians delivering end-of-life care

Palliative Care and Dementia

Delivered by Clinical Nurse Consultant

Queensland Government

Contact us

1300 PALLDR* (1300 725 537)

For doctors, NPs, paramedics and pharmacists

1300 PALLCR* (1300 725 527)

For nurses, allied health and Aboriginal and Torres Strait Islander health workers/practitioners in all care environments

pallconsult.com.au | pallconsult@health.qld.gov.au

Dementia and palliative care

What is dementia?

Dementia describes a collection of symptoms that are caused by disorders affecting the brain. It is not one specific disease.

Dementia affects everyone differently and can affect memory, emotional state or behaviour (e.g. involving repetitive actions or questioning, anxiety, agitation) and the ability to perform everyday tasks.

While dementia is more common in older people, it is not a normal part of ageing.

Prompts for End-of-Life Planning (PELP) Framework

Quality care in the last 12 months of life

TRIGGER: Would you be surprised if this person were to die in the next 12 months?

Applicable to ALL care settings to encourage culturally safe and person-centred care

ACP

Meds

Monitor

Family

Coordinate care

CLINICAL PROCESSES	Advance care planning (ACP) and person-centred care based on need	Transition focus of care needs from restorative to palliative	Terminal care needs	After-death care
PROGNOSIS	**At risk of dying** <12 months; timing uncertain	**Likely to die soon** medium term; timing uncertain	**Dying** short term, likely hours, days, or week; timing uncertain	**Bereavement**
PROMPTS	• Acknowledge importance of individual needs, including lifestyle factors, and prognostic uncertainty • If not already commenced, begin **ACP** » Discuss end-of-life options and limitations of treatments » Suggest completion of ACP documents including noting substitute decision-maker • Consider ongoing disease-modifying treatments and a palliative approach • Consider mentioning voluntary assisted dying for eligible patients, if jurisdictionally appropriate* and within scope of practice • Review medicines and deprescribe if appropriate • Monitor for indicators of deteriorating health • Explore availability of carers • Coordinate care across all services including respite care	• Review ACP and person-centred goal setting • Prepare **person-centred medical goals of treatment plan** and document » Include ceilings of medical treatments if acute deterioration • Coordinate care across all services » Establish GP as team leader, if available » Include palliative care team members, as required » Consider respite care • Review medicines, consider » Deprescribing » Anticipatory prescribing • Provide a palliative approach • Explore bereavement needs of person and carers	• Review ACP and person-centred medical goals of treatment documents • Prepare **terminal care management plan** for preferred place of death » Provide interventions for symptom control including non-pharmacological strategies » Consider anticipatory prescribing and deprescribing » Ensure culturally appropriate care and spiritual, individual and carer needs are met • Document the **plan** and share with carers and after-hours providers • Provide checklist for immediate after-death care • Consider bereavement care for all	• If required » Arrange bereavement care for all significant others » Refer to support services » Ensure team members have access to peer support, debriefing and counselling

CLINICAL IMPROVEMENT ⟷ CLINICAL DETERIORATION

SCAN CODE FOR LINKS TO OTHER RESOURCES

caringathomeproject.com.au

*Specific requirements for voluntary assisted dying vary between each state and territory. Healthcare services should familiarise themselves with the legislation in their jurisdiction and ensure patients and their families have access to appropriate information.

Adapted from:
1. Australian Commission on Safety and Quality in Health Care. National Consensus Statement: Essential elements for safe and high-quality end of life care. Sydney (AU) ACSQHC; 2023.
2. Alfred Health. End of Life Care Management Guideline. Melbourne (AU) Alfred Health; 2015. Prompt Doc No: AHG0068908 v10.1.
3. Reymond L, Cooper K, Parker D, Chapman M. End-of-life care: Proactive clinical management of older Australians in the community. AFP. 2016 Jan-Feb; 45(1): 76-8.

v2 07/2024

Why is EOL a challenge?

- Staff may have had challenges dealing with EOL issues.
- Hospitals and clinicians primarily work to restore health and patient function, when a patient dies it may feel like a clinical failure.
- We live in a society that doesn’t readily talk about or plan for death.
- There may be a lack of workplace mentors.
- Nurses might not recognise signs of early deterioration.
- Limited training might be offered regarding care at the end of life.

End-Of-Life signs and symptoms

- Limited speech or complete loss of speech
- Needing help with washing or dressing
- Difficulty eating and drinking, including problems with swallowing
- Weight loss
- Bowel and bladder incontinence
- Being unable to sit up, walk or stand and becoming bedbound
- Having frequent infections
- Changes in behaviour which may indicate increased symptoms

Symptom management

- People living with dementia may not be able to report their symptoms, evidence shows they are prescribed 50% less analgesia in acute hospitals than those without dementia.
- The use of Abbey pain scale, PAIN-AD, SHOULD NOT SUBSTITUTE CLINICAL ASSESSMENT
- New behavioural issues such as withdrawal, agitation, anger, aggression and resistiveness could be an indicator of pain.
- Consider views of family/carer who spend a significant amount of time with the patient.

Palliative care and dementia

- A third of older people die with dementia, yet there is a lack of consistency in delivering palliative care to people living with dementia.
- Palliative Care helps people with a terminal illness live as well as possible and die as well as possible.
- Palliative care treats the whole person, taking into consideration all aspects of their care including traditions, customs and religions and formulates a plan specific to this patient.

What is Palliative care?

- Palliative care is a family centred model of care, meaning that families and carers can receive practical and emotional support.
- Links to other services such as home help and financial support
- Relief of pain and other symptoms
- Planning for future medical treatment decisions and goals of care
- Counseling and grief support
- Early referral to palliative care can often prolong life and certainly support a better quality of life

Palliative vs EOL vs comfort care

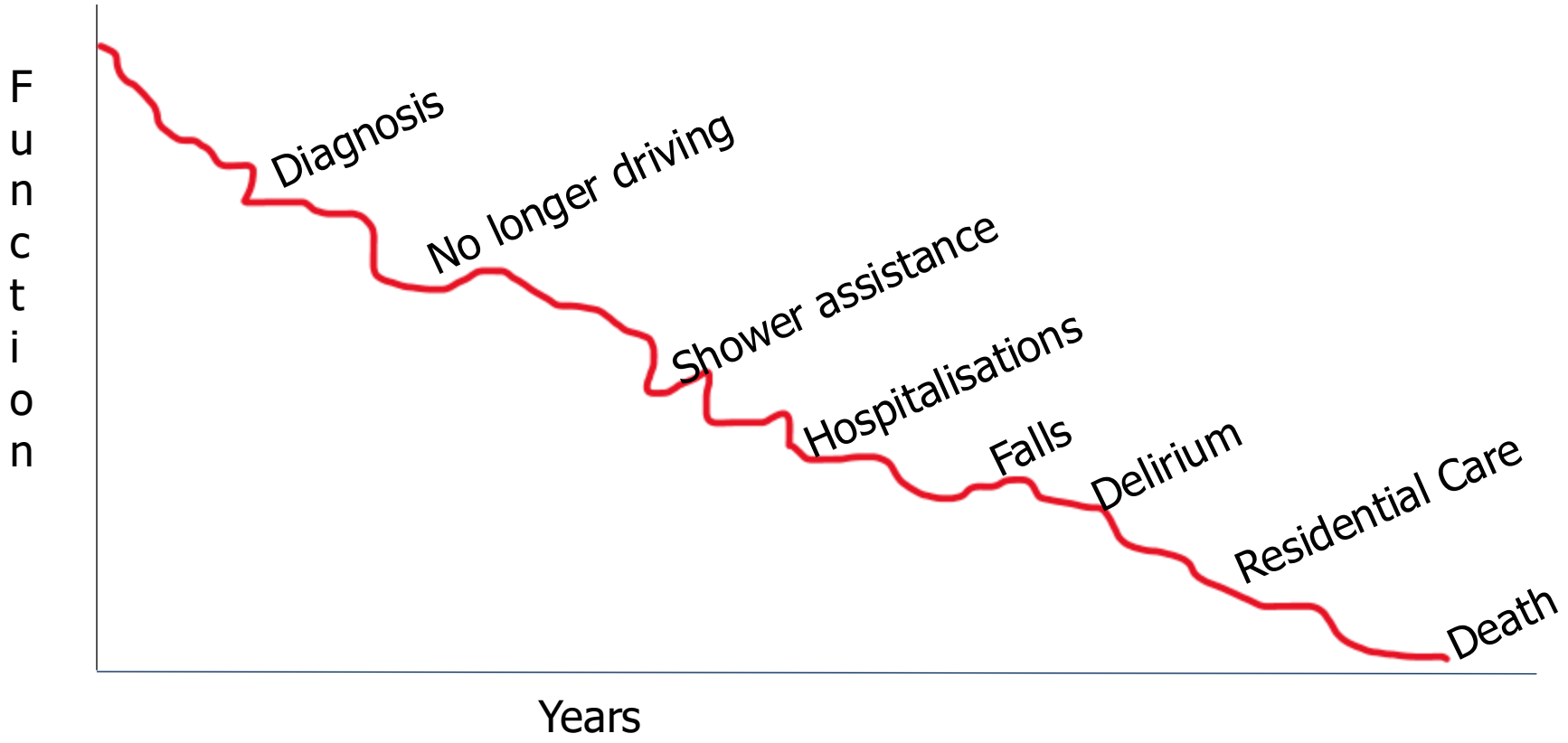
Comfort care?

- What is comfort care?

- Is a discussion with families to help them understand the relationship between dementia progression and signs of deterioration.
- Provides information on approaches the healthcare team may take
- Gives direction on hospital admissions and appropriateness of interventions

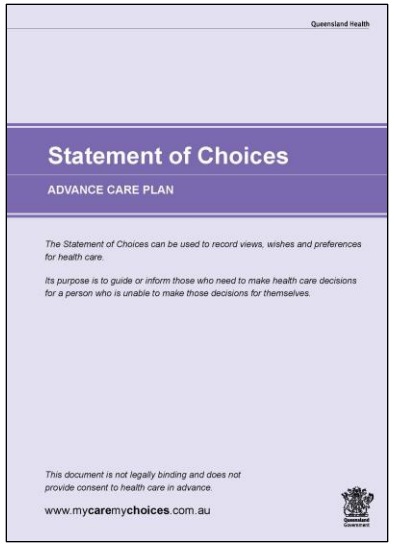
- Why do we call it comfort care?

When to refer?

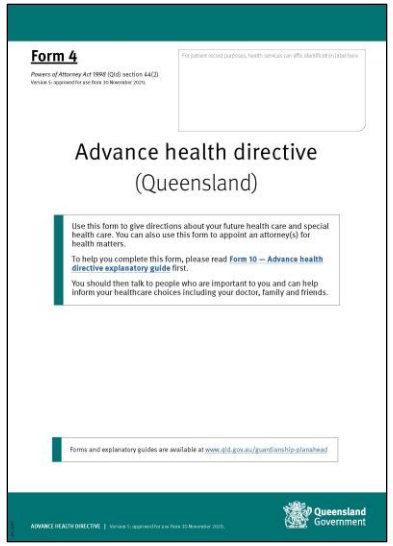


ACP Documents

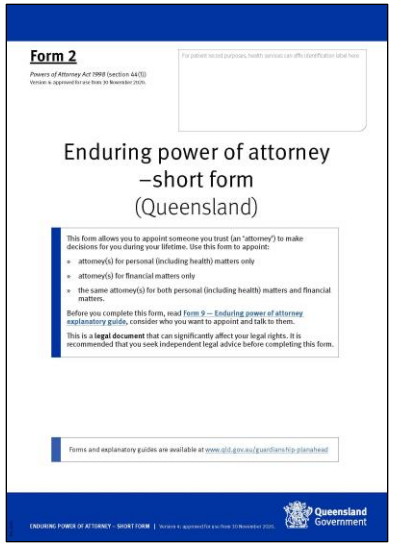
Statement of Choices (SoC)



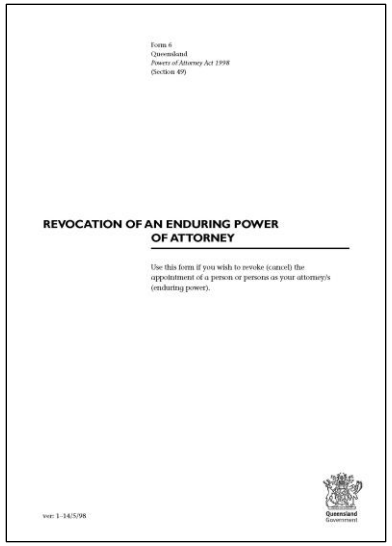
Advance Health Directive (AHD)



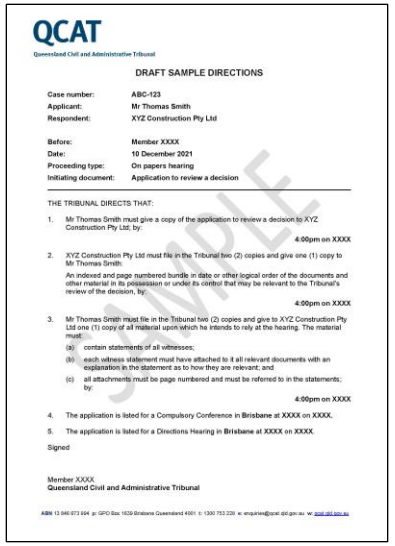
Enduring Power of Attorney (EPOA Long and Short)



Revocation of EPOA/AHDs



QCAT Decisions



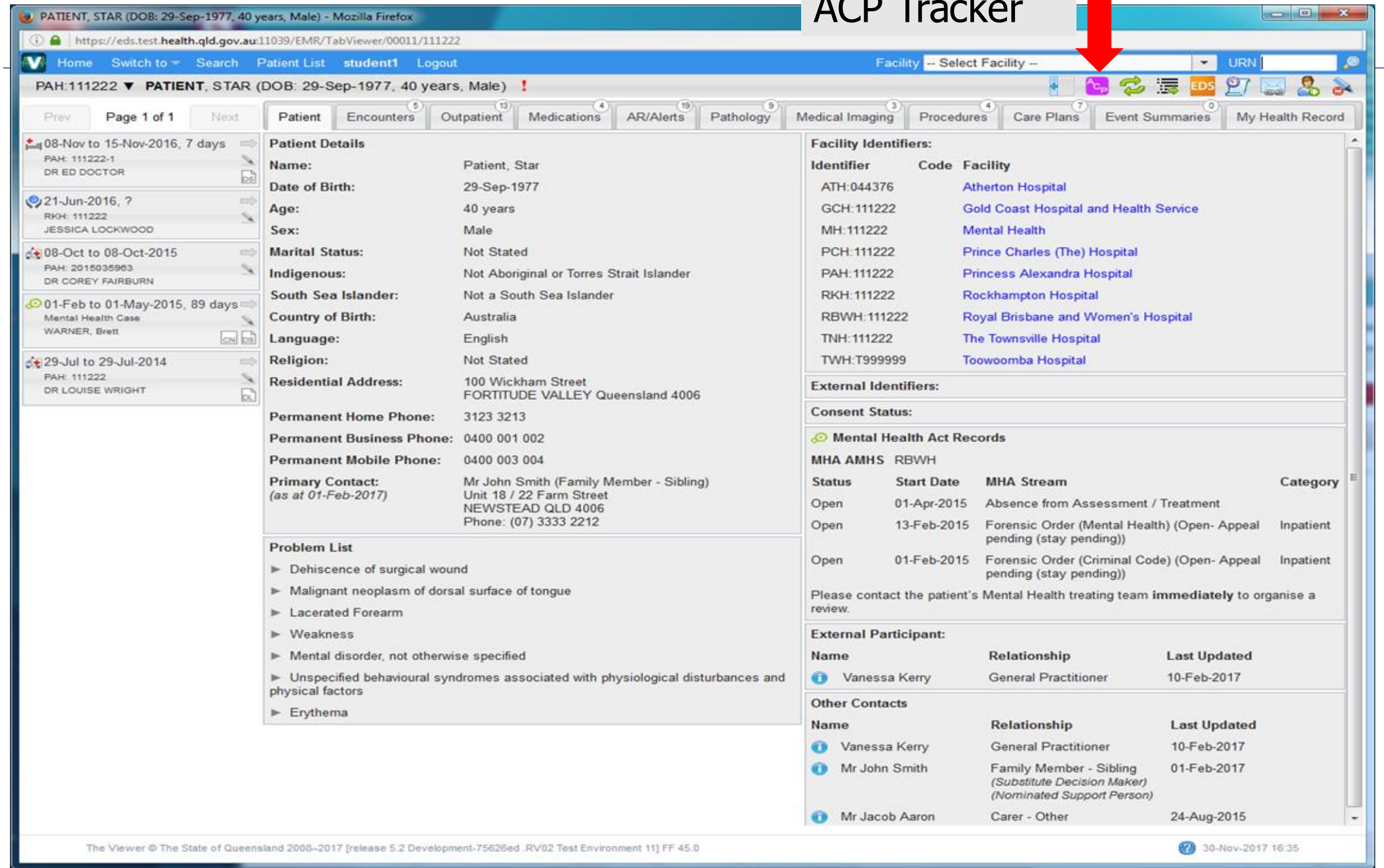
Enduring documents

ACP and dementia

1. ACP is voluntary
2. Early ACP is vital in dementia
3. Form B is the only document that can be used when a patient has lost capacity
4. Culturally appropriate advance care planning needs to be considered for people from First Nations and CALD communities living with dementia.
5. ACP involves the EPOA or SDM and discussions around future care/interventions.

- What is the viewer?

ACP Tracker


PATIENT, STAR (DOB: 29-Sep-1977, 40 years, Male) - Mozilla Firefox
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PAH:111222 PATIENT, STAR (DOB: 29-Sep-1977, 40 years, Male)
Prev Page 1 of 1 Next
08-Nov to 15-Nov-2016, 7 days
PAH: 111222-1
DR ED DOCTOR
21-Jun-2016, ?
RKH: 111222
JESSICA LOCKWOOD
08-Oct to 08-Oct-2015
PAH: 2015035963
DR COREY FAIRBURN
01-Feb to 01-May-2015, 89 days
Mental Health Case
WARNER, Brett
29-Jul to 29-Jul-2014
PAH: 111222
DR LOUISE WRIGHT
Patient
Encounters
Outpatient
Medications
AR/Alerts
Pathology
Medical Imaging
Procedures
Care Plans
Event Summaries
My Health Record
Patient Details
Name: Patient, Star
Date of Birth: 29-Sep-1977
Age: 40 years
Sex: Male
Marital Status: Not Stated
Indigenous: Not Aboriginal or Torres Strait Islander
South Sea Islander: Not a South Sea Islander
Country of Birth: Australia
Language: English
Religion: Not Stated
Residential Address: 100 Wickham Street FORTITUDE VALLEY Queensland 4006
Permanent Home Phone: 3123 3213
Permanent Business Phone: 0400 001 002
Permanent Mobile Phone: 0400 003 004
Primary Contact: (as at 01-Feb-2017) Mr John Smith (Family Member - Sibling) Unit 18 / 22 Farm Street NEWSTEAD QLD 4006 Phone: (07) 3333 2212
Problem List
Dehiscence of surgical wound
Malignant neoplasm of dorsal surface of tongue
Lacerated Forearm
Weakness
Mental disorder, not otherwise specified
Unspecified behavioural syndromes associated with physiological disturbances and physical factors
Erythema
Facility Identifiers:
Identifier Code Facility
ATH:044376 Atherton Hospital
GCH:111222 Gold Coast Hospital and Health Service
MH:111222 Mental Health
PCH:111222 Prince Charles (The) Hospital
PAH:111222 Princess Alexandra Hospital
RKH:111222 Rockhampton Hospital
RBWH:111222 Royal Brisbane and Women's Hospital
TNH:111222 The Townsville Hospital
TWH:T999999 Toowoomba Hospital
External Identifiers:
Consent Status:
Mental Health Act Records
MHA AMHS RBWH
Status Start Date MHA Stream Category
Open 01-Apr-2015 Absence from Assessment / Treatment
Open 13-Feb-2015 Forensic Order (Mental Health) (Open- Appeal pending (stay pending)) Inpatient
Open 01-Feb-2015 Forensic Order (Criminal Code) (Open- Appeal pending (stay pending)) Inpatient
Please contact the patient's Mental Health treating team immediately to organise a review.
External Participant:
Name Relationship Last Updated
Vanessa Kerry General Practitioner 10-Feb-2017
Other Contacts
Name Relationship Last Updated
Vanessa Kerry General Practitioner 10-Feb-2017
Mr John Smith Family Member - Sibling (Substitute Decision Maker) (Nominated Support Person) 01-Feb-2017
Mr Jacob Aaron Carer - Other 24-Aug-2015
The Viewer © The State of Queensland 2008–2017 [release 5.2 Development-75626ed .RV02 Test Environment 11] FF 45.0
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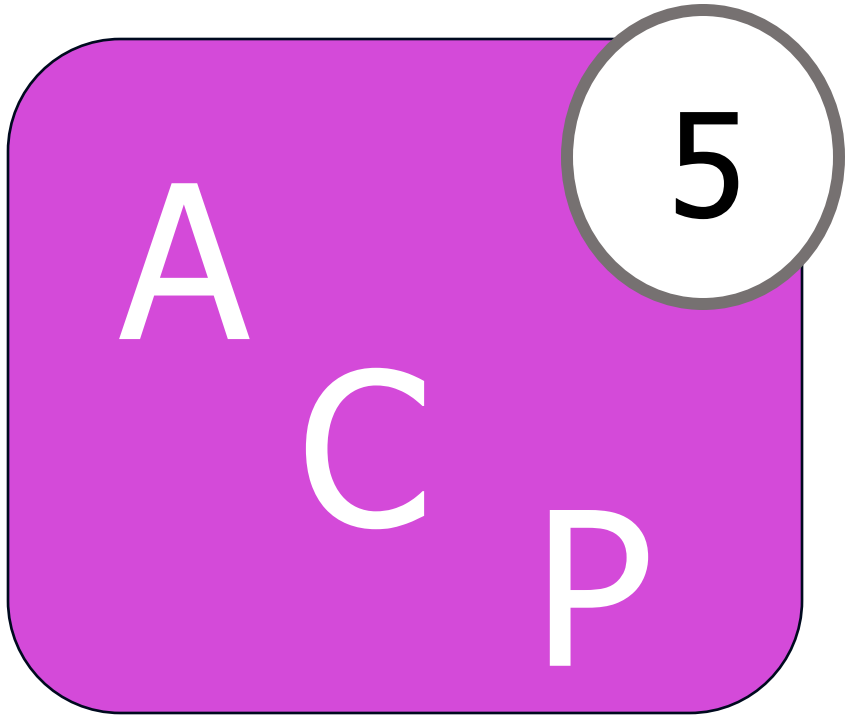
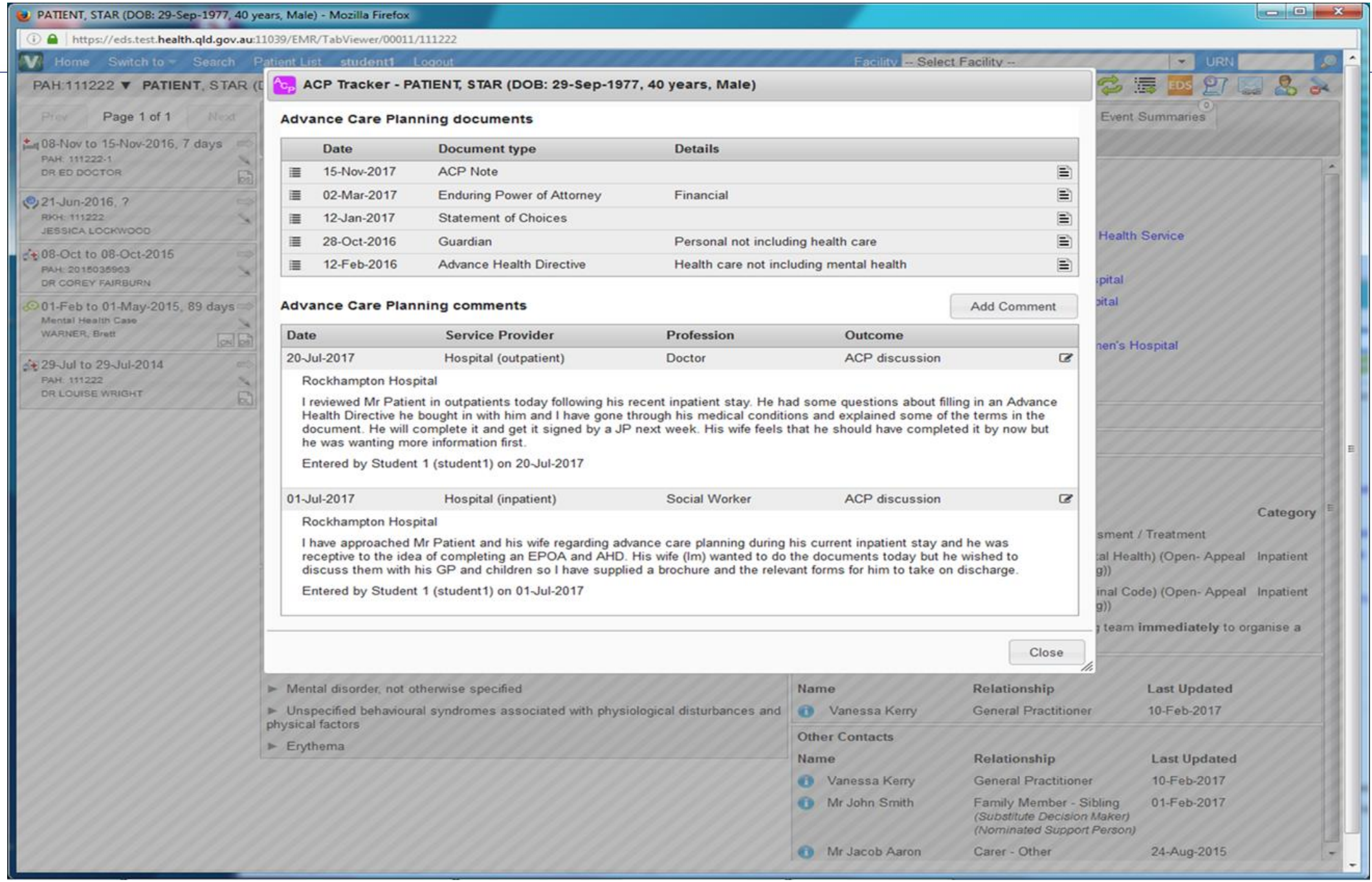
ACP Tracker

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Event Summaries
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► Mental disorder, not otherwise specified
► Unspecified behavioural syndromes associated with physiological disturbances and physical factors
► Erythema
Name
Relationship
Last Updated
Vanessa Kerry
General Practitioner
10-Feb-2017
Other Contacts
Name
Relationship
Last Updated
Vanessa Kerry
General Practitioner
10-Feb-2017
Mr John Smith
Family Member - Sibling
(Substitute Decision Maker)
(Nominated Support Person)
01-Feb-2017
Mr Jacob Aaron
Carer - Other
24-Aug-2015
ACP Tracker - PATIENT, STAR (DOB: 29-Sep-1977, 40 years, Male)
Advance Care Planning documents
Date
Document type
Details
15-Nov-2017
ACP Note
02-Mar-2017
Enduring Power of Attorney
Financial
12-Jan-2017
Statement of Choices
28-Oct-2016
Guardian
Personal not including health care
12-Feb-2016
Advance Health Directive
Health care not including mental health
Advance Care Planning comments
Add Comment
Date
Service Provider
Profession
Outcome
20-Jul-2017
Hospital (outpatient)
Doctor
ACP discussion
Rockhampton Hospital
I reviewed Mr Patient in outpatients today following his recent inpatient stay. He had some questions about filling in an Advance Health Directive he bought in with him and I have gone through his medical conditions and explained some of the terms in the document. He will complete it and get it signed by a JP next week. His wife feels that he should have completed it by now but he was wanting more information first.
Entered by Student 1 (student1) on 20-Jul-2017
01-Jul-2017
Hospital (inpatient)
Social Worker
ACP discussion
Rockhampton Hospital
I have approached Mr Patient and his wife regarding advance care planning during his current inpatient stay and he was receptive to the idea of completing an EPOA and AHD. His wife (Im) wanted to do the documents today but he wished to discuss them with his GP and children so I have supplied a brochure and the relevant forms for him to take on discharge.
Entered by Student 1 (student1) on 01-Jul-2017
Close

Palliative and end of life information, resources and services.

- Greater Choice for at Home Palliative Care measure https://www.health.gov.au/initiatives-and-programs/greater-choice-for-at-home-palliative-care-measure
- Palliative Care Australia https://palliativecare.org.au/
- National Palliative Care Standards (5.1 edition) https://palliativecare.org.au/national-palliative-care-standards/
- Caring @ Home https://www.caringathomeproject.com.au/
- End of Life Essentials https://www.endoflifeessentials.com.au/
- End of Life Directions for Aged Care (ELDAC) https://www.eldac.com.au/
- ELDAC Dementia Toolkit https://www.eldac.com.au/tabid/7397/Default.aspx
- Palliative Care Online Training https://www.pallcaretraining.com.au/
- Indigenous Program of Experience in the Palliative Approach (IPEPA)https://pepaeducation.com/about-ipepa/
- The Advance Project https://www.theadvanceproject.com.au/
- Palliative Care Clinic Box https://www.caringathomeproject.com.au/tabid/7437/Default.aspx

How can we help?

1300 PALLDR* (1300 725 537)

For doctors, NPs, paramedics and pharmacists

1300 PALLCR* (1300 725 527)

For nurses, allied health and Aboriginal and Torres Strait Islander health workers/practitioners in all care environments

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Questions?

Medications in BPSD

Dr Jen Lim

Geriatrician/General Physician

Feb 2025

Gold Coast Health
always care

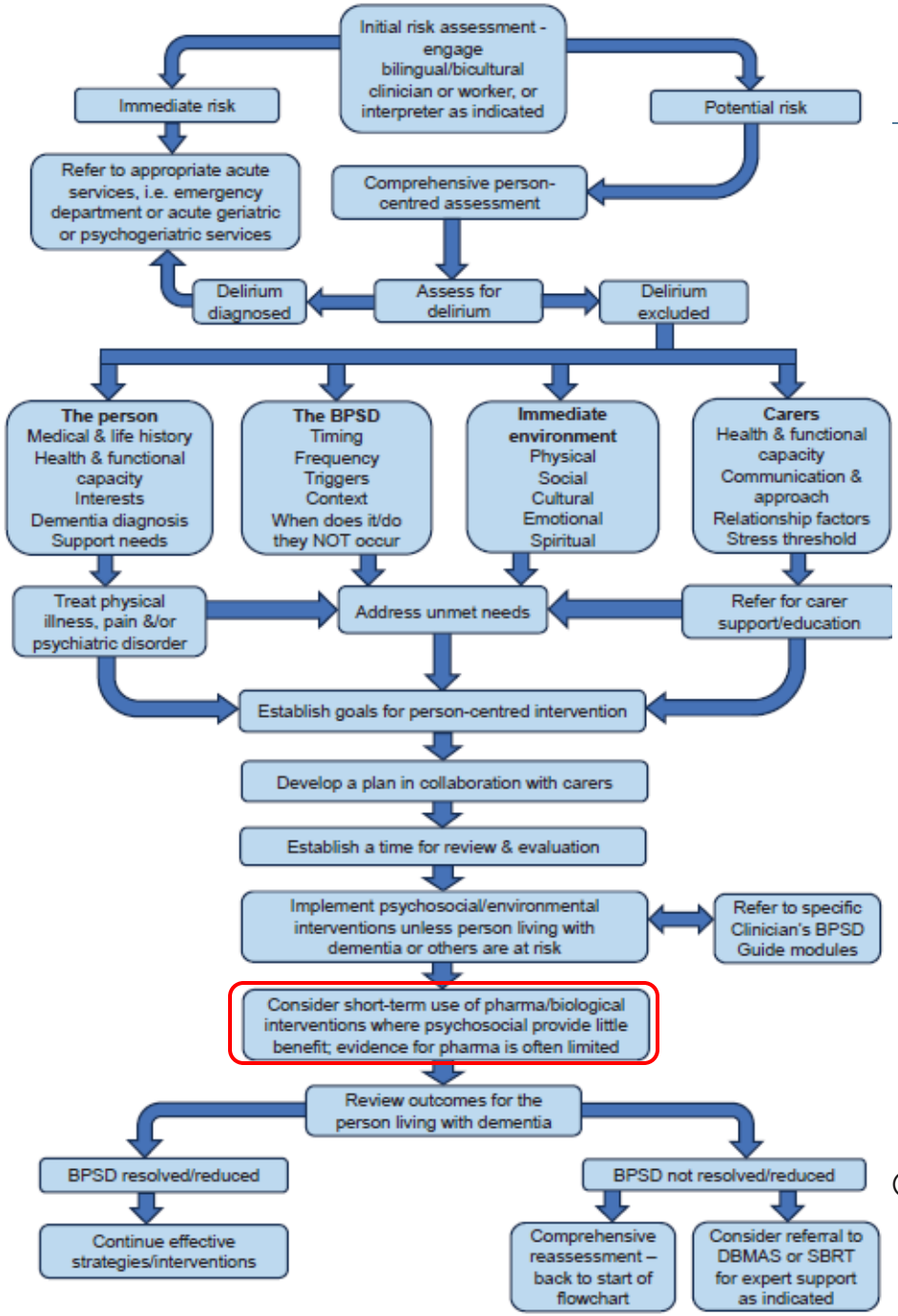
Queensland Government

Overview

- The good, the bad and the ugly aspects of medications for BPSD
- Medication choices
- Measures of efficacy and monitoring

Case example: Arthur 73M

- Mixed dementia dx Jan 2022
- Admitted with failure of independent living
- Smashing property
- Yelling at staff
- Exit-seeking



Step one:
Treat any causative/contributing factors

- Is there delirium?

- Pain*
- Insomnia
- Dehydration/malnourishment
- Medications

Medications

- Antipsychotics
- Antidepressants
- Anxiolytics

Commonly used antipsychotics in BPSD

- Risperidone
- Quetiapine
- Olanzapine
- Haloperidol

How long does it take to work?

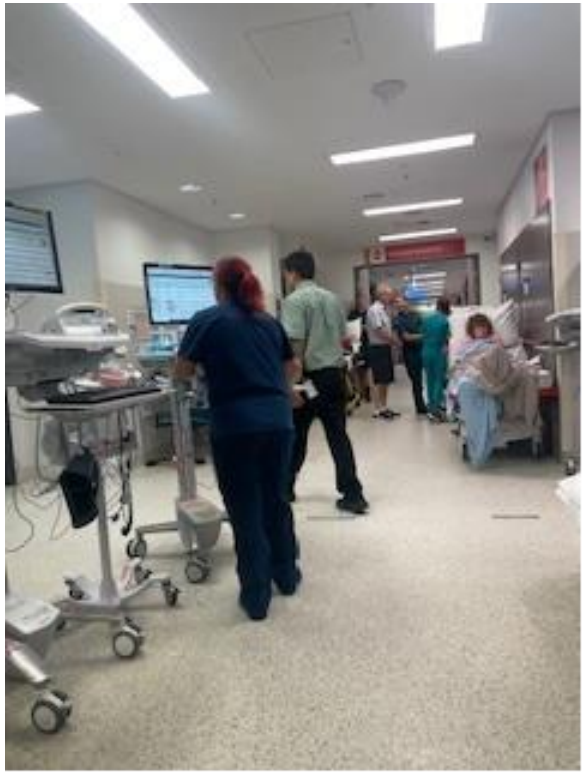
	Time to peak	Elimination
Risperidone	1hour	3-22h
Olanzapine	6hours	31-52h
Olanzapine IM	15-45min	
Quetiapine	1-1.5hours	7-12h
Haloperidol	2-6h	14-37h
Haloperidol IM	20min	

Table 2: Wilcoxon (Gehan) survival analysis to compare mean of time to first response in four groups

Groups	Mean±SD (day)	Min, Max (day)	*P*
Olanzapine	8.44±2.2	6, 12	
Risperidone	3.60±1.9	2, 6	
Haloperidol	6.60±2.5	2, 10	
Thiothixene	6.20±2.9	2, 10	
Total	6.15±2.9	2, 12	<0.003

SD=Standard deviation

Arthur: Hospital management



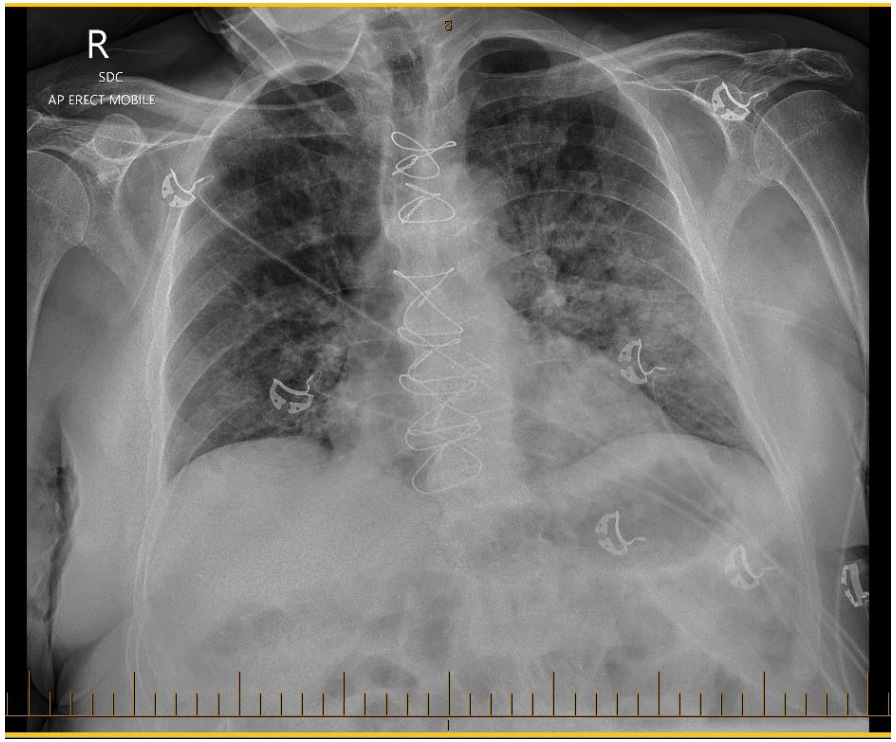
Arthur: cont'd

- 5 month admission
- Risperidone over-sedating
- Carbamazepine contraindicated
- Concerns about Valproate toxicity
- 3 falls
- Parkinsonism
- Leg swelling
- 7kg Weight gain

- Relevant discharge meds
  - Olanzapine 2.5mg bd
  - Sodium valproate 1g bd
  - Oxazepam 7.5mg PRN

Arthur: cont'd

- Readmitted 6 weeks later
- Covid pneumonitis
- RIP



Challenges and considerations

- Individual variability
- Limited evidence base
- Multiple adverse effects

Antipsychotics are medicines that can reduce symptoms of psychosis but have limited benefit for BPSD

Antipsychotics are overused for BPSD

Use of antipsychotics in Australia is **high** for BPSD in all settings

Around **1 in 5** residents in Australian aged care homes are prescribed at least one antipsychotic medicine

Guidelines recommend that antipsychotics **should not be used** as first-line treatment for BPSD

Inappropriate use of antipsychotics is a problem

For every **five** people with dementia given an antipsychotic, **only one will benefit**

Antipsychotics can cause harm and **increase the risk** of stroke, pneumonia and fractures

They are often used for **too long**, and without proper consent or monitoring

Only one antipsychotic (risperidone) is approved for BPSD on the PBS, and only to be used:

- on authority script for 12 weeks
- for dementia of Alzheimer's type with psychosis and aggression, and
- after non-pharmacological interventions have failed.

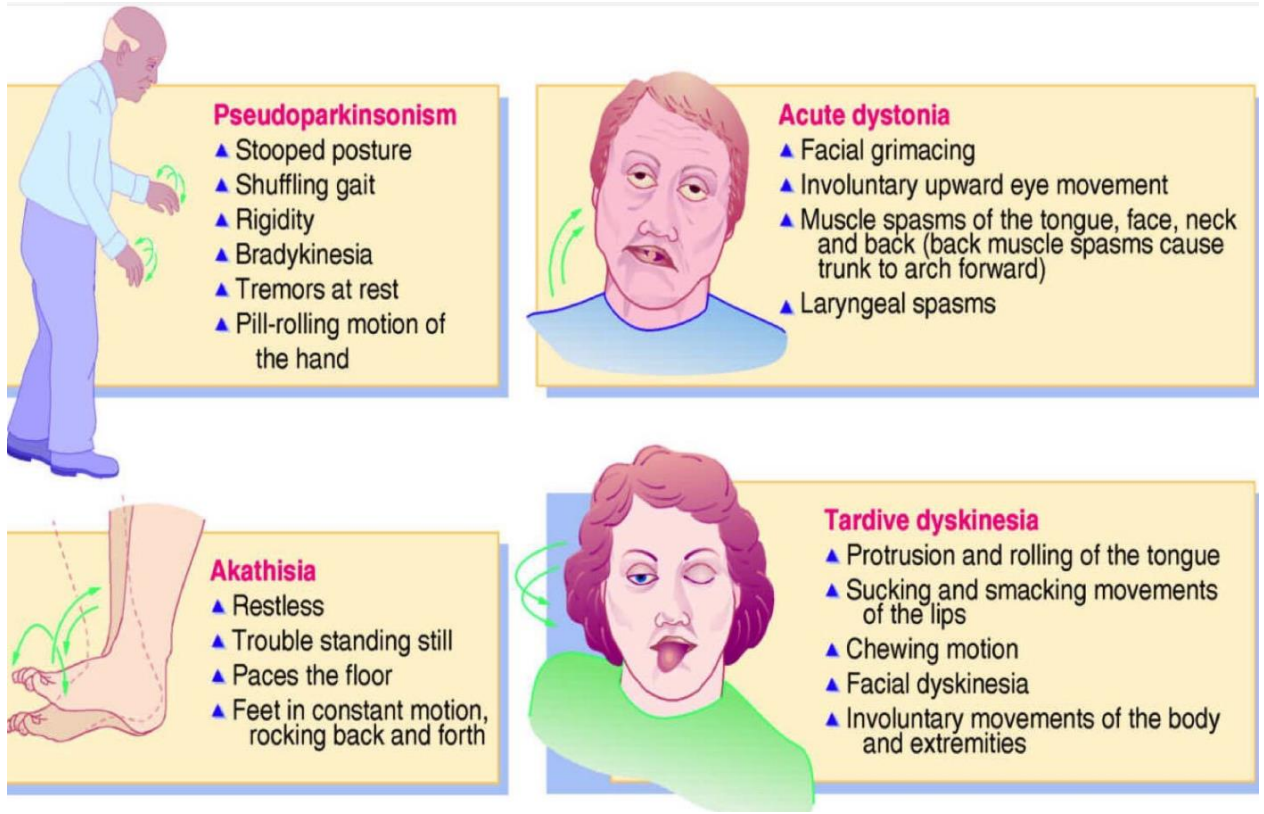
Gold Coast Health
always care

Queensland Government

Effects of antipsychotics

- Number needed to treat: 4-12
- Number needed to harm: 100

- Risks
  - Extrapyramidal side effects
  - 3x Stroke risk
  - Metabolic side effects
  - Mortality risk in elderly patients



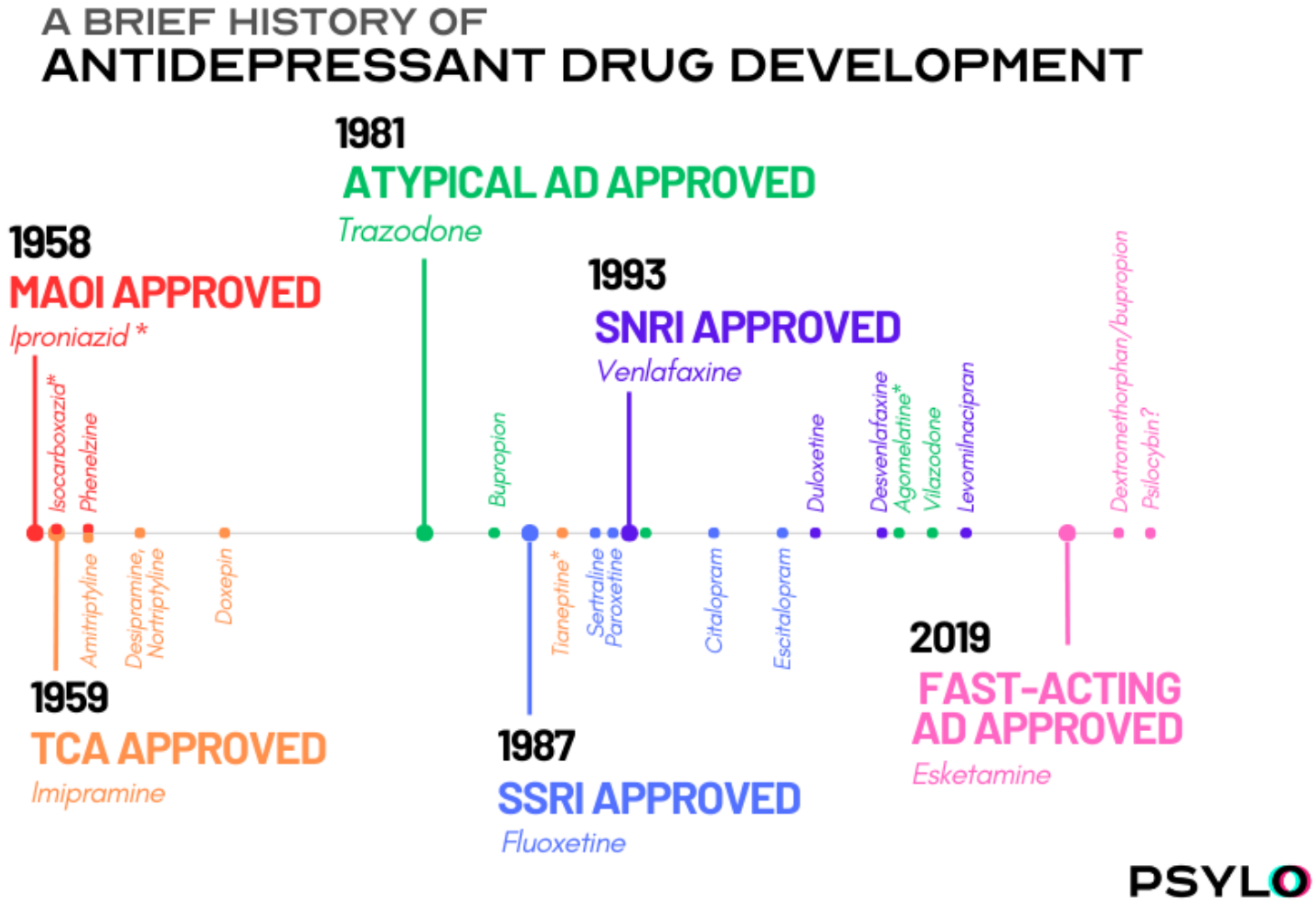
Parkinson's Disease (PD) and Lewy Body Dementia (LBD)

- More sensitive to antipsychotics
- Can have worsening of symptoms

- Avoid Haloperidol

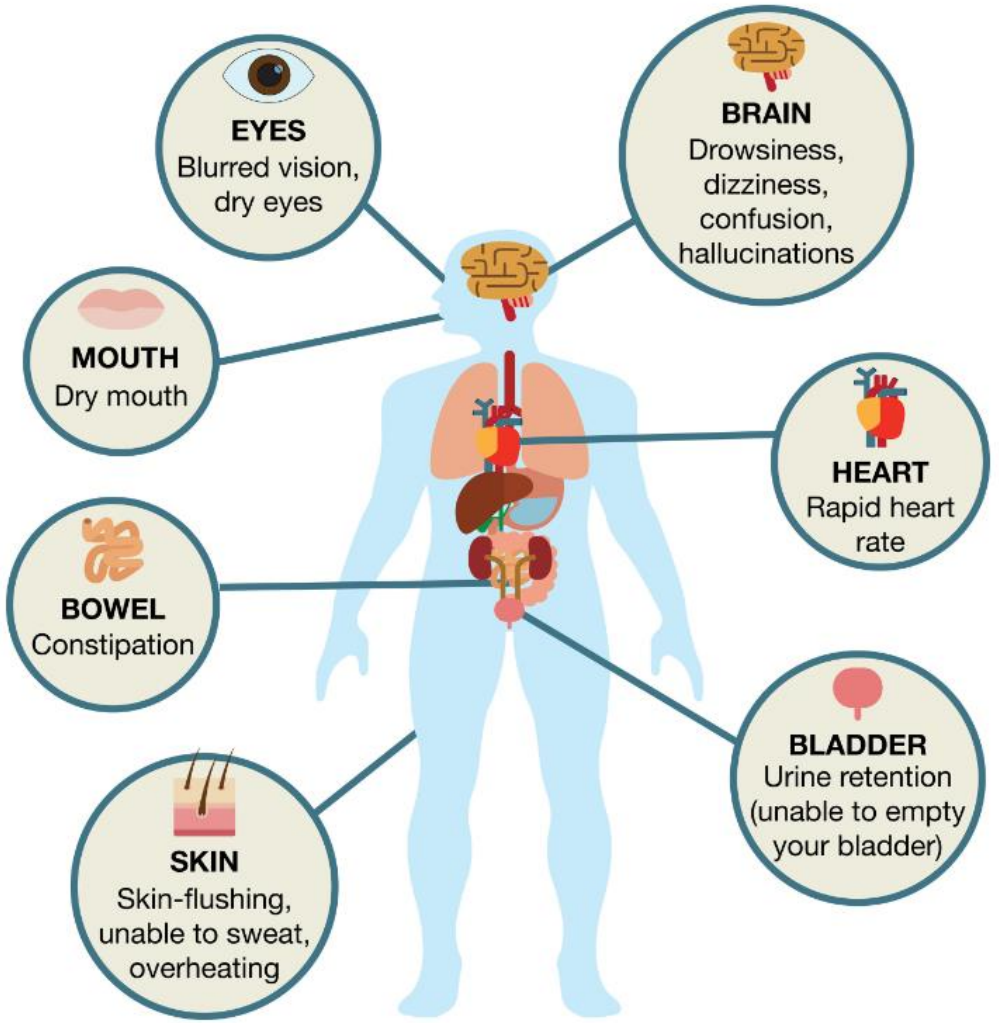
Antidepressant medications

- Aims to improve mood, reduce agitation, enhance well-being


A BRIEF HISTORY OF
ANTIDEPRESSANT DRUG DEVELOPMENT
1958
MAOI APPROVED
Iproniazid *
Isocarboxazid*
Phenelzine
1959
TCA APPROVED
Imipramine
Amitriptyline
Desipramine, Nortriptyline
Doxepin
1981
ATYPICAL AD APPROVED
Trazodone
Bupropion
1987
SSRI APPROVED
Fluoxetine
Tianeptine*
Sertraline
Paroxetine
Citalopram
Escitalopram
1993
SNRI APPROVED
Venlafaxine
Duloxetine
Desvenlafaxine
Agomelatine*
Vilazodone
Levomilnacipran
2019
FAST-ACTING AD APPROVED
Esketamine
Dextromethorphan/bupropion
Psilocybin?
PSYLO

Antidepressant use: considerations

- Side effects
  - Sedation
  - Anticholinergic effects
  - Falls risk
- Drug interactions



Canadian Medication Appropriateness and Deprescribing Network

Gold Coast Health
always care

Queensland Government

Anxiolytics

- Use in managing anxiety and agitation
- Benzodiazepines e.g. Lorazepam, Diazepam

How long does it take to work?

	Time to peak	Elimination
Oxazepam	1-4h	5-15h
Temazepam	1-2h	8-15h
Lorazepam	1-6h	10-20h
Clonazepam	1-2h	18-50h
Diazepam	1-2h	20-80h

Anxiolytic use: considerations

- Sedation risk
- Falls and fracture risk
- Paradoxical reaction
- Dependency

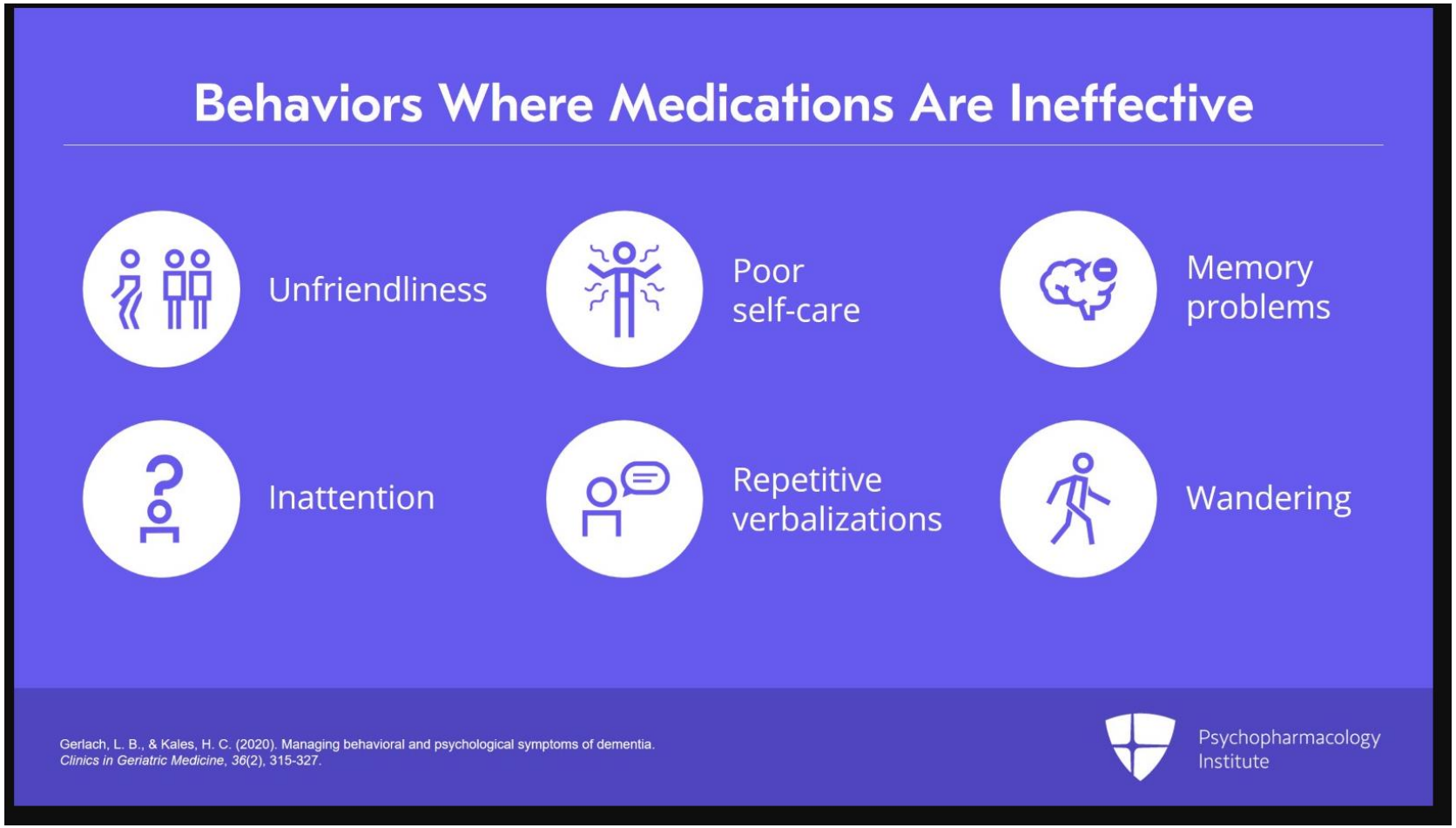
Assessing for efficacy

- Document, document, document
  - Frequency, duration, intensity of symptoms
  - Details/clarification of events
  - Location
  - People involved
  - Consequences
  - Circumstances when symptoms absent
  - Extent of discomfort and concern

Case example: Harold

- 91M vascular dementia

- Lives with son Albert who cares for him
- Thinks Albert stealing his wallet and getting into the roof
- Thinks people listening to his calls and giving info to police


Behaviors Where Medications Are Ineffective
Unfriendliness
Poor self-care
Memory problems
Inattention
Repetitive verbalizations
Wandering
Gerlach, L. B., & Kales, H. C. (2020). Managing behavioral and psychological symptoms of dementia. Clinics in Geriatric Medicine, 36(2), 315-327.
Psychopharmacology Institute

Individualised medication plans

- Consider symptom severity
- Medication tolerability
- Drug interactions
- Patient/caregiver preferences
- Medication review

Summary

- There are varied presentations for BPSD
- Not all symptoms warrant or respond to meds
- Individualised, MDT management plans
- Good non-med strategies can enhance treatment efficacy and minimise need for high-risk medication
- Judicious use of meds with close monitoring of side effects and regular med reviews

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Practical strategies for supporting changed behaviours

Louise Charlton & Raquel Mitchell

February 2025

Session Overview

- ✓ DSA brief overview and data
- ✓ Changes in behaviour – Identify, Assess and Plan
- ✓ Supportive staff responses to changed behaviours
- ✓ Best practice behaviour support & Resources
- ✓ Dementia Centre Services

- Behaviours and psychological symptoms of dementia (BPSD)

Prevalence

Experienced by up to **90%** of people living with dementia.

Impact

Distressing and disruptive to quality of life of people with dementia and their carers.

Challenge

Psychotropics remain **overprescribed** in the treatment of BPSD.

Intervention

Non-pharmacological
=
First-line
Gold standard
(e.g. DSA's services)

EDITORIAL

WILEY

Language paradigms when behaviour changes with dementia: #BanBPSD

1 | BPSD: A BACKGROUND

2 | THE INFLUENCE OF KITWOOD

'Language paradigms when behaviour changes with dementia: #BanBPSD'

published in the International Journal of Geriatric Psychiatry, 2019

-written by C. Cunningham, S. Macfarlane, and H. Brodaty

Dementia Support Australia

- When a person living with dementia is experiencing changes to their behaviour,
- DSA works with you to understand the causes – and helps you improve their quality of life.

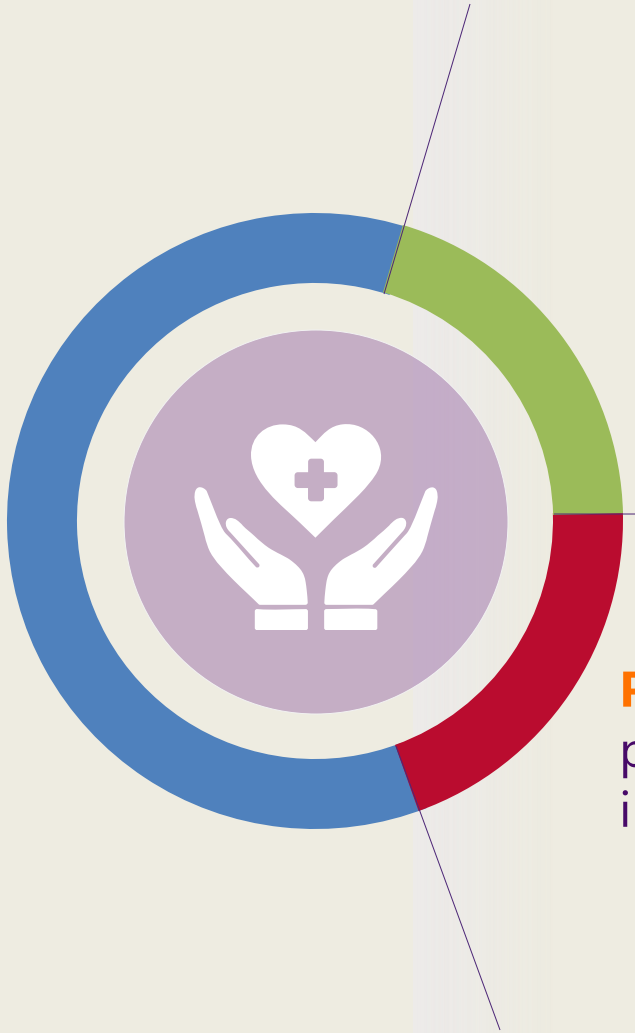
- **Free 24/7 – 1800 699 799**
- **www.dementia.com.au**

Our model of care

- Biopsychosocial approach

- Pain
- Loneliness
- Delirium
- Mood disorders
- Over/under stimulation
- Carer Approach

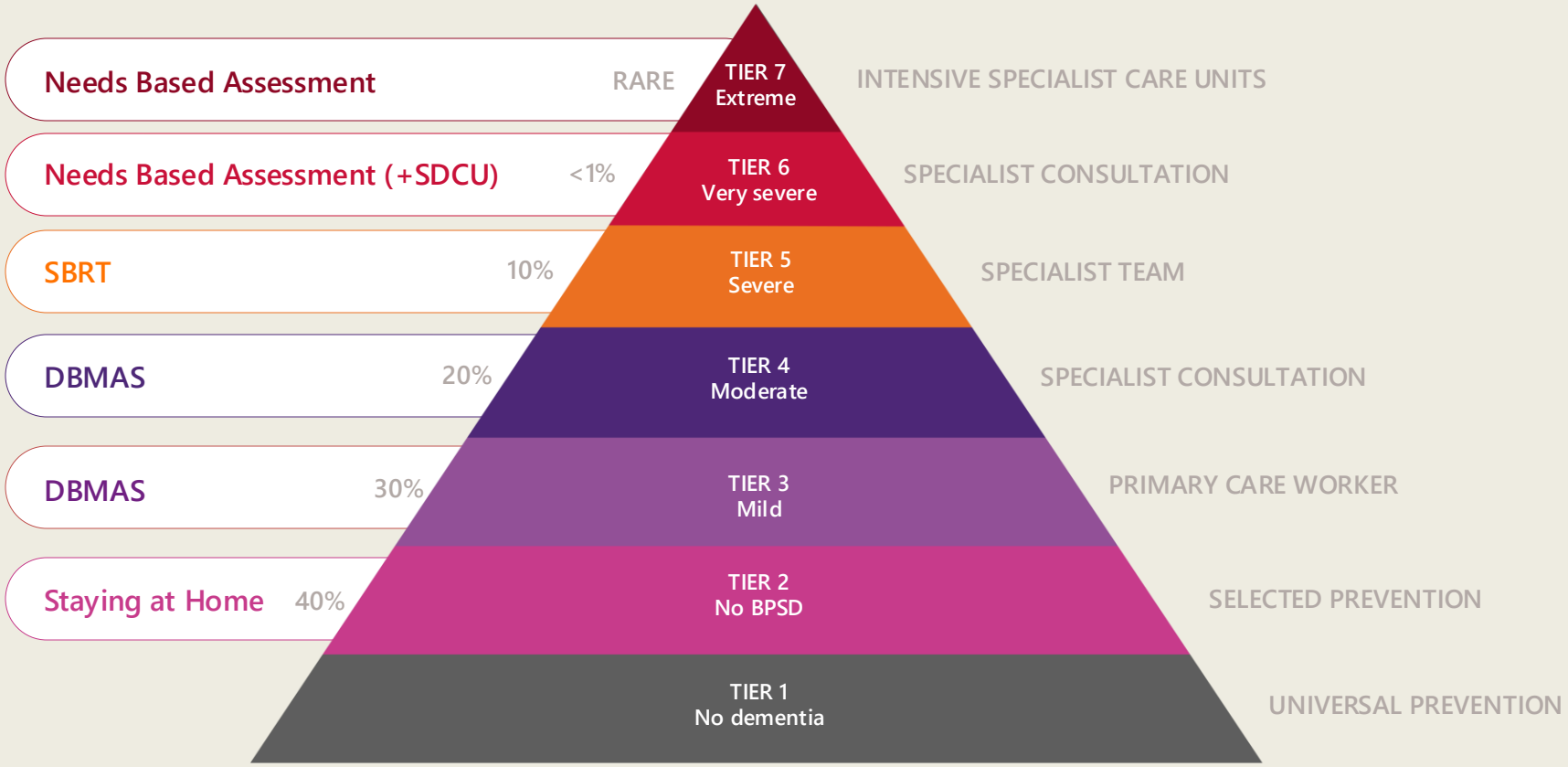
Identifies **causes** of behaviours that contribute to referrals, rather than focussing on symptoms.



Relies upon a detailed **psychosocial history.**

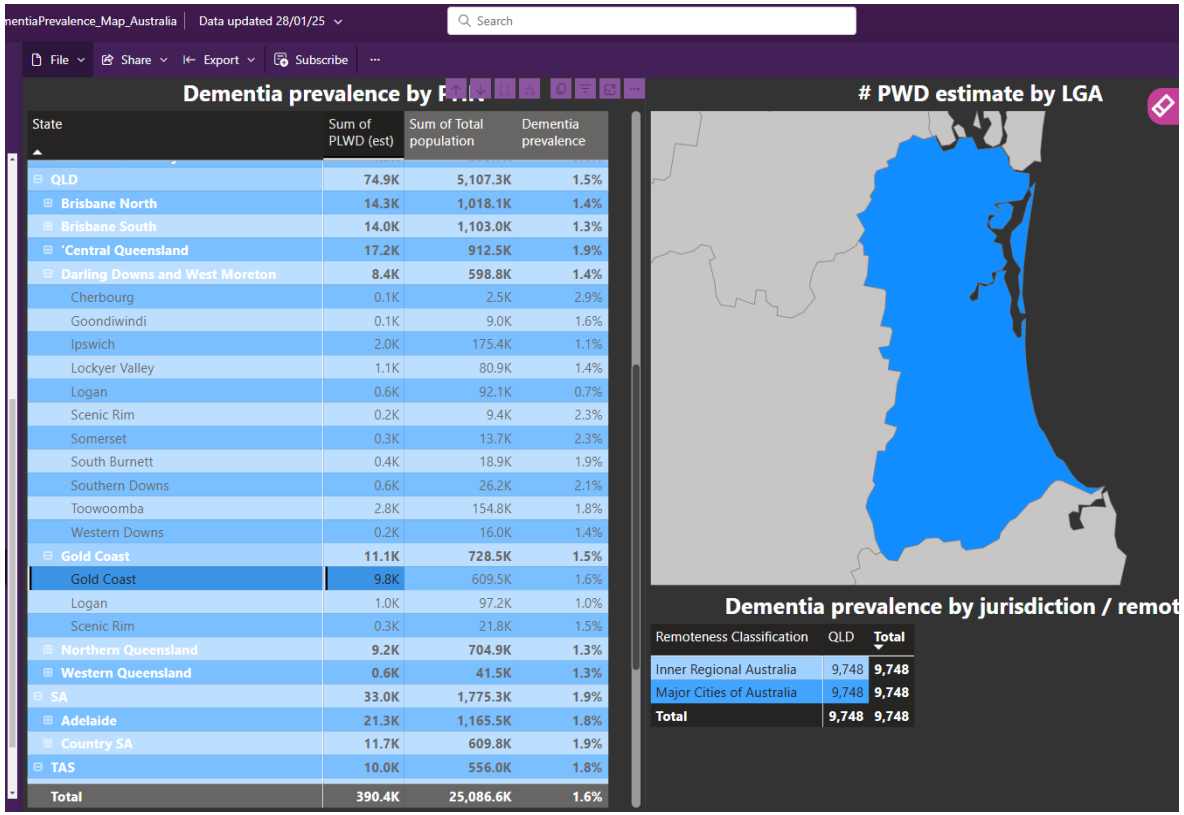
Promotes quality use of psychotropic medication, including de-prescription

- Seven-tier model of service delivery

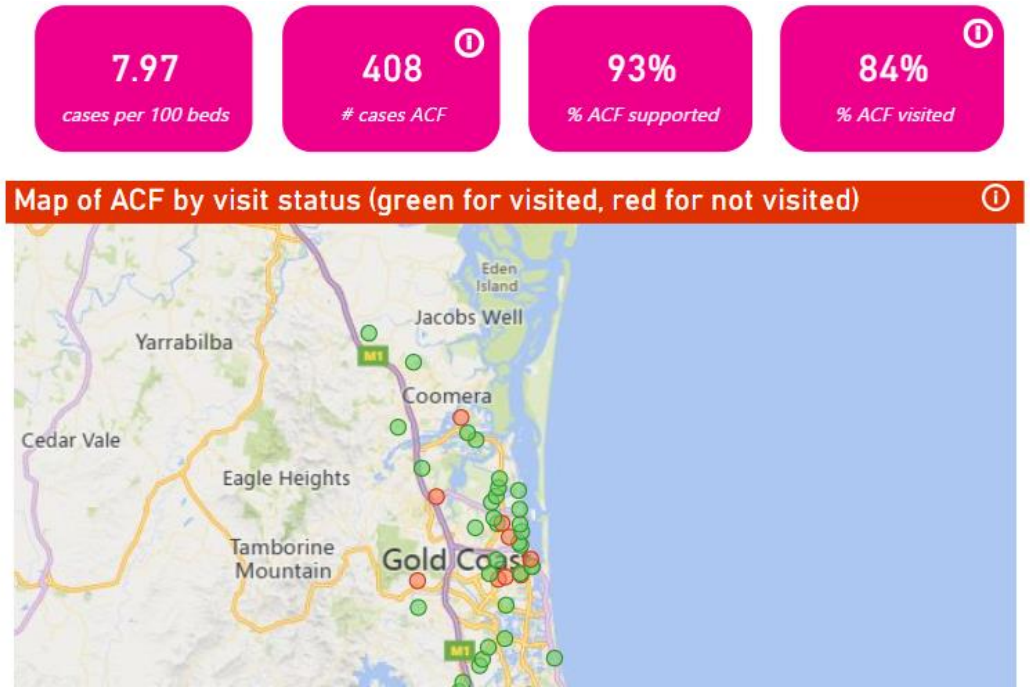


- * Adapted from: Brodaty, H., Draper, B. M., & Low, L.-F. (2003). Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. *The Medical Journal of Australia*, *178*(5), 231–234.

Gold Coast PHN support



State	Sum of PLWD (est)	Sum of Total population	Dementia prevalence
QLD	74.9K	5,107.3K	1.5%
Brisbane North	14.3K	1,018.1K	1.4%
Brisbane South	14.0K	1,103.0K	1.3%
*Central Queensland	17.2K	912.5K	1.9%
Darling Downs and West Moreton	8.4K	598.8K	1.4%
Cherbourg	0.1K	2.5K	2.9%
Goondiwindi	0.1K	9.0K	1.6%
Ipswich	2.0K	175.4K	1.1%
Lockyer Valley	1.1K	80.9K	1.4%
Logan	0.6K	92.1K	0.7%
Scenic Rim	0.2K	9.4K	2.3%
Somerset	0.3K	13.7K	2.3%
South Burnett	0.4K	18.9K	1.9%
Southern Downs	0.6K	26.2K	2.1%
Toowoomba	2.8K	154.8K	1.8%
Western Downs	0.2K	16.0K	1.4%
Gold Coast	11.1K	728.5K	1.5%
Gold Coast	9.8K	609.5K	1.6%
Logan	1.0K	97.2K	1.0%
Scenic Rim	0.3K	21.8K	1.5%
Northern Queensland	9.2K	704.9K	1.3%
Western Queensland	0.6K	41.5K	1.3%
SA	33.0K	1,775.3K	1.9%
Adelaide	21.3K	1,165.5K	1.8%
Country SA	11.7K	609.8K	1.9%
TAS	10.0K	556.0K	1.8%
Total	390.4K	25,086.6K	1.6%



1 IDENTIFY

Identify the changed behaviour and take immediate action.

2 ASSESS

Assess the antecedent, the behaviour and the consequences of the changed behaviour.

3 PLAN IMPLEMENT EVALUATE

Develop strategies to support the person with changed behaviours, implement these strategies and evaluate the effectiveness.

Best Practice behaviour support

1. Identify and address factors which increase the likelihood of distressing behaviour **before** it occurs
2. Conduct a comprehensive assessment of the changed behaviour
3. Use of non-pharmacological strategies as the mainstay of an individualised plan
4. If pharmacological intervention is unavoidable, it complements – not replaces nonpharmacological strategies
5. Antipsychotic medications should not generally be prescribed, but if used treatment should be reviewed every 4-12 weeks

Source: Guideline Adaption Committee: Clinical Practice Guidelines and Principles of Care for People with Dementia (2016).

- a. Diversional therapy

b. Music therapy

c. Child representation therapy

d. Aromatherapy

e. Antipsychotics

f. All of the above

g. None of the above

- a. Diversional therapy

b. Music therapy

c. Child representation therapy

d. Aromatherapy

e. Antipsychotics

f. All of the above

g. None of the above (yet!)

Why?

‘Agitation’ is a type of **changed behaviour**

‘Agitation’ might have **many contributing factors (CF)**

Support + management of CFs = **resolution of the changed behaviour**

5

Slow

Slow down your rate of speech and wait for the person to respond (this can sometimes take a while).

Simple

Keep what you say **simple** - one idea at a time, using short sentences.

Specific

Talk about **specific** people, objects or events they may remember. Use names (John, Mary) instead of pronouns (he, she).

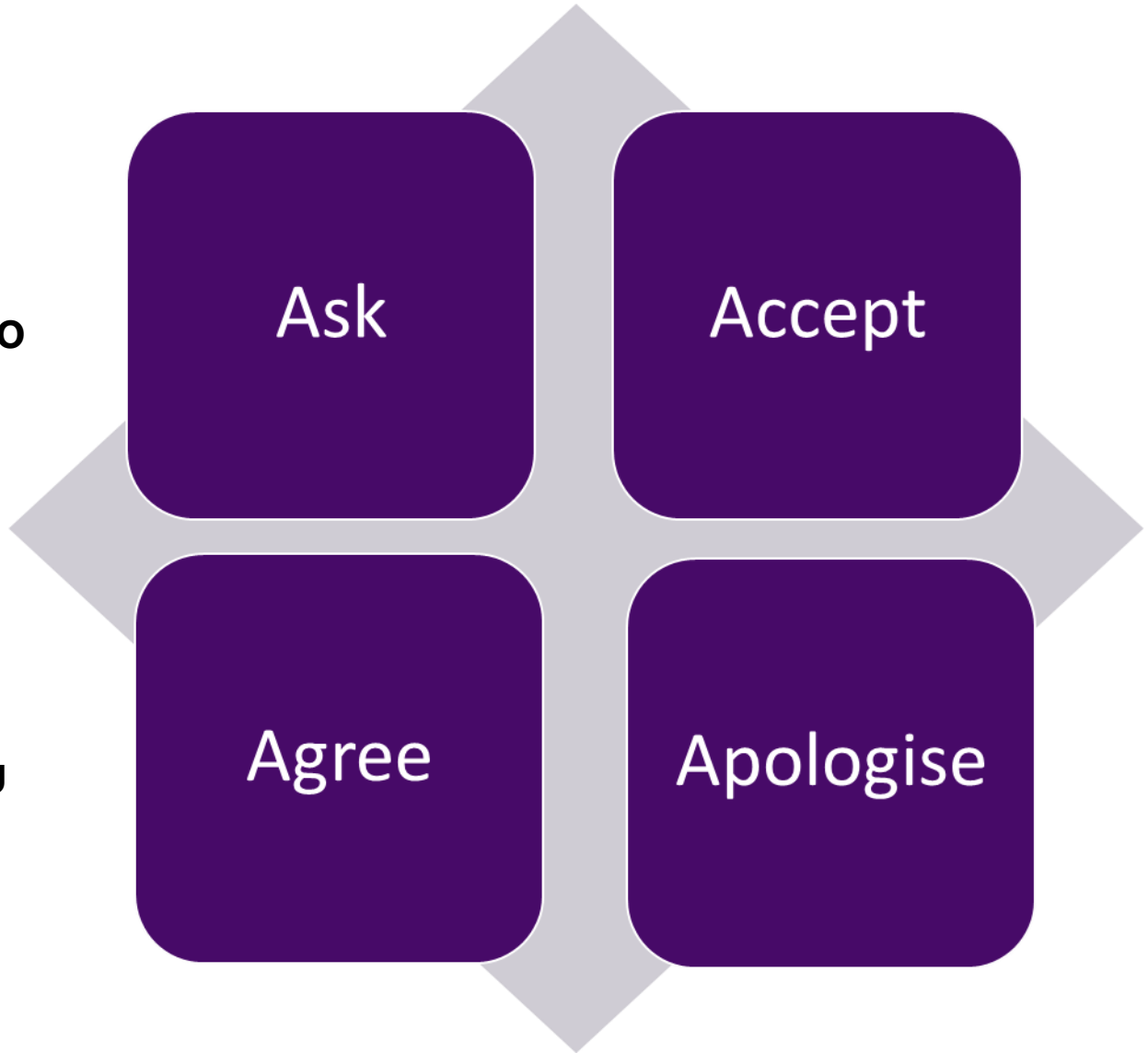
Show

Use gestures, point to items, use visual examples such as photographs, or **show** choices...if you are saying “would you like to wear the blue cardigan?”, show the cardigan.

Smile

Facial expressions can be understood long after verbal language is lost. Send a message with a **smile**!

Offer a choice
Don’t TELL or DO



Accept his or her reality
Don’t ‘correct’

Don’t argue
Avoid reasoning

Genuinely empathise
Be on his or her side

- Why these questions?

About me | In brief

Dementia Support Australia

Funded by the Australian Government
A service led by HammondCare

Name:

Surname:

D.O.B:

I like to be called: *(nickname, title, preferred pronouns)*

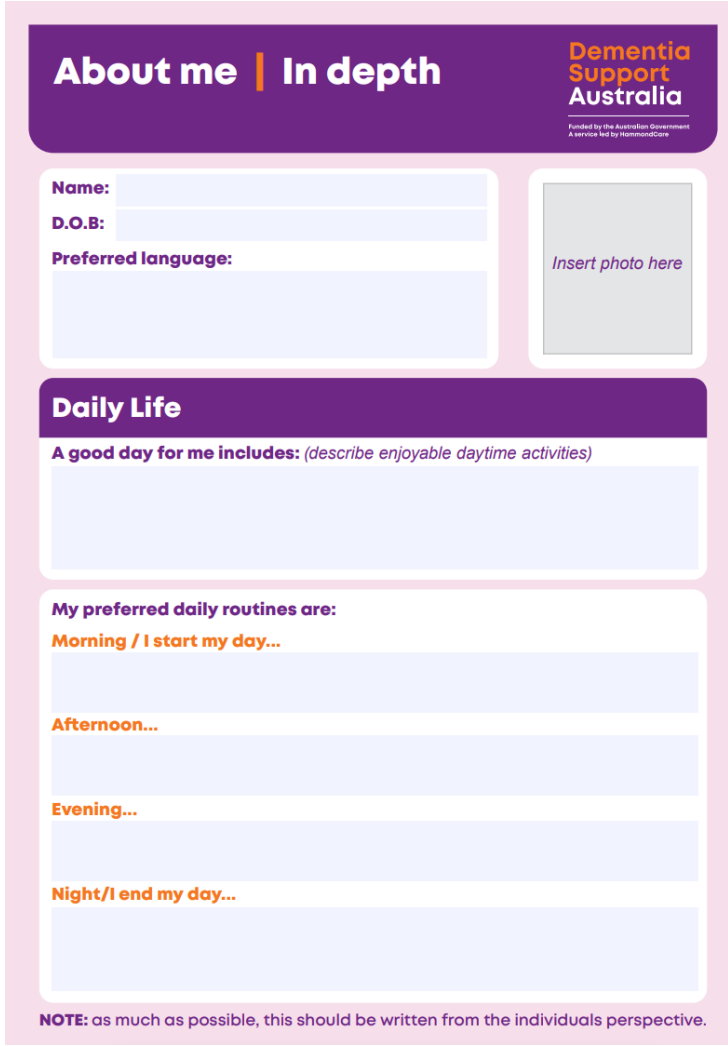
Insert photo here

In the past I... *(note significant life events and roles including past careers, places the person lived, events or activities, and important aspects of their past and identity)*

I like to talk about...

I enjoy... *(Note the things the individual enjoys such as favourite foods, activities, topics of conversation, people, music)*

NOTE: as much as possible, this should be written from the individuals perspective.



About me | In depth

Dementia Support Australia

Funded by the Australian Government
A service led by HammondCare

Name:

D.O.B:

Preferred language:

Insert photo here

Daily Life

A good day for me includes: *(describe enjoyable daytime activities)*

My preferred daily routines are:

Morning / I start my day...

Afternoon...

Evening...

Night/I end my day...

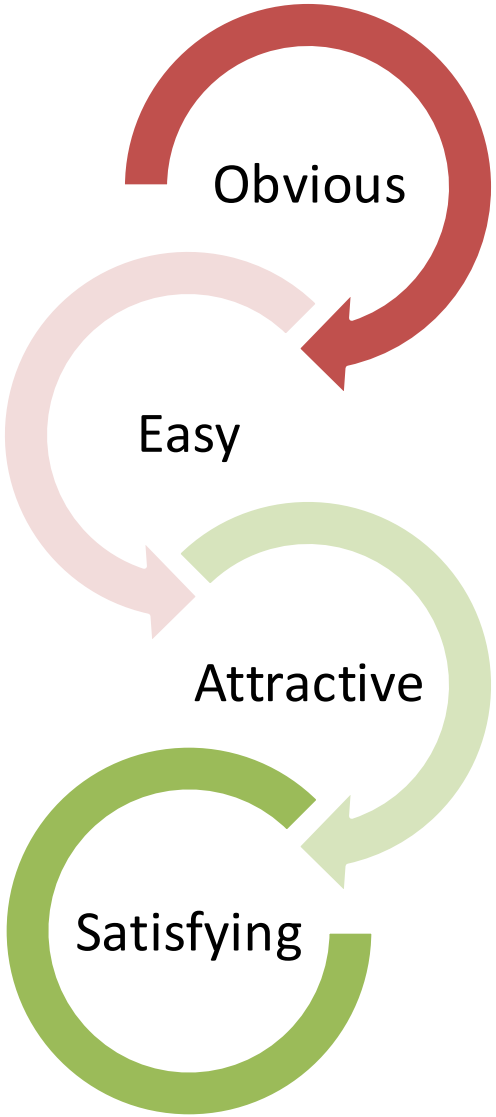
NOTE: as much as possible, this should be written from the individuals perspective.

- Resources to download

Delirium Screen
Are there behaviour changes?
Dementia Support Australia
INFECTION
MEDICINES
PAIN
BOWEL
Assessments to be completed
INFECTION CHECK COMPLETED
MEDICATION REVIEW WITH GP OR COMMUNITY PHARMACIST
CLINICAL INVESTIGATION COMPLETED, APPROPRIATE CHANGES MADE
ABBEY PAIN SCALE COMPLETED
CHECK BOWEL CHART (7 DAYS)
Abbey Pain Scale
For measurement of pain in people with dementia who cannot verbalise
Behavioural assessment form
Residential Care Facility:
Client Name:
Instructions: The Behavioural assessment form should be completed every time a significant incident takes place.
Section A:
1. Behaviour – begin by filling out the middle column, i.e. clearly describe the behaviour.
2. Antecedents – describe what was happening before the behaviour occurred.
3. Consequences – what happened immediately afterwards (before you intervened).
Antecedents or activating events (what was happening before the incident)
Behaviour (what, exactly, was the incident). Start in this section by describing the behaviour
Consequences of the behaviour (what happened immediately afterwards? Who was affected and how?)
Date:
Time:
Where did it take place?
What interaction was going on?
What else was happening? (Noise, unexpected events, etc.)
Observed behaviour:
How long did it last?
What interaction/s took place immediately after the behaviour occurred?
What else happened?
Section B:
Describe what your actions were and what effect they had on the person's behaviour.
Intervention/s
Effect
1800 699 799
dsa@dementia.com.au
dementia.com.au

- Make behaviour support easier to implement by having clear instructions, which are easily accessible, notice and encourage your colleagues or your team's efforts towards good practice.
-

  This may include:
- Displaying the person's life story in their room.
- Keeping copies of life stories, recommendation reports and behaviour support plans in centralised locations accessible to staff.
- Huddles at the beginning of each shift to set the focus and intentions.
- Validate your team's efforts



DEMENTIA RESPITE EDUCATION AND MENTORING

DREAM.UTAS.EDU.AU

Scan to learn more

Dementia Support Australia

UNIVERSITY of TASMANIA

WICKING

Dementia Research and Education Centre

The DREAM Project

Aims to boost the capability of the workforce to deliver quality dementia respite care. It offers:

- **Education**
  - 5 modules with curated resources addressing key learning needs in dementia respite care
  - Wicking Centre's Understanding Dementia MOOC
  - EQUIP Aged Care Learning modules.
- **Community of Practice:** an online forum for the exchange of ideas to learn from and share insights with peers.
- **Dementia Support Coaches:** provide tailored mentoring to help put dementia knowledge into practice.

To access, visit dream.utas.edu.au or scan the QR code to log in.

Dementia Support Australia

Free 24/7 dementia support

Call us:
1800 699 799

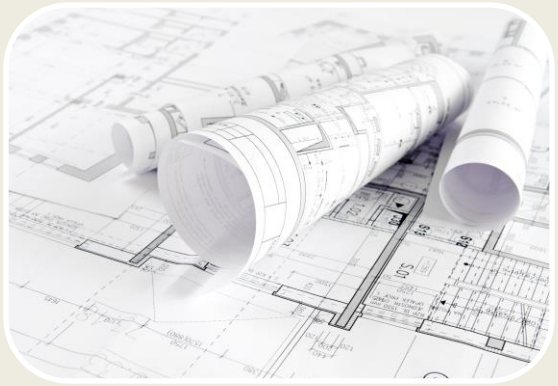
Email us:
dsa@dementia.com.au

Visit us:
www.dementia.com.au

Live chat
accessible via the website

The Dementia Centre.

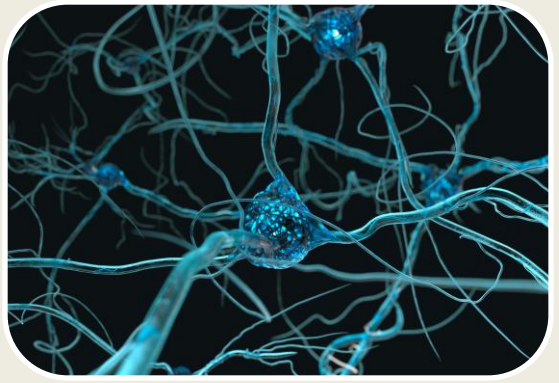
Dementia Centre Services



Design

Education & Training

Consulting



Research

National Aged Care Design Principles & Guidelines

Education and Training

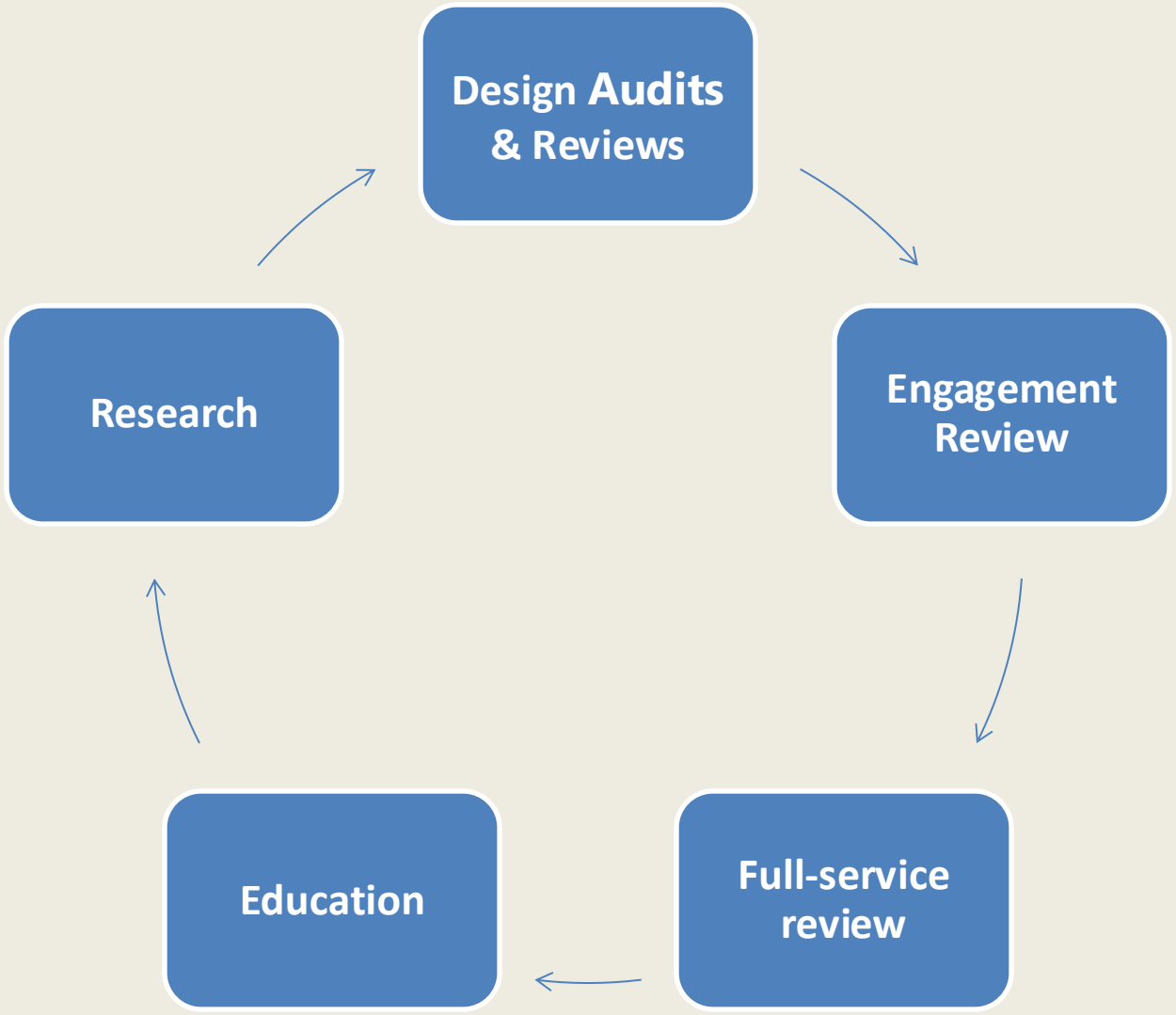
Build your teams capability to care for the whole person

The Dementia Centre.

Workshop menu

1. Understanding Dementia
2. Communication & approach
3. Understanding changed behaviours
4. Meaningful engagement
5. Sexuality, Intimacy & Dementia NEW
6. Creating supportive spaces
7. Intervene to manage pain
8. Music speaks
9. The dining experience
10. Night-time care
11. About me
12. Trauma informed practise NEW
13. How to have a better visit NEW

Dementia Centre Consultancy



consulting@hammondcare.com.au

https://www.dementiacentre.com/contact

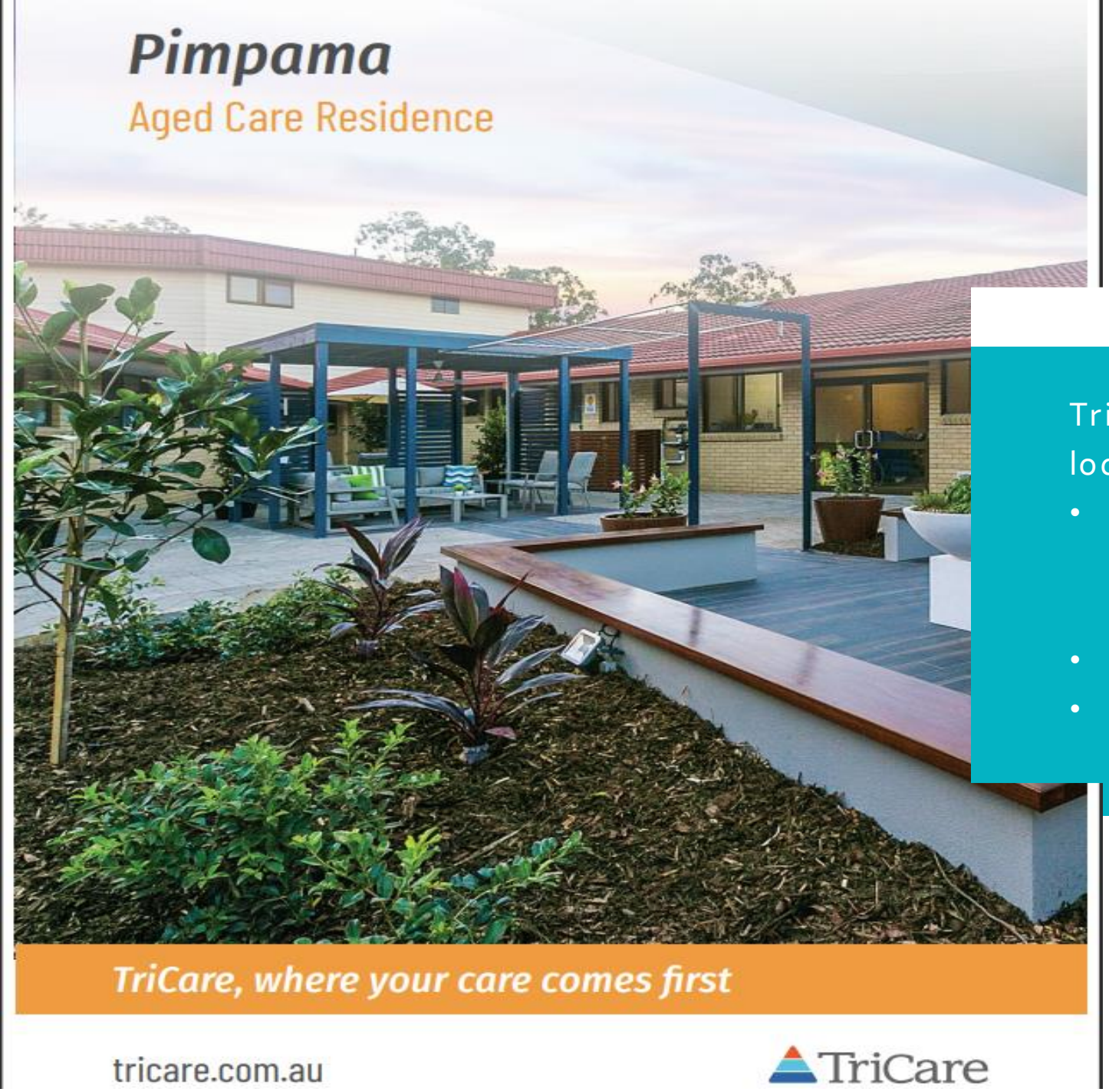
0468 572 969

The Dementia Centre.

BREAK

RESIDENT CARE AND MANAGEMENT OF BEHAVIORS IN RESIDENTIAL AGED CARE

April Pacifico, Regional Care and Compliance Coordinator



ABOUT US

TriCare Pimpama Aged Care Residence is centrally located between Brisbane and the Gold Coast.

- 92 bed facility, single rooms with private to shared ensuites and rooms with shared bathrooms.
- Considered specialized in dementia care
- Secured dementia unit

CURRENT RESIDENT POPULATION

MULTICULTURAL

Diverse culture and care needs are considered in the current aspects of care provided to the resident

A VARIETY OF SOCIOECONOMIC BACKGROUNDS

Concessional residents and high number of residents who are supported by the Public Guardian and Public Trustee

DEMENTIA AND MENTAL HEALTH CARE

95% of residents living in care has a diagnosis of dementia, Alzheimer's and or a mental health diagnosis.

ADMISSIONS

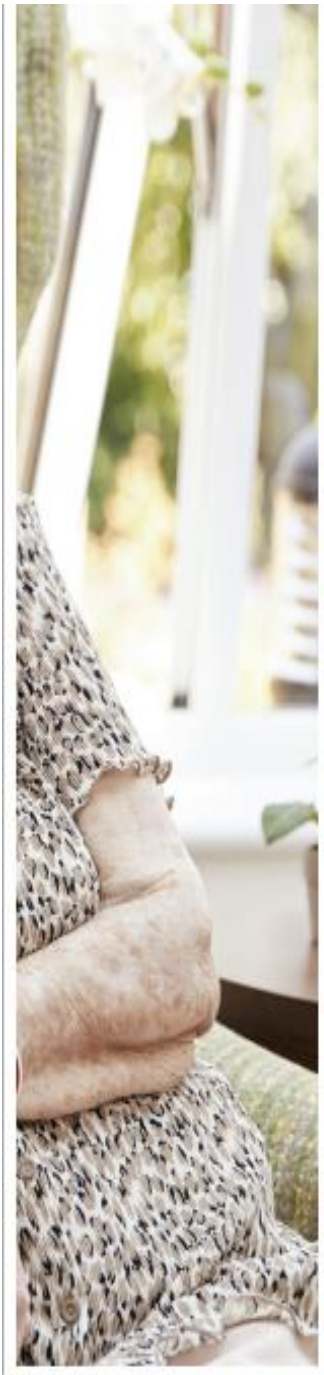
Average of 2 permanent admissions in a month.

REFERRALS

Most admissions and referrals are direct from GCUH and Robina Hospital.
Internal TriCare facility transfer
Other RACF transfer, relocation, etc.

LEVEL OF IMPAIRMENT

On admission, the majority of residents exhibit moderate to severe cognitive impairment.



OUR APPROACH

FAMILY-CENTERED

We treat every resident and their representative as a family. Collaborative care.

COMPASSION

We take pride in our deep understanding of our residents and their families, enabling us to provide tailored support and care.

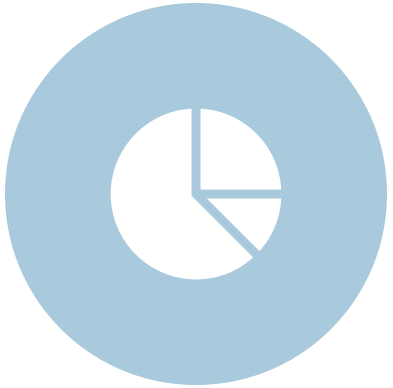
CARE

Outline care needs and interventions based on the residents' acceptance of the care provided.

RESPECT

Address residents' wants and preferences while working in consultation to manage risk-taking behaviours.

BEHAVIOUR MANAGEMENT



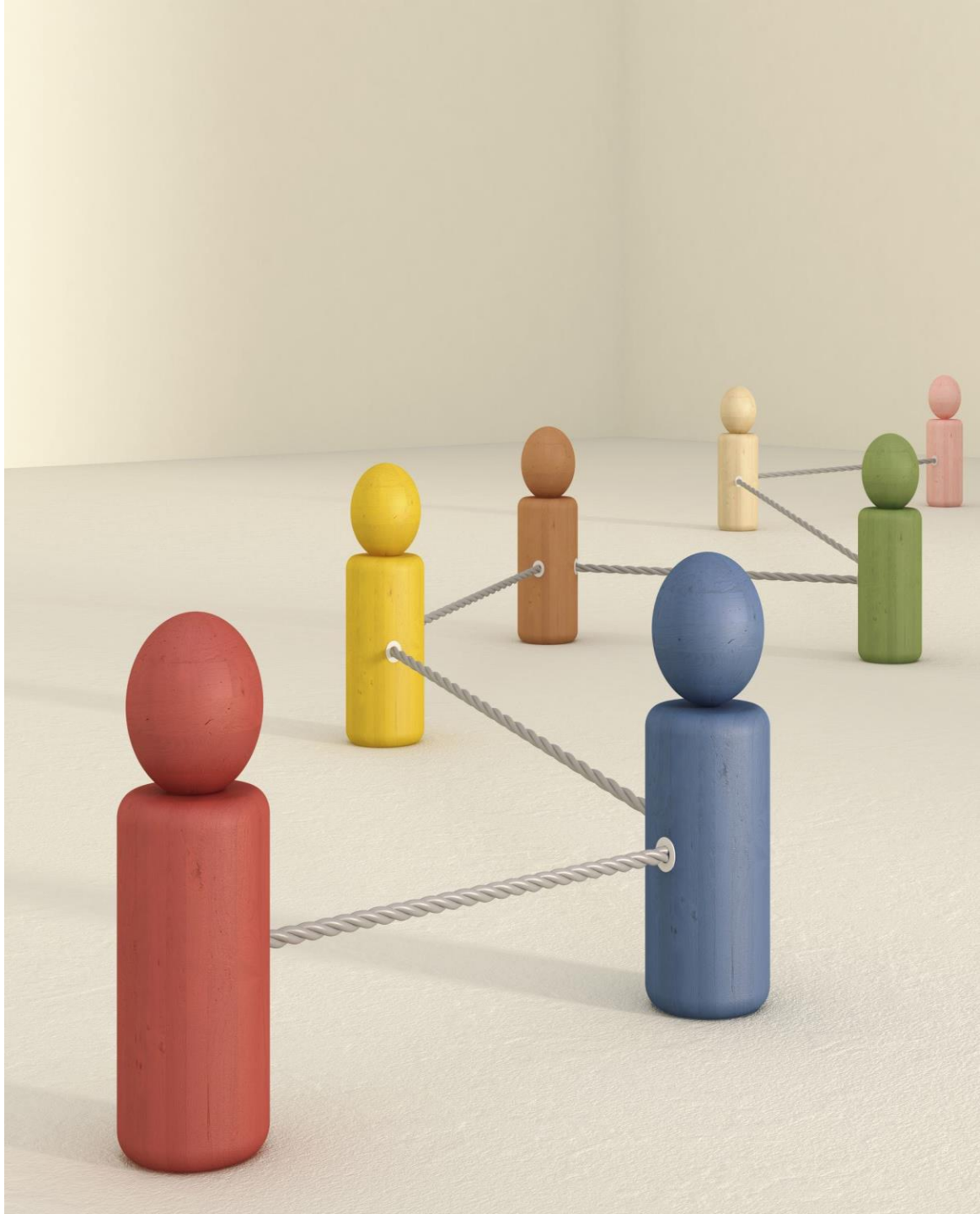
ASSESSMENT AND CARE PLANNING STRATEGIES

PERSON-CENTERED APPROACH

STRATEGIES TO ADDRESS BEHAVIOURS

PERSON CENTRED APPROACH
FOUR (4) KEY ELEMENTS
VIPS:

1. Valuing people (V)
2. Treating people as Individuals (I)
3. Looking at the work from the perspective of the Person (P)
4. A positive Social environment in which the person can experience relative wellbeing (S)



ASSESSMENT AND CARE PLANNING PROCESS

Challenging behaviours that impact other residents must be recorded within incident reporting processes and recorded in progress notes and on assessment forms.

Challenging behaviour management strategies will be recorded in each resident's behaviour support plan and evaluated routinely (at least every 3 months) and as indicated by changes in resident care needs.

Behaviour support planning will give high priority to maintaining safety and reducing stressors and causative factors associated with behaviours.

Changes in residents' behaviour, particularly sudden unusual changes in behaviour, may be signs of underlying pathology such as pain, hunger or infection and will be assessed and treated appropriately.

Residents will be referred for appropriate specialist allied health and medical assessment where required (following consultation with the resident/their representative, the resident's Medical Practitioner and the Clinical Manager).

BEHAVIOURS ARE A PICTURE OF OUR PAST LIFE AND EXPERIENCES

STRATEGIES TO ADDRESS THESE BEHAVIOURS

Simple and efficient strategies

PROVIDE YOUR UNDIVIDED ATTENTION

put down what you are currently doing

adopt an open, welcoming stance

soften your facial expression - no frowning

touch people as a gesture of comfort

BE THE ENERGY YOU WANT TO ATTRACT

VALIDATE THE EMOTIONS OF THE INDIVIDUAL

- say 'you seem upset'
- 'are you uncomfortable?'
- "you appear angry"
- "it must be frustrating for you"
- Don't try to talk them out of how they are feeling

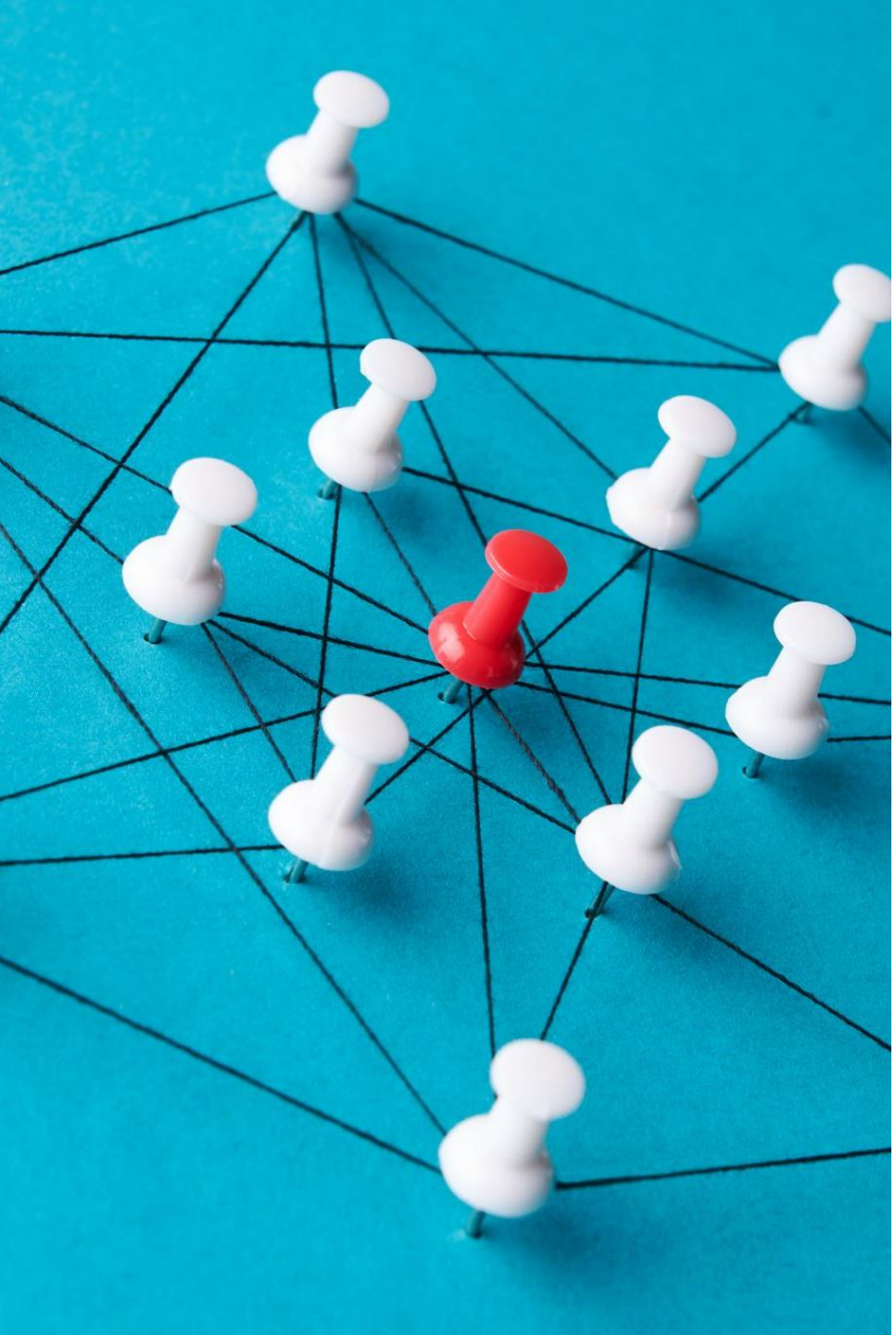
UNCONDITIONAL POSITIVE REGARD

- acceptance and support of a person regardless of what the person says or does
- setting aside your own personal opinions and biases
- your attitude should isolate behaviours from the person who displays them
- to suspend judgement, and to listen to a person with an attitude that the resident has within himself/herself the ability to change
- do not speak to them as if you are 'in charge' or you 'know better' than they do

Redirect the person in a meaningful way

KNOW WHAT THE RESIDENT ENJOYS DOING AND ASK THEM IF THEY WOULD CARE TO JOIN/ASSIST YOU

SOMETIMES DOING NOTHING IS A PLAN



END OF LIFE CARE- DEMENTIA

Over the past year, the recorded deaths at TriCare Pimpama have primarily been attributed to the progression of dementia, comorbidities, physical decline necessitating changes in care, and clinical deterioration not necessarily linked to a dementia diagnosis.

CHALLENGES AS A ....

NURSE

Care to be provided is in line with legislation and the Aged Care Quality Standards

Day to day changes in care

Sudden change in condition and acute clinical events

Innovations in care and to ensure residents are still provided with meaningful engagement despite cognitive decline.

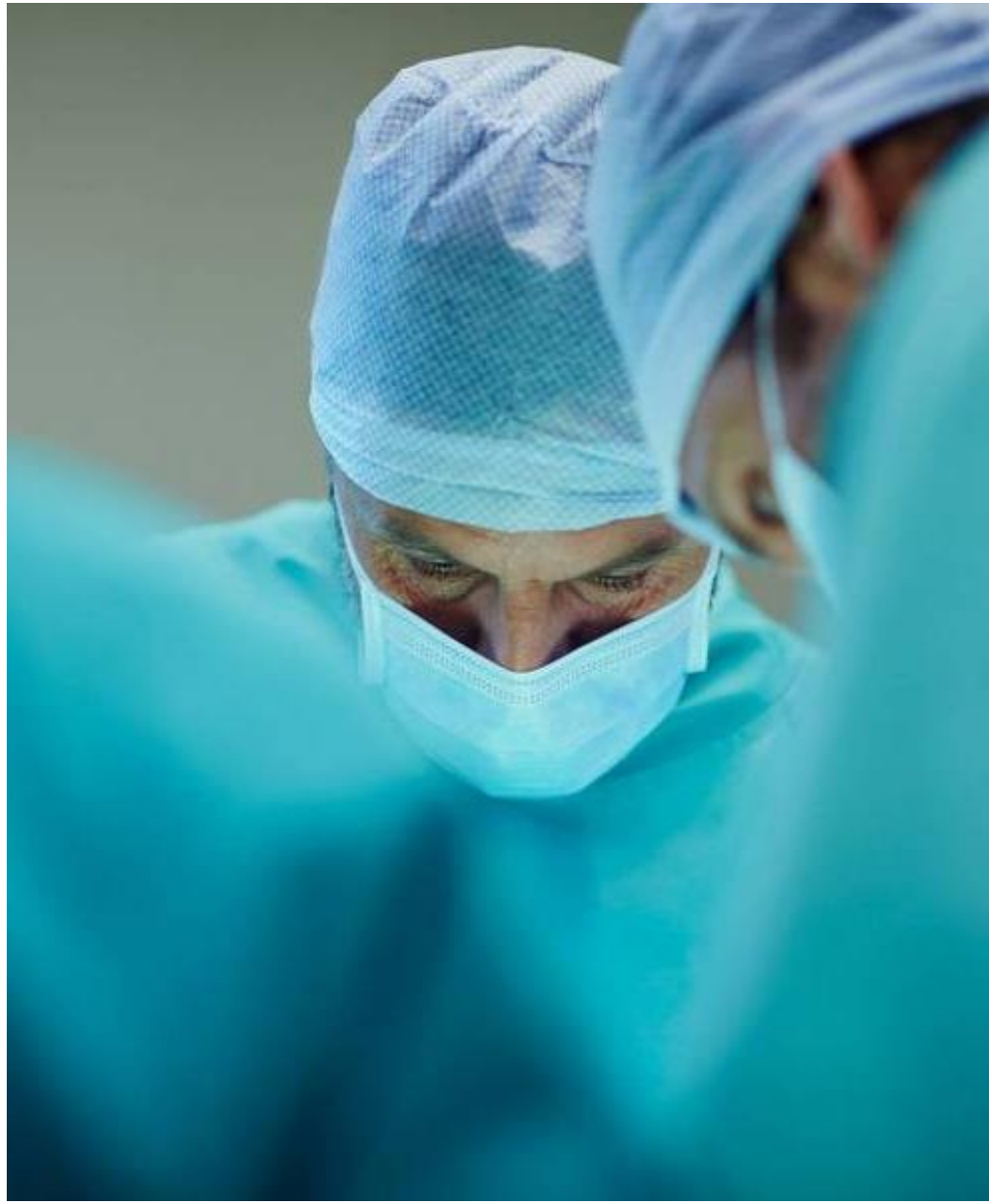
MANAGER

Family interactions

Family acceptance

Navigating around resident representative's preferences and resident's choices and or capabilities

Staff Knowledge and ongoing training



IT IS A DAY TO DAY CHALLENGE

SUMMARY

Our commitment to care, dedication and passion is our top priority.

It is challenging but THIS IS what we DO BEST!


THANK YOU

Improving Outcomes: GP-Nurse Collaboration in Dementia Management

Dr Prajwal Das
MRCS, MRCGP,FRACGP

Lake Orr Family Practice

Bridging the Gaps

OUR BACKGROUND

We are a dedicated family practice with extensive experience in aged care, with our GP having managed patients in Residential Aged Care Facilities (RACFs) across both the UK and Australia for many years.

Our practice currently oversees the care of **90 residents** across **six nursing homes**, with facilities ranging from as few as **two residents** to a maximum of **36**.

Effective coordination with aged care nurses and seamless GP management is **crucial**, as the majority of our residents experience **cognitive impairment or dementia**.

OUR BACKGROUND

We recognize the value of having a **private geriatrician** as part of our team, ensuring access to expert advice over the phone whenever needed.

We deeply appreciate the support of the **RASS team**, particularly during peak clinic hours, when their assistance is invaluable.

We also seek **greater collaboration with the LARU team from QAS**, as their involvement plays a vital role in strengthening our overall healthcare approach.

CHALLENGES IN DEMENTIA

- **Communication Barriers**: Dementia patients often struggle to articulate their symptoms, making diagnosis and treatment more challenging.
- **Dependence on Nursing Staff**: During the day, patients rely heavily on nursing staff, as GPs are occupied in the clinic and visit only once a week.
- **Hospital vs. Facility Dilemma**: Determining whether a patient should be hospitalized or managed within the RACF can be complex.
- **Limited Support Availability**: While **Dementia Australia** provides valuable resources, access is not always immediate.
- **Family Concerns**: Families who live far away experience anxiety, as they cannot easily communicate with their loved ones.

CHALLENGES IN DEMENTIA

- **Paramedic Challenges**: Young or inexperienced paramedics may struggle to assess dementia patients, often leading to unnecessary hospital transfers.
- **Hospitalization Issues**: Being in an unfamiliar hospital environment can increase confusion and agitation in dementia patients.
- **Preferred Care Approach**: Whenever possible, managing patients **within the RACF** is the most effective option.
- **Training Gaps**: New graduate nurses often lack specialized training in dementia care, impacting the quality of patient management.

COMMON CHALLENGES FOR THE NURSING STAFF

Limited Access to Expert Advice: Dementia patients may become unpredictably aggressive, but immediate guidance is not always available.

Medication Accessibility: Even when the GP or RASS team recommends medication, obtaining and charting it can be challenging.

Reliance on Telephone Advice: Nurses often have to make critical decisions based solely on phone consultations.

Physiotherapy Support: A full-time physiotherapist would help assess post-fall injuries in dementia patients, improving patient care.

COMMON CHALLENGES FOR THE NURSING STAFF

Restraint Limitations: Restrictions on physical restraints can make managing agitated patients more difficult.

Psychotropic Medication Restrictions: Limited use of psychotropic medications further complicates patient management.

Staffing Challenges: The **patient-to-nurse ratio** can be overwhelming, especially when dealing with aggressive patients or fall risks, requiring a **multidisciplinary team approach**.

TEAM COLLABORATION: ENHANCING PATIENT CARE THROUGH COORDINATION

Gather

Gather Comprehensive Incident Details: Nursing staff should obtain a thorough history of the event, including observations and, if possible, urine dip test results.

Collect

Collect Collateral Information: Gather additional insights from caregivers and any witnesses to ensure a complete understanding of the situation.

Assess

Assess Patient Safety: Confirm that the patient is stable, ensuring **ABC (Airway, Breathing, Circulation)** is clear.

Engage

Engage with Family or Next of Kin: Briefly discuss the situation with the patient's family to understand their awareness and expectations.

TEAM COLLABORATION: ENHANCING PATIENT CARE THROUGH COORDINATION

1. **Review Advance Care Plans**: Check for any existing **Advance Care Directives** or **Enduring Power of Attorney (EPOA)** to align care decisions accordingly.

2. **Escalate Urgent Situations**: Call **000** immediately if the situation is critical.

3. **Notify the GP Practice**: Contact the **GP surgery reception** and provide detailed information via email for the GP's review.

4. **Confirm Urgency with Reception**: Ensure the receptionist understands the urgency of the matter. If non-urgent, establish a **realistic timeframe** for a GP callback.

5. **Utilize RASS Support**: If the primary GP is unavailable and the issue is pressing, nurses can contact the **RASS team** for guidance. The **RASS team** may provide telephone advice or send an assessor to evaluate the patient.

TEAM COLLABORATION: ENHANCING PATIENT CARE THROUGH COORDINATION

Escalate

- **Escalate If Necessary**: If no immediate advice is available, nursing staff should call **000** and request attention from **LARU officers (QAS)**.

Leverage

- **Leverage LARU Paramedics**: These specialized paramedics act as **independent practitioners**, responding faster than a full ambulance crew and handling minor injuries and ailments.

Facilitate

- **Facilitate Non-Urgent GP Consultations**: Non-urgent cases can be scheduled for **telephone advice** via the practice's phone line or online booking system.

Encourage

- **Encourage GP-Family Communication**: Most GPs are open to discussing patient concerns with families during a dedicated timeslot, helping align care goals and expectations.

Queensland Ambulance Service Case Study:

Supporting the care of a behaviourally disturbed elderly patient in an RACF

Senior LARU Paramedic and Senior Clinical Educator David Krygger

Case study

- 85 year-old patient with deteriorating behaviour towards other residents
  - Verbally aggressive
  - Physically aggressive
- De-escalation strategies from the RACF staff had failed and the patient is now confined to their room for other resident and staff safety.
- RACF requesting transport of this patient by QAS to hospital

Delerium or Dementia

- Attempting to differentiate these conditions will aid with QAS support and inter-disciplinary decision making and whether transport is required.
- In this specific case study, irrespective of the cause the behaviour has now deteriorated to a situation where the patient is too high risk to remain in the RACF

What happens before we arrive?

- Emergency Medical Dispatchers take the call and prioritise the response based on the information gathered (AMPDS)
- Majority of calls from a QLD RACF are now reviewed prior to an ambulance being dispatched.
- This occurs by the QAS Clinical Hub and may result in a proactive referral to local RaSS teams or discussions about alternative care pathways
- Appropriate ambulance may be dispatched (Advanced Care Paramedics, Specialised LARU Paramedics, Specialist Critical Care Paramedics or Patient Transport Services)
- Ambulance crew receives a brief story about the clinical issue on our MDT in the ambulance prior to driving to scene

What is the QAS Clinical Hub?

- The QAS Clinical Hub is a multi-million dollar secondary triage service that utilises a muti-disciplinary approach to triage ambulance requests for service.
- Consultant Emergency Doctors, Specialist Mental Health Nurses, Senior Social Workers, Senior LARU and Critical Care Paramedics
- Centrally supported by the QAS Medical Directors office

On-scene (de-escalation and care strategies)

- Paramedics will seek a handover from the on-site RN to understand the situation and concerns about the patient

- Gaining an understanding of the circumstances of the behavioral disturbance and discuss what has worked in the past (if anything)

On-scene

- Making contact with the patient is preferably done after we fully understand the concerns of the RACF in non-life-threatening situations

- QAS Paramedics are educated to take our time with behaviorally disturbed patients. Prioritising an approach that de-escalates behaviour and engages with the patient, RACF staff and wider support services .

Strategies for paramedic engagement and de-escalation

- Calm approach preferably with known RACF staff or family (if on scene and appropriate)
- Assessment of the environment
  - Are there any dangers?
- Using family members or staff to assist with identifying triggers and providing insights into past strategies that may help
- Use of distraction techniques
- Engaging with the patient as a partner in care wherever possible
  - Use of calming techniques like active listening, distance and patience can improve rapport or sometimes reduce some aggressive behaviours
- QAS paramedics are trained and advised to take their time with these complex patients
  - Scaffolding of strategies
- If a patient is successfully de-escalated the paramedics may work with the RACF to see what care could be provided in the RACF. This may include a chat with the RaSS team, or decision to re-integrate with the GP.
  - This depends on the likelihood of future escalation

Patient management – safe transportation

- Care needs to be taken when a successfully de-escalating a patient as some may deteriorate again while in the ambulance
- An ambulance is a foreign, small, uncomfortable environment with a paramedic they are not familiar with
- Being able to bring a family member (where appropriate) assists with rapport and ongoing maintenance of reduced behaviours.
  - Consideration should be given to call trusted family members to attend hospital with the patient to support them.
- It is common for dementia patients to be increasingly confused in an ambulance, become disorientated and become increasingly aggresive.
  - Many assaults on paramedics occur as a result of aggressive elderly patients with dementia.
  - This is also the case when we arrive at ED

Patient management - sedation

- Sedation of any patient is associated with a higher risk or disability or mortality
  - Especially in older patients
- It is a decision not taken lightly
- QAS data indicates that vast majority of complex behavioural issues in the elderly **do not** require sedation.
- However, significant behaviourally disturbed patients may require **olanzapine** or **droperidol** from QAS to ensure their safety and facilitate appropriate transport.
- Any decision to sedate an elderly patient will always be conducted as a last resort with the final call being made by the attending paramedic.

What are the biggest challenges?

- Patients who are experiencing extreme levels of agitation/aggression that are unable to be de-escalated
- Minimising the risk of secondary injury to the patient, other residents or staff during patient care
- Differentiating the many reasons for elderly aggression and making attempts to partner with the RACF to navigate care options

Take home messages about paramedic care

Paramedics will work as part of a multi-disciplinary response to care for complex presentations

Expect additional time to be taken on scene to safely and appropriately assess and manage these patients to facilitate care

Paramedics will explore strategies that may avoid hospital admission in suitable cases. Consultation with outside agencies, the patients GP and family will likely occur.

Transporting behaviorally disturbed patients is complex and has safety implications

Sedation is a last resort and will often only occur after consultation

BREAK

Dementia in Residential Aged Care

Untangling the intricacies Gold Coast 2025

Presenter
Detective Senior Sergeant Debbie Phillips

- I respectfully acknowledge the Yugambeh & Kombumerri peoples as the Traditional Owners and Custodians of the land I am on today.

- I recognise their connection to land, sea and community. I pay my respects to them, their cultures, and to their Elders, past present and emerging.

- I further extend this respect to any First Nations people present in this room with me today

Senior Sergeant Debbie Phillips

VULNERABLE PERSONS POLICING

State Domestic, Family Violence and Vulnerable Persons Command

Senior Sergeant Debbie Phillips

Roles and Responsibilities

- **Direction, guidance, advice**
- **Build partnerships**
- **Co-ordinate/implement strategies**
- **Interpretation of information**
- **Training**
- **Liaison**

WHY

148

Recommendations

Aged Care Quality and Safety Commission's

Our vision is for older Australians to trust and have confidence that aged care **services protect and enhance their safety, health and quality of life.**

Everyone has the right to safe, compassionate care. We preserve this right and ensure that people who use aged care are treated with **dignity and respect.**

Senior Sergeant Debbie Phillips

Serious Incident Response Scheme (SIRS)

- **As a worker, you must know your obligation to report all incidents to the appropriate staff member.**
- **Priority 1 reportable incidents**
- **Priority 2 reportable incidents**

Reporting to the police

- **Providers must report an incident to the police where there are reasonable grounds to do so.** This includes scenarios where the provider is aware of facts or circumstances that lead to a belief that an incident is unlawful or considered to be of a criminal nature. An example is sexual assault. These incidents **must also be reported to police within 24 hours of becoming aware of the incident.**

Priority One

8 types

- Unreasonable use of force
- Unlawful sexual contact or inappropriate sexual conduct
- Neglect
- Psychological or emotional abuse
- Unexpected death
- Stealing or financial coercion by a staff member
- Inappropriate use of restrictive practices
- Unexplained absence from care

WHAT IS ELDER ABUSE

- If an older person is being harmed in some way by a person they trust, that's elder abuse.

- It is common for elder abuse to be experienced at home, in places visited regularly, or where services or care are accessed.

- It is not uncommon for elder abuse to remain unreported, hidden and even unsuspected.

- As defined by the World Health Organisation –

"Elder abuse is a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person."

ELDER ABUSE is a CRIME

What are the common trends which QPS are notified of

Domestic and Family Violence &

Criminal Offences :

1. **Fraud – Section 408C Criminal Code**
2. **Stealing – Section 398 Criminal Code**
3. **Wilful Damage – Section 469 Criminal Code**
4. **Extortion – Section 415 Criminal Code**
5. **Serious Assault – Section 340 Criminal Code**
6. **Failure to Provide Necessaries – Section 324 Criminal Code**
7. **Abuse of persons with impairment of the mind - Section 216 Criminal Code**

WHY ISN'T ELDER ABUSE REPORTED

- The person does not want to get family members in trouble
- Victim fears retaliation from the abuser
- There may be a loss of access to grandchildren as a result of reporting
- Shame
- Fear of loss of support or independence
- Fear of being put in a nursing home
- Lack of knowledge on how to get help

CASE Studies

JOAN & SEBASTIAN

Joan

- 86 yrs
- Advanced Stage Dementia; nonverbal
- Regional Aged Care facility
- Another patient seen in her room having sex with her

Sebastian

- 87yrs
- Dementia
- Can be aggressive
- Has previously threatened to fight staff
- Another resident has approached and engaged in a fight

Senior Sergeant Debbie Phillips

Gold Coast Health always care | phn GOLD COAST An Australian Government Initiative | Queensland Government

THANK YOU

Please scan the QR Code and complete the post-evaluation survey