Dementia Training Australia

DTA Guest Lecture: Best Practice Interventions for Unmet Needs in Dementia - 3 Jun, 2021

Audience Q&A's

QUESTIONS	ANSWERS
What are the 12 risk factors please?	Hearing loss, traumatic brain injury, hypertension, alcohol, obesity, smoking, depression, social isolation, physical inactivity, air pollution, diabetes https://www.thelancet.com/article/S0140-6736(20)30367-6/fulltext.
Is there new terminology for those that walk and pace? Is active exit seeker a correct term?	No specific term as far as I am aware. Active exit seeker is more specific to those who try to abscond.
Does neurofilament light, rate as a possible early indication for Alzheimers Dementia?	Neurofilament light chains are a sign of non-specific neuronal injury and are elevated in a range of conditions. Lots of research looking into whether specific levels, especially in the blood, can be indicative of specific disorders such as AD. There is a bit of a way to go until we have a 'blood test for AD' if we ever do get there.
How do you know depression is part of dementia rather than just a progression of aging and losing identity, engagement and participation etc?	Short answer - you can't be 100% sure. Lots of overlap bewteen this and symptoms of depression. We try to look for the severity and impact of the symptoms and the specific signs mentioned in the diagnostic criteria e.g. sleep disturbance, loss of appetite and weight loss, unexplained new onset of anxiety and agitation, expressions of pessimism, suicide or wanting to die, guilt, low energy and psychomotor changes.
Depression and anxiety are often difficult to treat in patients with dementia. Can you comment of the effectiveness of SSRI/SNRI in this population of patient?	The currently available meta-analyses (e.g. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003944.pub2/full) do not provide good evidence to support their efficacy in depression in dementia. That said, very few trials have been done in this area and we are not always sure if what we are treating in clinical trials is what we see in day-to-day practice. It really comes down to trying to make sure you are using them for the right indication. Anti-depressants do not work for apathy or low mood due to psychological distress/grief over change of circumstances, coming to terms with a life-limiting illness etc.
There are quite a large number of medical conditions with neuropsychiatric manifestations. Is it possible that some persons have been/are misdiagnosed as suffering from dementia when they may be suffering from another condition? I've often wondered about this in residential aged care settings.	Yes it can happen although many of these conditions can cause dementia (the syndrome of multiple cognitive deficits causing functional impairment). It is always important to exclude reversible causes (e.g. metabolic conditions, delirium) and pseudo-dementia presentations (e.g. depression, anxiety) as a cause of the cognitive impairment.
What are person centred practices that can be implemented for the person with dementia who is at the end of their life? Is there any recent research on this topic that is available?	There is quite a lot of literature about palliative/end of life care in dementia. Here is a link to a recent review of this https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7394698/.
Should risperidone be given as PRN (as required)?	Can do if medications are indicated. Usually at doses of 0.25-0.5mg depending on the individual. The problem with PRN is that often by the time you are able to administer it, the behaviour has already led to a lot of distress and also may resolve on its own accord.
How can anxiety be diagnosed for people living with dementia?	Through clinical assessment. Screening tools such as the RAID can sometimes be helpful https://www.tandfonline.com/doi/abs/10.1080/13607869956424).

Is there a correlation with chronic depression &/or personality disorders in earlier life, which then going on to develop into dementia in later life?	There is a lot of research into whether depression is a risk factor in dementia and this is listed as a potential modifiable risk factor in the Lancet paper referenced above. Not much on personality disorders as far as I am aware but these are risk factors for various psychiatric disorders, including depression, so may be linked to dementia that way. We also commonly encounter the scenario where people present with what seems like depression, but does not get better with treatment, and it subsequently becomes evident that this was actually the start of their dementing illness.
Do GP's have training about deprescribing? We have some great GP's that do try to deprescribe and we have had mixed outcomes from this. In my experience a few GP's will not deprescribe, just in case we need it (especially PRN's)	I am not sure if they get specific training during their training but suspect this is discussed and taught. One of my colleagues here at the WA Centre of Health and Ageing, Dr. Chris Etherton-Beer, has done a lot of great work in this area. There are also resources on the GP College website https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/deprescribing.
Are there things you can do now as healthy individuals to help slow down the onset of dementia?	Please see Lancet reference above. What I tell people is the following: Maintain regular exercise (30 minute a day at least 5 times a week), remain as intellectually engaged as possible, remain as socially engaged as possible, look after your general physical health as best as you can, especially managing your vascular risk like diabetes, smoking, hypertension, cholesterol and avoid excessive alcohol intake.
Are Benzodiazepines used for responsive behaviours?	Not a great idea generally. Can increase confusion, falls and other medical complications. We do still use on the odd occasion but usually in short bursts rather than longer term management. If using, go for a shorter acting agent like oxazepam or lorazepam rather than diazepam or clonazepam.
Some practical strategies for distracting would be appreciated again. It can be so hard when the person is getting very insistent about their issue of concern, and especially when the person is a close relative. Even though you know a lot about them, in the heat of the moment it can be hard to distract.	There is some good advice for this on the DSA (Dementia Support Australia) and DA (Dementia Australia) websites. Sometimes it is helpful to enlist a colleague to assist, especially if the issue is causing distress for the caregiver.
In aged care residencial facilities, is a GP able to give the diagnosis of dementia or it should be done by a specialist?	If available, assessment by a geriatrician or psychogeriatrician can be helpful but in practice GPs often do make the diagnosis. Most metropolitan areas will have Memory Clinics or CADMS where patients can be referred to.
Risperidone - what's your thoughts about it? Is it true that it shouldn't be used more than 3 months as it won't be effective? Also using it as PRN? What's the maximum dose a doctor prescribe for Risperidone?	The 3 months is something that came out of the Royal Commission but is not set in stone. I think the point is that we don't want to just prescribe it and then forget about it. Only use it as long as is necessary. It certainly helps in some cases and I do still prescribe when necessary. I don't tend to use doses above 2mg in dementia.
I work as a Personal Care Assistant. How can I know if the person living with dementia has had their medications reviewed or updated? Is there something I can do to initiate this step.	This would depend on your facility's policy/approach to this and should hopefully be recorded in the resident's file/health record.
Is PRN Haloperidol a drug of choice for refusal of wound care?	Wouldn't be my first line. Sometimes, If all else fails we do use a small dose of a benzodiazepine such as oxazepam.

I'm wondering about the usage of non pharm interventions like art/creative therapy etc? Have there been RCT's (Randomised controlled trials) done on the efficacy of this approach as yet?	There is a reference in my slides to a systematic review looking at specific non-pharmacological therapies SENATOR-on Top. Not enough research in this area unfortunately but many of these interventions are worth trying if you have the resources.
What do we do with a resident that is physically and verbally aggressive, incontinent and is hitting, kicking and biting staff?	Sometimes it's about picking your time and waiting it out. Distraction, enlisting the help of another etc. Sometimes you have no choice but to try a 'as needed' medication but by that stage it can be hard to administer. If this is a repetitive behaviour then assessment by a psychogeriatric team is worthwhile.
Any suggestions for a resident who is trying to abscond. Very agile, climbing fences, moving furniture to climb fences, previoulsy let out of secure unit by visitors.	Can be tricky and sometimes needs to be in a facility that may be better able to manage this. That said, some people are very resourceful and can leave from pretty much anywhere. Good idea to make sure they have identification on them e.g. Medic Alert bracelet. Regular observations and noting of whereabouts, what they are wearing is helpful. Signs to warn visitors about potential absconding risk. trying to enagage resident in activities etc. to allow less time for them to plot their escape.
Is there more research based on exercise and dementia?	I presented a slide on this in webinar. Not a great deal. My colleagues showed that exercise may be helpful in mild cognitive impairment and are currently finishing up a trial in Alzheimers Disease https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3016362/.
Diet has such an impact as a risk factor for dementia. Once dementia is established how much diffference does diet have on the speed of decline?	Probably not a great deal but evidence is lacking.
What are your feelings and how important do you think therapeutic recreation is, for people living with dementia?	Very important. OT's (Occupational Therapist's) and OTA's (OT Assistant's) are a great asset to any service.
How can we identify severe pain in someone living with dementia?	Discussed in webinar. There is a handy app available here to help https://www.painchek.com/how-it-works/.
What are some of the other factors we could look for, if we observe a person living with dementia is showing signs of pain?	Chronic pain conditions such as back pain, pressure areas/ulcers, osteoarthritis, gastric reflux, constipation.
Have there been any studies done in regards to wearing of masks/social isolation during the Covid pandemic and how this has affected people living with dementia?	Not sure is these have been published yet but I suspect are an area of interest. Here is a link to a handy editorial in the Journal Nature https://www.nature.com/articles/s41582-020-00450-z.
22 years in aged care and I can honestly say having an Occupational Therapist who is supported in providing individual, group and community programs incorporating humour (SMILE Study), art, music, inter generational programs, general leisure and recreation activities and cultural/religious activities creates a much better home environment within the aged care setting. Do you suggest these services?	Absolutely agree and do recommend when available.
Do you recommend topical analgesia like patches instead of oral analgesia in dementia patients? Which way can we administer medication if the person living with dementia spits the medications out?	Yes I do and analgesic patches are used a lot in practice. The second part depends on the person and their surrogate decision-maker. In practice, disguising meds in food or administering with sweet treats is used freqeuntly. You need to be careful of the paranoid person however who may then think they being poisoned!
If there was one change that could be made in all care situations to improve the quality of life for people living with dementia, what would it be?	Gosh, that's a tricky one. Universal respect of the individual?

Do you have an opinion on herbicides and poisons that are constantly sprayed on all our supposed fresh fruit and vegetables, having an adverse effect on the increase in disease in the population, dementia included?	No real opinion sorry.
Is there a tool you would recommend to measure behaviour?	There is a behaviour assessment chart on the DSA website. I like the NPI best for measuring behaviour.
I work in residential care as an OT, and have a resident, female of 80yrs old, that has extreme short term memory loss. She is quite cognitive but becomes distressed when she can't remember things. She will pace very quickly through the passageways, become verbally agitated and try exiting through any door she finds. This happens 7-8 times a day. I will reorientate her back to the present, take her to her room and show her some personal belongings (photo's etc), of at which point she calms down. I have been working with DSA, however, the recommended therapies are not working. Can you offer any advice?	I would probably suggest considering assessment by a psychogeriatric service if the behaviour is not improving with time and the strategies suggested. There probably is not a simple answer to the complex issues at hand.
It's really hard to care for residents not able to settle in aged care facilities, always wanting to go home. Can you offer any appropriate strategies here?	I agree and that is why it is essential that staff looking after these individuals are adequately supported and offered training how to manage such situations. The only thing that really seems to help is distraction but this can be quite exhausting at times.
Is there any evidence out there comparing benefits from aged care facilities using a Montessori approach to care to those using traditional care methods?	Not sure. In an ideal world, specialist dementia-friendly facilities would be great but we often have to work with what we have. There is a lot written about this and a fantastic place called Hogewyk in Holland - https://www.bbc.com/news/av/health-20727157.