This series of workshops is endorsed by ACN according to our Continuing Professional Development (CPD) Endorsed Course Standards. It has been allocated 3 CPD hours in total according to the Nursing and Midwifery Board of Australia – Continuing Professional Development Standard.
Introduction

• Do you feel as if you are armed with enough knowledge on Delirium, Depression/Anxiety and Dementia?

• Can you help people with cognitively impairment find their way to diagnosis and good management?
Delirium Dilemmas
Key Learning Outcomes

- Understand the risk factors, causes, non-pharmacological and pharmaceutical management of delirium
- Recognise some of the ethico-legal issues
- Appreciate the importance of family / carer participation as well as education and advocacy in the management of these conditions
What is delirium?

A confusional state with:

- Acute onset
- Inattention
- Fluctuating course
- Disorganised thinking or
- Altered level of consciousness

Think of a client who had delirium:

- What was the cause / causes?
<table>
<thead>
<tr>
<th>Feature</th>
<th>Delirium</th>
<th>Dementia</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Usually sudden, often at twilight</td>
<td>Chronic, usually insidious and progressive</td>
<td>Often abrupt and coinciding with life changes</td>
</tr>
<tr>
<td>Duration</td>
<td>Hours to less than one month, rarely longer</td>
<td>Months to years</td>
<td>Months to years</td>
</tr>
<tr>
<td>Progression</td>
<td>Abrupt, fluctuating</td>
<td>Slow but even</td>
<td>Variable and uneven</td>
</tr>
<tr>
<td>Thinking</td>
<td>Disorganised, slow, incoherent</td>
<td>Scarcity of thought, poor judgement, words hard to find</td>
<td>Intact with themes of helplessness, generally negative</td>
</tr>
<tr>
<td>Memory</td>
<td>Impaired, sudden (immediate memory loss may be noticeable)</td>
<td>Impaired</td>
<td>Selective or patchy</td>
</tr>
<tr>
<td>Sleep</td>
<td>Nocturnal confusion</td>
<td>Often disturbed, nocturnal wandering</td>
<td>Early morning wakening</td>
</tr>
<tr>
<td>Awareness</td>
<td>Reduced</td>
<td>Clear</td>
<td>Clear</td>
</tr>
<tr>
<td>Alertness</td>
<td>Fluctuates, lethargic or hypervigilant</td>
<td>Generally normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Attention</td>
<td>Impaired, fluctuates</td>
<td>Generally normal</td>
<td>Minimal impairment but easily distracted</td>
</tr>
</tbody>
</table>
Delirium = medical urgency / emergency

delirium can be superimposed on dementia / depression
A. Disturbance in attention
B. Disturbance develops over a short period of time and tends to fluctuate in severity during the course of a day.
C. An additional disturbance in cognition
D. Not better explained by another pre-existing, established, or evolving neurocognitive disorder
E. There is evidence of a cause.
Altered Conscious State

Hyperactive Delirium

🔔 Agitated - Think Delirium

Hypoactive Delirium

🔔 Lethargic / Drowsy - Think Delirium
Imagine you are your client with delirium.

What are you feeling / experiencing?
Psychomotor Activity

- Any vivid dreams or nightmares?
- Any hallucinations, illusions, delusions?
- Rapid changes in emotion (fearful, depressed, angry)?
Delirium is Multi-factorial

- Predisposing Factors
- Precipitating Factors

Delirium
Pre-Disposing or Risk Factors for Delirium

- Pre-existing cognitive impairment including dementia
- Illness / infection
- Age ≥ 70 years
- Visual impairment / Hearing impairment
- Depression
- Abnormal serum sodium
- Use of indwelling catheter
- Use of physical restraints (hospital use less)
- Multiple medication use
- Alcohol related health concerns
- Exposure to benzodiazepine
Identify and Treat Causes

D - Dehydration, Drugs
E - Electrolyte imbalances
L - Lack of drugs: benzodiazepine, EtOH (withdrawal/excess)
I - Intracranial: CVA, tumour, trauma
R - Restraints, reduced sensory input, respiratory/heart failure
I - Any Infection (Urine, wound), indwelling lines
U - Uncontrolled pain, urinary/faecal retention
M - Metabolic, ward moves
*Psychosocial conditions
Nursing Assessments

- History * E.g. medications / drugs / alcohol intake
- Vital signs
- Oxygen saturation
- Blood glucose level
- Urinalysis
- Urinary output & hydration
- Bladder scan for urinary retention
- Bowels (constipation or diarrhoea)
- Pain levels / body language (acute / chronic)
- Neurological observations
Case Study: Mrs Having Difficulties

- 74 year old living alone
- Community Services: domestic assistance fortnightly
- Referred for ulcer management
- 2 falls in the last month
- Worried about how she will cope, a bit anxious
- Son visits occasionally, she states
Case Study: Medical History

- Congestive heart failure
- Hypertension
- Hyperlipidaemia
- Diabetes Mellitus Type II – diet managed
- Gastro-oesophageal reflux disease
- Stress urinary incontinence
- Osteoarthritis, lower back pain
Case Study: Medication

- Paracetamol Modified release 665mg 2 tablets twice per day
- Esomeprazole 20mg nocte
- Amitriptyline 10mg nocte
- Metoprolol 50mg daily
- Oxybutynin 5mg twice per day
- Aspirin 100mg daily
- Promethazine 25mg daily
- Candesartan 8mg daily
- Pregabalin 25mg twice per day

Make some points: concerns you have re: this woman’s health
Case Study

- Paracetamol Modified release 665mg 2 tablets twice per day
- Esomeprazole 20mg nocte
- Amitriptyline 10mg nocte
- Metoprolol 50mg daily
- Oxybutynin 5mg twice per day
- Aspirin 100mg daily
- Promethazine 25mg daily
- Candesartan 8mg daily
- Pregabalin 25mg twice per day
Drugs and Delirium!

• Drugs of ALL kinds can cause Delirium - prescription, over-the-counter, complementary or illicit.

• Medications account for / contribute to 12% – 39% of all cases of delirium.

• Drugs commonly associated with delirium are anticholinergics, antipsychotics, histamine receptor antagonists, narcotics and sedatives.

• Anticholinergic Burden
Anticholinergic Cognitive Burden

3 Points (Pharmacy / GP / Geriatrician review: aim to try and cease 3 pt medication / exchange for similar efficacious medication with less anticholinergic side effects

- **Antidepressants** – Amitriptyline, Nortriptyline, Doxepin, Paroxetine
- **Antipsychotics** – Olanzapine, Quetiapine, Clozapine
- **Antiepileptics** – Carbamazepine(2)
- **Bladder Antimuscarinics** – Oxybutynin, Solifenacin, Darifenacin, Tolterodine
- **Other** – Amantadine(2), Pethidine(2), Promethazine
Pharmaceutical Review
Anticholinergic Load

- 3 or more medication with anticholinergic effect can cause / contribute to delirium

Reduce Polypharmacy
- Use single daily dose frequency wherever possible to simplify drug regimens.
- Limit the use of “when necessary medications”.
- Discontinue a drug if it is ineffective or intolerable adverse effects occur.
- Attempt to prescribe a drug that will treat more than one existing problem.
Pharmacological Treatment of associated agitation:
Benzodiazepines are only in the treatment of:

- Alcohol withdrawal (regimen according to agitation scale)
- Benzodiazepine withdrawal
- and the disorders Dementia with Lewy Bodies, Parkinson’s Disease or Parkinsonian symptoms.
- Little evidence thus research suggests that they should not be used, except as stated above, as outcomes are poor and adverse effects more common than with antipsychotics.
- have an increased mortality risk
- Unless side effects of antipsychotic medication
Antipsychotic Side Effects
Can cause delirium also Extrapyramidal Effects

• **WATCH** for:
  • **Drowsiness / worsening** of cognitive condition

• **Extrapyramidal** side effects: are tardive dyskinesia (involuntary, irregular muscle movements, usually in the face), akathisia (restlessness), dystonia (muscular spasms of neck, eyes, tongue, or jaw), drug-induced Parkinsonism (muscular ‘cogwheel’ rigidity, bradykinesia / akinesia, resting tremor, and postural instability)
Preventative Strategies for Delirium

1. Conduct baseline cognitive function assessments*
   - Does patient/client have a cognitive impairment?
     - Yes
       - 2. Determine any changes in cognitive function
         - Has there been a recent change in cognitive function?
           - Yes
             - 3. Assess for Delirium
               - Does patient have a confirmed diagnosis of delirium?
                 - Yes
                   - Adapt care plan
                     - Consider who is consenting to care
                     - Identify and address causes pg 8-10
                     - Manage symptoms pg 11
                     - Pharmacological management pg 12
                     - Provide supportive care pg 13
                     - Prevent complications pg 5
                     - Monitor resolution following facility guidelines*
                     - Manage modifiable risk factors pg 4
                     - Educate patient and family, give facility pamphlet on pg 14
                     - Consider use of interpreter
                     - Refer to advanced care plan
                 - No
                   - 4. Consider subclinical delirium
                     - Does patient/client have some symptoms of delirium?
                       - Yes
                         - Adapt care plan
                       - No
                         - 5. Monitor and respond to any sudden changes in cognitive function by repeating pathway
                 - No
                   - 2. Determine any changes in cognitive function
                     - No
                       - Differential diagnosis (refer to Poole's Algorithm pg 6)
   - No
     - Include in care plan
       - Prevention pg 5
       - Screen at regular intervals for change in cognitive function pg 3
       - Risk factor assessment and management pg 4

* Information from patient/client, carer, GP, medical record or facility assessments
* Delirium diagnostic tools or diagnosis by Expert* pg 7
  - Cognitive function assessment tools "pg 3 or ensure appropriate referral is made
  - Known risk factors for the development of delirium pg 4
  - Monitor resolution following facility guidelines*
The Delirium Clinical Care Standard aims to ensure that patients with delirium at the time of presentation to hospital receive optimal treatment to reduce the duration and severity of the condition. It also aims to ensure that patients at risk of delirium during a hospital admission are identified promptly and receive preventive strategies.

Different Screening tools for different conditions

Delirium, Depression, Dementia

- 3D-CAM (3D-Confusion Assessment Method validated for delirium hospital setting)
- Depression screening tools
- Cognitive screening tools more focused on chronic cognitive problems
- **Not diagnostic. Part of the assessment.**
A new client?

How do you review the person’s cognition?

And report to GP / others?
Mini-Cog Test

- 3-minute instrument that can increase detection of cognitive impairment in older adults.
- It consists of two components, a 3-item recall test for memory and a simply scored clock drawing test.
- **not** a diagnostic test.
- As with all screening tests, false positive and false negative results are possible.

http://mini-cog.com/
MINI COGNITIVE TEST
SCREENING TOOL FOR COGNITIVE FUNCTION

STATEWIDE

FACILITY: __________________________

STEP 1 – WORD REGISTRATION

Look directly at person and say:

“Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now.”

If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies. For repeated administrations, use of an alternative word list is recommended.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Banana</td>
<td>Leader</td>
<td>Village</td>
<td>River</td>
<td>Captain</td>
<td>Daughter</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Season</td>
<td>Kitchen</td>
<td>Nation</td>
<td>Garden</td>
<td>Heaven</td>
</tr>
<tr>
<td>Chair</td>
<td>Table</td>
<td>Baby</td>
<td>Finger</td>
<td>Picture</td>
<td>Mountain</td>
</tr>
</tbody>
</table>

STEP 2 – CLOCK DRAWING

Say: “Next, I want you to draw a clock for me. First, put in all of the numbers where they go!” When that is completed, say: “Now, set the hands to 10 past 1!”

Use pre-printed circles for this exercise (on reverse of this page). Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

STEP 3 – THREE WORD RECALL

Ask the person to recall the three words you stated in Step 1.

Say: “What were the three words I asked you to remember?”

Record the word list version number and the person’s answers below.

Word List Version: __________________________

Person’s Answer: __________________________

SCORING

Word Recall _______ 0 – 3 points

One point for each word spontaneously recalled without cueing.

Clock Draw _______ 0 or 2 points

Normal clock = 2 points.

Inability or refusal to draw a clock (abnormal) = 0 points.

A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 1, 2, 3, 6, and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored.

Total Score _______ 0 – 5 points

Total score = Word Recall score + Clock Draw score.

A total score of 3 or less strongly suggests cognitive impairment and further evaluation of cognition is required. Scores greater than 3 do not exclude cognitive impairment and if this patient, family, or clinician has concerns further evaluation of cognition should be considered.

MINI COGNITIVE TEST

PRINT NAME: __________________________

DESIGNATION: __________________________

SIGNATURE: __________________________

DATE: __________________________

LOCATION: __________________________
Mini-Cog: Scoring

3-Item Recall Score:
• 1 point for each word recalled without cues.

Clock Drawing Score:
• Normal Clock = 2 points.
• Inability or refusal to draw a clock (abnormal) = 0 points.
• A normal clock has all numbers placed in the correct sequence and approximately correct position (eg 3, 6, 9, 12 in anchor points). Hands are pointing to 11 and one pointing to 2 (11.10). Hand length is not scored.
Scoring the Mini-Cog

- Total score = Word Recall score + Clock Draw score.

- A total score of 3 or less strongly suggests cognitive impairment and further evaluation of cognition is required. Scores greater than 3 do not exclude cognitive impairment and if the patient, family or clinician has concerns further evaluation of cognition should be considered.

- NB The Mini-Cog™ is not a diagnostic test for Alzheimer’s disease or any other dementia or cause of cognitive impairment. Diagnosis of brain disorders that cause cognitive impairment requires a medical examination and additional examinations. (NB It could indicate delirium or depression).
Administer the Clock Drawing Test (CDT)

Clock Drawing Test (CDT)
Abnormal score on Mini-Cog

- What does that mean?
- How do you know if the change in cognition is acute?
Delirium: Collateral History

• The Family Confusion Assessment Method (FAM-CAM)

• The FAM-CAM may help with early detection of delirium by family caregivers.
  – choose someone who knows the person well and sees them regularly

• The FAM-CAM is NOT intended to be used as an independent diagnostic instrument
Family Confusion Assessment Method (FAM-CAM)
For Clinical and Research Uses

Evaluator:
Caregiver/Informant: 

Patient: 

Date: 

Time: 

[Screening for an appropriate caregiver is recommended: See Instructions]

Circle the answer to each question

These questions are intended to identify changes to [family member’s name] thinking, concentration, and alertness during recent days. Please stop me at any time if you do not understand the questions.

1. I’d like you to think about the past [month/week/day]*. During this [month/week/day]*, have you noticed any changes in his/her thinking or concentration, such as being less attentive, appearing confused or disoriented (not knowing where he/she was), behaving inappropriately, or being extremely sleepy all day?
   Yes  No  Don’t Know

* Adjust time frame as appropriate for your purposes

2. Did he/she have difficulty focusing attention, for example, being easily distracted or having trouble keeping track of what you were saying at any time?
   Yes  No  Don’t Know

3. Was his/her speech disorganized, incoherent, rambling, unclear, or illogical at any time?
   Yes  No  Don’t Know

4. Did he/she seem excessively drowsy or sleepy during the daytime at any time?
   Yes  No  Don’t Know

5. Was he/she disoriented, for example, thinking he/she was somewhere other than where he/she was, or misjudging the time of day at any time?
   Yes  No  Don’t Know

6. Did he/she seem to see or hear things which weren’t actually present, or seem to mistake what he/she saw or heard for something else at any time?
   Yes  No  Don’t Know
7. Did he/she behave inappropriately, such as wandering, 

   Yes  No  Don’t

yelling out, or being combative or agitated at any time? 

Know

8. Please tell us more about the changes you noticed in any of the behaviors in #1-7 above. 
   Record as much detail as possible

9. Were any of the changes (#1-7) present all the time, or did they come and go from day to day? 

   All the time  Come and go  Don’t know

10. When did these changes first begin? Would you say they began: 

    Within the last week
    Between 1 and up to 2 weeks ago
    Between 2 and up to 4 weeks ago
    More than 4 weeks ago

11. Overall, have these changes been getting better, worse, or staying about the same? 

    Better  Worse  About the Same  Don’t Know

Copyright 2003, Hospital Elder Life Program. Not to be reproduced without permission.
What does the screening mean?

- Could be false positive for delirium?
- Better to fully investigate and not assume it is dementia / other mental health disorder
How long does delirium last?

**Figure 1** Proportion of older hospital inpatients who recover from delirium by each time point

Cole, MG Persistent delirium in older hospital patients
2010
Prevention Plan for Delirium

1. Early recognition of cognitive deficits/Orientation/social support
2. Provide sensory aids
3. Mobilisation/Independence
4. Prevent or early identification & treatment of dehydration/nutrition/constipation/wound infection, other
5. Good sleep hygiene
How can you help care for someone with delirium?

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. Encourage other family members or friends to help as well.

- Speak slowly in a clear voice when talking to someone who has delirium. Identify both yourself and the person by name.
- Encourage and assist someone with delirium to have adequate food and fluids.
- Knowing the time of day can reduce confusion. Remind them where they are, and what day and time it is. Open the curtains in their room.
- Visual or hearing impairment can make their confusion worse. If someone with delirium usually wears glasses or hearing aids, help them to put them on.
- If someone with delirium is agitated or aggressive, do not try to restrain them. If they want to walk around, let them, but try to make sure that they are safe from falling and that the area is free from hazards.
- Bring personal mementos that help remind the person of home, such as photos, their dressing gown, radio or CD/tape player with favourite music.
- Let staff know any special personal information that may help calm and orient someone with delirium, such as, the names of family and friends, hobbies, significant events, etc.

Contacts

Carers Resource Centres
Ph: 1800 242 636

Aged Care Information Line
Ph: 1800 500 853

National Dementia Helpline
Ph: 1800 100 500

Carers Australia
www.carersaustralia.com.au

Alzheimer’s Australia
www.alzheimers.org.au

If you have any concerns or questions about delirium, talk to your doctor.

Delirium is a common medical problem that is characterised by changes in mental function and occurs more often among older people.

When delirium occurs people are confused and may be either very agitated or quiet and drowsy.

The onset of delirium is always sudden. It usually only lasts for a few days but may persist for longer periods.

It can be a serious condition.
<table>
<thead>
<tr>
<th>Environmental Strategies</th>
<th>Clinical Practice Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Lighting appropriate to time of day – windows with a view</td>
<td>- Encourage/assist with eating and drinking to ensure adequate intake</td>
</tr>
<tr>
<td>to outside, curtains and blinds open during the day, and</td>
<td>- Ensure that patients who usually wear hearing and visual aids are assisted to use them</td>
</tr>
<tr>
<td>minimal lighting at night may reduce disorientation</td>
<td>- Regulation of bowel function – avoid constipation</td>
</tr>
<tr>
<td>- Provision of single room – reduces the disturbance</td>
<td>- Encourage and assist with regular mobilisation</td>
</tr>
<tr>
<td>caused by staff attending other patients in the same room</td>
<td>- Encourage independence in basic ADLs</td>
</tr>
<tr>
<td>- Quiet environment especially at rest times – noise reduction strategies (eg: use of vibrating pagers rather than call bells)</td>
<td>- Medication review</td>
</tr>
<tr>
<td>- Provision of clock and calendar that clients can see</td>
<td>- Promote relaxation and sufficient sleep – can be assisted by regular mobilisation, massage, encouraging wakefulness during the day</td>
</tr>
<tr>
<td>- Encourage family and carer involvement – includes</td>
<td>- Manage discomfort or pain</td>
</tr>
<tr>
<td>encouraging them to visit</td>
<td>- Provide orienting information including name and role of staff members</td>
</tr>
<tr>
<td>- Encourage family/carer to bring in client’s personal and</td>
<td>- Minimise use of indwelling catheters</td>
</tr>
<tr>
<td>familiar objects</td>
<td>- Avoid use of physical restraints</td>
</tr>
<tr>
<td>- Avoid room changes – frequent changes may increase</td>
<td>- Avoid psychoactive drugs</td>
</tr>
<tr>
<td>disorientation</td>
<td>- Use of interpreters and other communication aids for CALD patients/clients</td>
</tr>
</tbody>
</table>
Resolving Delirium

- A person may be cared for at home if the delirium has sufficiently resolved or is very mild.

- **And an able carer is present** to instigate urgent review with GP / Ambulance as needed.
Delirium has serious complications

Delirium is associated with:
- Increased morbidity and mortality
- Functional decline and institutionalisation
- Increased rates of dementia
- Post-traumatic stress disorder
- Carer burden
Delirious!
What do I do if they refuse GP or hospital care?

- Phone ambulance
- Phone family
- Notify GP
Consent & Substitute Decision Maker

Substitute decision maker nominated by person concerned
1. Enduring Guardian
   Administration and Guardianship Board  1300 799 625
2. Enduing Power of Attorney (finances only in Tasmania)
   OR
2. Spouse
3. Unpaid carer
4. Other person with best interests at heart

Community Social Worker can assist here prn
Communication to GP or other health professionals

- Template letter to GP for ease of use
- Algorithm for guide and with specialist service information
Recap

• Delirium is caused by medical illness or medication / intoxication

• It could be a medical emergency

• Acute onset and needs medical assessment and intervention

• Delirium can potentially be prevented or reduced in length or severity
Tasmanian HealthPathways
Older Person’s Health

https://tasmania.healthpathways.org.au/

ID: Connecting Care
Password: Health

- Delirium
- Depression in Older People
- Cognitive Impairment and Dementia
References

- Agar et al. Efficacy of oral risperidone, haloperidol or placebo for symptoms of delirium among patients in Palliative Care. A Randomised clinical trial. JAMA, 2016
- Hospital Elderlife Program http://www.hospitalelderlifeprogram.org/about/
- Mini-Cog http://mini-cog.com/
Depression & Generalised Anxiety Disorder

Key Learning Outcomes

• Risk factors definitions of some types of depression / anxiety and screening
• Non-pharmacological and pharmacological treatment for depression and generalised anxiety disorder
• Identify suicide risk and red flags
Late Life Depression is not a normal part of ageing

- 10 and 15 per cent of older people experience depression and about 10 per cent experience anxiety

- Bereavement (normal response) is a stressor that can precipitate or worsen mental disorders

- Some clinically significant depressive symptoms may not fulfill the DSM-V criteria for major depression
Case Study: Mrs X File, 79 year old

• Feels flustered with anything new
• Has recently forgotten appointments
• Difficulty sleeping: gets about 4-5 hours per night; doesn’t have a nap
• Poor appetite and weight loss
• Independent with personal ADLs

Medical history
• Hypertension; hyper-cholesterolaemia
• Previous acute myocardial infarction
• Vision problems: first appointment with ophthalmologist next week

What questions would you ask?
Some questions you could ask:

**Onset - ?Delirium? .....**

Anything worrying her? How is it going with her family?

- Son in a court case hearing coming up (ex-partner, financial)
- Often arguing with daughter (long-standing personality difference / disagreements over little things)

Any bereavements in the family?

- History of 6 years ago: finding granddaughter who suicided
Five or more of symptoms persisting over a 2 week period causing clinically important distress or impairing work, social or personal functioning (with depressed mood or decreased interest or pleasure as one of the five).

What are some of the symptoms of depression?
• Occurs most of the day, occurring most days (subjective or observed)
• Markedly diminished interest / pleasure most of the day, nearly every day
• Significant weight or appetite change
• Insomnia or hypersomnia
• Psychomotor agitation or retardation (observable by others)
• Fatigue or loss of energy
• Feelings of worthlessness or inappropriate guilt
• Diminished ability to concentrate or make decisions
• Recurring thoughts of death or suicide plans
Persistent Depressive Disorder (Dysthymia)

- A chronic disorder that manifests as depressive symptoms that occur on the majority of days for at least 2 years

Minor Depression (Sub-Syndromal Depression)

- Fewer symptoms than major depression, limited duration
- Higher risk of major depression / suicidal ideation
Psychotic or delusional depression

Major depression with psychotic features

- Delusions tend to be in themes of inadequacy, worthlessness, impoverishment, exaggerated guilt, death and dying
- Somatic delusions of misperceptions of impaired or poorly functioning bodily systems
- Paranoid or jealous delusions
- Hallucinations are uncommon
Vascular depression

What is vascular depression?

Cerebrovascular disease / stroke may be sub-clinical
- may occur after an acute event (post-stroke depression)
- depends upon stroke location and time since stroke

- cerebral atrophy
- subcortical deep white matter disease / periventricular white matter disease
One example of cerebrovascular disease:
MRI image of Periventricular white matter disease
Vascular Depression

Vascular depression compared with other late life depression may have:

- psychomotor slowing or Parkinsonism,
- anhedonia
- increased functional impairment and lower incidence of psychosis’, less agitation,
- more cognitive impairment
- less guilt, and
- less insight into their illness.’

UpToDate 2016
Dementia and Depression

When is the most common time for onset of depression in relation to onset of dementia?

A) 1-2 years pre-diagnosis  
B) At time of diagnosis  
C) 6-12 months after diagnosis  
D) 1-3 years after diagnosis  
E) 3+ years after diagnosis
What are some risk factors for depression?
Risks Factors for Late Life Depression

Older people have an increase in health problems which make them at higher risk of depression

Also

- Poor self-rated health care
- Being female
- Low socio-economic status
- External locus of control
- CALD background
Risks Factors for Late Life Depression

- Feelings of loss of esteem and self-respect: losses: relationships, independence, work and income, self-worth, mobility and flexibility
- Social isolation
- Divorced or separated, widowed
- Those who are carers
- Admission to hospital / admission to aged care facility
- Bereavement death of family, friend or pet / bereavement anniversaries and the memories
Comorbid Psychiatry

- Somatization – symptoms are **real to them, and are not created or faked on purpose.** (All symptoms need to be investigated)

- Substance abuse: alcohol, prescription pain / hypnotic medications

- Anxiety which may be treated yet the depression over-looked and not treated.
How do you help assess for Depression?

- Rule out delirium including drug / alcohol effects, particularly thyroid disease, diabetes, pain.

- Determine the individual’s history from the individual, their relatives and community service providers

- Screening tool
Depression Screening examples

- Depression, Anxiety and Stress Scale (DASS 21)
- Geriatric Depression Scale 15

Two Question Screen  Sensitivity 100% & specificity 77%

- During the past two weeks, have you been bothered by feeling down, depressed or hopeless?
- During the past month, have you been bothered by little interest or pleasure in doing things?
Mrs X File

Geriatric depression scale: 10/15

What now? Your processes, are they the following?
• Any thoughts of self-harm or suicide?

YES

• Notify GP
• Mental Health Team referral 1800 332 388
• Supports eg family

NO

Letter to GP
Other?

Suicide in Australia 2010

Figure 1. Male and female suicide rates per 100,000 population across age groups in 2010 (ABS, 2012)
Suicide Risk
Australian Bureau of Statistics, 2012

- Close to 80 per cent of all suicides in Australia are men
- With the highest gender disparity - female : male 1 : > 3
- Suicide is the number one killer of men under 44 years
- The next closest age group is 75 to 84 year old men (25.8 per 100,000).
The first 3 warning signs for suicide:

- Threatening to hurt or kill self
- Looking for ways to kill self; seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide
Suicide Risk factors continued

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped — like there’s no way out
- Increasing alcohol or drug abuse
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic changes in mood
- No reason for living, no sense of purpose in life
- Access: eg to firearms
Treatment for Depression

Age of onset, changes in the ageing brain and presence of co-morbidities influence the type and expression of depression and treatment responsiveness

- **Mild depression**
  - Psychological and Social management
  - Exercise

- **Major depression**
  - Medication and
  - Psychological and Social management
  - also Exercise
Exercise may be first line treatment for minor depression

- 3-5 sessions 30-45 minutes per week for 3-4 months
- May be difficult to engage the participants / unable to exercise
- Cardiovascular (aerobic) such as walking, cycling, swimming has a more consistent result than and resistance training such as lifting weights (non-aerobic) the latter which is still beneficial

Fraser et al 2005
Psychological Approaches
alone or in conjunction with medication

People with minor depression or dysthymia may be more likely to benefit from psychotherapy than from antidepressants

- Cognitive Behavioural Therapy
- Interpersonal Psychotherapy

Collaborative care model – better outcomes

Pinquart 2006
Support Groups and Services

- Crisis Assessment and Treatment Team 1800 332 388
- Older Person’s Mental Health Service
  - Stay Chatty: speak up, stay chatty
  - Beyond Blue: 1300 22 4636 [www.beyondblue.org.au](http://www.beyondblue.org.au)
  - Suicide call back service: 1300 659 467
    24 hr /day free counselling [www.suicidecallbackservice.org.au](http://www.suicidecallbackservice.org.au)
- Relationships Australia
Side effect profiles should be a major determinant in medication selection:
- Typical and atypical antidepressants
- Tricyclics and tetracyclics
- Mono-Amine oxidase inhibitors (rarely used unless previously initiated and tolerated)
Medication efficacy

- generally resolution within 4-6 weeks but can take much longer in older adult

Studies vary in outcome:

- In elderly patients a full antidepressant response may not occur until 8 to 12 or even 16 weeks of therapy or another
- who had no improvement at all by 4 weeks of treatment were unlikely to respond even after 8 additional weeks
Neurotransmitters
Simplistic Categories of Neurotransmitters

- **ADRENALINE**: Fight or flight neurotransmitter
- **NORADRENALINE**: Concentration neurotransmitter
- **DOPAMINE**: Pleasure neurotransmitter
- **SEROTONIN**: Mood neurotransmitter
- **GABA**: Calming neurotransmitter
- **ACETYLCHOLINE**: Learning neurotransmitter
- **GLUTAMATE**: Memory neurotransmitter
- **ENDORPHINS**: Euphoria neurotransmitter
Selective Serotonin Reuptake inhibitors

SSRIs selectively inhibit the presynaptic reuptake of serotonin (5-hydroxytryptamine, 5HT).

- considered first line as better tolerated (not better efficacy)
  - eg sertraline, citalopram

What are some of the side effects of SSRIs?

- Care with people with Parkinsonism, akathesia, anorexia, sinus bradycardia, hyponatraemia, postural hypotension
- Citalopram: dose dependent QT interval prolongation
- For severe forms: SSRIs less effective than some others / ECT
Serotonin-norepinephrine reuptake inhibitors SNRI

e.g. duloxetine, venlafaxine

- Second-line agents
- Venlafaxine XR – less GI symptoms than duloxetine
- Hx of epilepsy: increase risk of seizures
- Long half-life
Serotonin Syndrome / Excess

- Myoclonus, tremors, hyper-reflexia, fever, autonomic changes, delirium etc

- Avoid combination with tramadol, St John’s wort, MAOI, valproate, antipsychotics or similar
Atypical: Mirtazapine
noradrenergic and specific serotonergic activity

- Tetracyclic antidepressant
- Side effects: sedation, weight gain, dry mouth, constipation
- Serotonin 5HT\textsubscript{2} and 5HT\textsubscript{3} receptors and presynaptic blockade of central alpha\textsubscript{2}-adrenergic inhibitory autoreceptors. It is also a potent H\textsubscript{1} antagonist which accounts for its sedative effects.
Tricyclic and tetracyclic
norepinephrine and 5-HT reuptake inhibitors

- While no longer first or second line
- Useful for other treatment failure
- A few studies state that they may have superior efficacy with melancholic or delusional depression.
- Only class to show reduction in relapse after ECT
Monoamine Oxidase Inhibitors

Eg selegiline (also used in PD), moclobenide (reversible)

- Rarely used unless previously initiated and tolerated
- Some studies state improved efficacy for atypical depression, mixed anxiety-depressive states and panic disorder (but little research in elderly)
Medication Treatment Response

- 40-50% older people with non-psychotic major depressive disorder respond to a first trial of an antidepressant.

- Of those who do not respond, 50% may respond to alternative treatments.

- Factors influence response: severity, reoccurrence, comorbid anxiety, medical burden, cognitive impairment, >85 years (Mock et al 2010).

- Relapse is higher in older people.
Medication Efficacy
Depression with Dementia

- Antidepressant treatment efficacy suggestive not confirmed (Nelson & Devanand 2011)

- Mirtazepine, sertraline and placebo: absence of benefit and risk of side effects these antidepressants as first line treatment for depression in Alzheimer’s Disease should be reconsidered (Banerjee et al 2011)
Electroconvulsive Therapy

- Important and valid treatment option
- Used for severe depression in those not responding to medication treatment
In summary
Assessment for Depression

• Any previous episodes of depression (and Tx); family history of depression precipitating events

• Use of depression assessment scales, cognitive testing, physical examination, medication review, investigations

• Assess the risk of self harm

• Differentiate depression from dementia - psychometric testing prn
Anxiety Disorders

90% of presentations of late-life anxiety are accounted for by either generalized anxiety disorder (GAD) or a specific phobia

10% of anxiety disorders are accounted for by obsessive-compulsive, post-traumatic stress, and panic disorders

Reference: Cassidy & Recto 2008
Anxiety Disorders (Reference: Cassidy & Recto 2008)

- Generalized anxiety disorder
- Social anxiety disorder (fear of social embarrassment)
- Specific phobia (fear of specific object or situation)
- Panic disorder (episodic overwhelming anxiety and autonomic signs) with/without agoraphobia
- Obsessive Compulsive Disorder (OCD) (intrusive thoughts and repetitive behaviours)
- Post Traumatic Stress Disorder (PTSD) (traumatic event re-experienced, creating anxiety)
Risk Factors for Anxiety

- psychological disorder
- poor coping strategies
- stressful life events
- being female

(Vink et al 2008)

also poor health such as cardiovascular disease, stroke, dementia
Clinical Manifestations of GAD

Although **excessive and persistent worrying** is widely regarded as the main feature of generalized anxiety disorder (GAD), most patients present with other symptoms relating to:

- hyperarousal, autonomic hyperactivity and muscle tension.
- poor sleep, fatigue and difficulty relaxing.
- headaches and pain in the neck, shoulders, and back.
Effective treatments for generalized anxiety disorder include psychological interventions such as:

• cognitive-behavioural therapy and
• applied relaxation, and
• medications including selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors.
Older Person and Anxiety

- Late-onset GAD is usually associated with certain demographic, clinical, and environmental risk factors.
- May be associated with neurodegenerative disease such as dementia, Parkinson’s Disease
Diagnosis of GAD (DSM V Criteria)

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months

B. The individual finds it difficult to control the worry

C. The anxiety and worry are associated with three (or more) of the six symptoms (with at least some symptoms having been present for more days than not for the past six months)

D. Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Treatment options

• Cognitive Behavioural Therapy

• Antidepressant therapy: first-line: Selective Serotonin Reuptake Inhibitors eg citalopram, being mindful of side effects

A combination of CBT and antidepressant therapy is often needed to optimise treatment

Is the suffering so great that they do need benzos??

(Exercise can assist)
Questions?
Depression on-learning
Professional Education to Aged Care (PEAC) program


References:
• Tasmanian Suicide prevention Strategy (2016-2020)
Depression references

- Beaton, Susan Beaton & Forster P. Insight into Mens Suicide. InPsych 2012.
- Depression in older age: a scoping study Final Report September 2009 by National Ageing Institute, funded by Beyond Blue
- Diagnosis and management of late-life depression (Espinoza & Unutzer 2013)
- Royal College of Psychiatry UK http://www.rcpsych.ac.uk/mentalhealthinfoforall/treatments/cbt.aspx
Depression References

- Shear, AK, Reynolds C, Simon NM, Zisook S. Grief and bereavement in adults: Clinical features. UptoDate 2016
Dementia

Can we turn the hazardous Yellow Brick Road into a better directed route?
Dementia

Key Learning Outcomes: have knowledge and understanding of:

- Why diagnose dementia?
- Dementia is a terminal disease
- Types of dementia and how dementia affects a person
- Prevention of Dementia
- Validity / some types of short cognitive screening tools
- Communication with GP, other health professionals and consumers
- Support Services
Timely Diagnosis

**Diagnosis**
- to find the cause of cognitive symptoms
- to look for reversible causes
- to convey information to person with cognitive symptoms (patient, client) and the person's family.

**Planning**
- legal
- financial
- life decisions
- work safety
- driving safety
• **Treatment**
  – to ensure compliance with usual medications
  – to consider ‘dementia’ medications

• **Prognosis**
  – to be able to advise the person with cognitive symptoms and the person's family about likely future developments.

• **Help the care team(s),** i.e. acute, primary, community, residential, etc., develop the best Health Plan.
Dementia

- progressive, terminal disease of generalised brain degeneration
- single greatest cause of disability in older Australians
- 1,800 new cases of dementia’ diagnosed in Australia each week
- half of people with dementia in Australia are ever diagnosed
- many have to wait an average of 3.1 years from the first symptoms to a confirmed diagnosis.

Alzheimer’s Australia
I'll email this to myself so I can remember it.

Hey look, a new email!
How dementia affects a person
Alzheimer’s Association Australia

- Functional impairment

Affects:
- Memory (memory is affected late in fronto-temporal type)
- Judgement
- Abstract thinking / empathy
- Verbal fluency

Associated with
- Impaired social function
- Impaired physical functioning
- Behavioural changes
- Psychological changes
Potential psychiatric features

Depression
- may or may not be the onset of dementia
- need to probe family/client history

Hallucinations
- “False or distorted sensory experiences that appear to be real”
- Paranoia

Delusions
- fixed false beliefs
Behaviours and Psychiatric Symptoms of Dementia

- Apathy, disinhibition, wandering, aggression,
- Perseveration
- Disappearance of old behaviours; Emergence of new?
- Common cause of carer burn-out

- Unmet needs??? Is there a cause or antecedence for behaviour? is there something worrying the person.
- Have to look at the individual and what is happening for the person
General progression

Each person with dementia is **individual** and decline also depends on other comorbidities

- Walking slows, the person shuffles, becomes more rigid, and has falls
- or some may pace and be very active but perhaps not eating
  - Incontinence develops
  - Eating and swallowing
  - Aspiration pneumonia
Rule out Delirium / other causes

- Medications
- Tumours
- Infections
- Subdural haematomas
- Metabolic
- Some vitamin and hormone deficiencies
- Infections
- Brain tumours
- Depression
Assessment

- **History**
- Function (instrumental activities of daily living)
- Cognitive screening tools
- Neurological assessment
- Neuroimaging
- Serum investigations (rule out contributing factors / causes): thyroid function, Na, Ca, vit B12, folate, Hb, glucose, syphilis, HIV
Types of Dementia

- Alzheimer’s disease (most common form)
- Lewy Body Dementias
- Vascular dementia
- Mixed AD & vascular dementia
- Fronto-temporal dementia
- Alcohol-related (Korsacoff’s syndrome)
- Other e.g., HIV/AIDS, CJD, Huntington’s chorea
Modifiable Risk Factors for Dementia (Alzheimer’s / Vascular dementia)

- Diabetes
- Midlife hypertension
- Midlife obesity
- Physical inactivity
- Depression
- Smoking
- Low educational attainment

- Addressing these seven risk factors could potentially prevent around 30% of Alzheimer's disease cases
Risk Factors for Dementia

Healthy diet, exercise and moderation with ETOH are indicated in reduction of risk.

Cardiovascular risk factors:
- Smoking
- High cholesterol/high blood pressure
- Brain infarcts, heart disease and mid-life hypertension increase the risk of Alzheimer's disease and Vascular dementia.

Diabetes:
- A recent study found that having diabetes increases the risk of developing Alzheimer's disease by 65%.

Dosage effect

As cardiovascular risk factors accumulate, AD dementia risk increases.

- Hypertension
- Smoking
- Hypercholesterolemia
- Obesity
- Diabetes
- Physical inactivity

Luchsinger et al 2005

Slide adapted from Michael Valenzuela.
Physical activity

- Physical activity benefits older adults to prevent dementia: Never too late to start
- Moderate intensity (brisk walking) 30 min 5d/week is minimum
  - more is better, puffed and sweaty
- Evidence for specific exercise:
  - more than one type exercise may be better
  - resistance training may be better (SMART)

The power of physical activity

Erickson et al., 2011
Dementia and Genetics

- Having a close relative with the Alzheimer’s disease is not evidence of a genetic link.

- People who are influenced by risk factor genes are only at a slightly increased risk in developing the disease than the average population.

- Younger onset dementia: many have a genetic factor
Mild Cognitive Impairment

- generally defined as significant memory loss without the loss of other cognitive functions
- have more memory problems than would be expected from someone at a similar age
- able to function independently and do not show other signs of dementia, such as impaired reasoning or judgment

Alzheimer’s Association Australia
Mild Cognitive Impairment

• 3 to 5 times more likely to develop dementia, esp. Alzheimer’s disease

• more severe diagnosis of MCI found that about 10-15% of subjects progressed to dementia each year.

• does not always lead to dementia and can take many years to do so.
DSM diagnostic criteria: Alzheimer’s disease

Multiple cognitive deficits with
A  Memory impairment and
       One or more of
         - Aphasia (language)
         - Apraxia (motor activities)
         - Agnosia (recognition)
         - Disturbance in executive function (planning, organising, sequence, abstracting)
B  Gradual onset & continuing cognitive decline
C  Significant impairment of social or occupational functioning
Alzheimer's  Normal
Vascular Dementia

Similar DSMV criteria as Alzheimer’s disease plus

• neurological feature on examination and / or

• varying degrees of small-vessel disease, ischaemic related white matter changes and one of more micro-infarcts via gradient echo T2 weighted MRI sequences

de Souza et al 2012
Lewy Body Dementias

Umbrella term:
Second most common type

Two Types:
• Dementia with Lewy Bodies
• Parkinson’s Disease Dementia
Lewy Body Dementias
alpha-synucleine neuronal inclusions: Lewy Bodies and Lewy neurites
Dementia with Lewy Bodies

- Fluctuating cognition
- Recurrent visual hallucinations
- Spontaneous parkinsonism

Suggestive features:
- Rapid eye movement sleep behaviour disorder
- Severe sensitivity to antipsychotics
- Low dopamine transporter uptake in the basal ganglia demonstrated by SPECT or PET imaging

Supportive features (not proven):
- Repeated falls and syncope, transient loss of consciousness
Parkinson’s Disease Dementia

- 80% of those with PD progress to dementia
- 50% after 10 years of PD
- Dementia onset one year after well established PD
Fronto-temporal dementias

Three clinical subtypes

- Behavioural variant (bvFTD)
- Language variants of progressive non-fluent aphasia (PFNA) and
- Semantic aphasia

Structural MRI: frontal and / or temporal atrophy may be see

Functional neuroimaging: hypo-metabolism / hypo-perfusion in frontal / temporal lobes with severe impairments in orbitofrontal, anterior insula cortices and anterior cingulate cortices

de Souza et al 2012
Neuroimaging in dementias
De Souza et al 2012

Structural MRI
- Medial temporal atrophy - not specific to dementia – other neurodegenerative diseases, even depression and normal aging
- Progression of hippocampal atrophy may be a better indicator of Alzheimer’s disease

PET – hypometabolism in neocortical association areas with relative preservation of visual and sensorimotor areas and cerebellum.
SPECT scans similar hypoperfusion – can help distinguish early Alzheimer’s from MCI
SPECT scans can help distinguish Dementia with Lewy Body form Alzheimer’s dementia
striatal dopamine (dopamine transport)
Frontal Lobe
The frontal lobe is responsible for higher cognitive functions involving planning, problem solving, starting and stopping actions and regulating social behaviour.

Damage to this region causes
- Inability to initiate activity
- Repetitive behaviour
- Inability to regulate mood or emotional state
- Rude and socially inappropriate behaviour

Parietal Lobe
The parietal lobe processes and integrates tactile information (touch, pressure, temperature and pain) along with information from the occipital lobe, to create an understanding of ourselves and the world around us.

Damage to this region causes
- Inability to locate and recognise objects
- Lack of coordination
- Disorientation

Temporal Lobe
The temporal lobe plays a vital function in learning & memory, understanding language, perception and recognition.

Damage to this region causes
- Difficulties in understanding speech, recognising faces and objects
- Long and short term memory loss
- Increased aggression
- Changes to interest in sexual behaviour
- Persistent talking.

Occipital Lobe
The occipital lobe separately encodes visual information received by the retina in the eyes into colour, orientation and movement and passes this information to the temporal and parietal lobes.

Damage to this region causes
- Hallucinations
- Blindness
- Inability to see colour or motion
- Synaesthesia (eg hearing colours, tasting sounds).

Limbic System
The limbic system has a primary role in processing and regulating emotions, memory and sexual arousal.

Damage to this region causes
- Increased agitation
- Uncontrolled emotions
- Disturbed day/night cycle
- Changes to sexual arousal.
The three principal goals of rehabilitation for individuals with dementia are to:

• help the individual maintain or improve function and engage in daily activities to the extent possible and as the disease progresses;

• restore or compensate for functional decline due to an acute insult such as an injury or traumatic health episode such as a stroke, or fall which occurs over and above the dementia; and

• provide family caregivers with education and knowledge about the disease and specific skills to provide a supportive environment at home and reduce excess disability

Reifler and Larson 1990
Getting old isn't so bad, except for a little forgetfulness.
Person Centred Care

Person with dementia:
- Live in the moment (utilise their skills / likes / dislikes)
- Plan for the future involving the person with dementia
- Daily exercise assists in improvement / mood
- Music therapy / Reminiscence / Diversional Therapy

Exercise
- regular exercise and physical activity can help improve things like coordination, balance, functional ability, cognition and create a better sense of wellbeing.
Communication
Each person with dementia is unique and difficulties in communicating thoughts and feelings are very individual.

- Difficulty in finding a word - a related word might be given instead of one they cannot remember
- They may speak fluently, but not make sense
- They may not be able to understand what you are saying or only be able to grasp part of it
- Writing and reading skills may also deteriorate
- They may lose the normal social conventions of conversations and interrupt or ignore a speaker, or fail to respond when spoken to
- They may have difficulty expressing emotions appropriately
- **Check hearing and eyesight**
Communication

Three parts:

• 55% is body language which is the message we give out by our facial expression, posture and gestures
• 38% is the tone and pitch of our voice
• 7% is the words we use.
Acetyl-cholinesterase inhibitor medications may help with attention and concentration

- Mild-moderate dementia (MMSE 11-24)
- Specialist diagnosis
  - rivastigmine (Exelon patch)
  - donepezil (Aricept)
  - galantamine (Reminyl)
- Memantine (MMSE <11)
- Patients who do not respond to one acetylcholinesterase inhibitor may respond to another.
Some side effects of CHE-I

• Gastrointestinal side effects are common.
• Monitor patients who have a history of peptic ulcer or who are taking NSAIDS.
• Monitor patients for bradycardia who are taking β-blockers or other rate slowing medications.
• Living with / regular contact with carer.
What do you think about people with dementia driving?
Driving and Dementia
signs that may highlight difficulties

• Become disorientated or lost while driving in familiar areas
• Forget the purpose of the trip
• Lose the car in a familiar car park
• Difficulty making quick decisions at intersections or busy roads
• Drive through Stop/Give Way signs or traffic lights without giving way
• Unexplained dents and scratches on the car
• Slower reaction times, have difficulty using the brake, accelerator or steering wheel
Driving and Dementia

- MAZE task test
- Psychometric testing mostly does not sufficiently or consistently correlate with on-road performance.
- Occupational Driving Test
- Roads Transport Driving Test
- Anyone can Write to Registrar of Motor Vehicles re concerns (the concerned party must include name, address and list concerns)
Capacity Assessment

- Presume to have capacity until evidence proves otherwise
- Only assessed if need arises and is domain specific e.g., financial administration, accommodation decisions
- Assess the person’s decision making, not the decision they make
- Substitute decision maker is a last resort
Capacity Assessment

- Understand the facts and the choices involved
- Weigh up the consequences and
- Communicate the decision

Tasmanian Capacity Tool Kit

Websearch: capacity tool kit Tasmania for pdf
Cognitive Capacity Assessment

Utilise multi-disciplinary assessment to help with supportive evidence:

- Occupational therapy assessment: simple money management, simple meal preparation etc
- Nurses, physios reports eg needs prompting for dressing, can’t learn a new activity such as using the brakes on a walking frame

Neuropsychiatry, psyche-geriatrician geriatrician assessment prn
Palliative Approach to Care
Dignity and autonomy are important to us all

- Reduce suffering by early recognition and treatment of discomfort, anxiety, pain and other distressing symptoms
- Affirming life and treating dying as a normal process
- Care for spiritual, psychological and cultural needs also
- Support for family – team approach

Talking about Dementia and Dying 2011
Medical Goals of Care

If needed / appropriate:

- **Anticipatory end-of-life care medication for events / symptoms**
This form is to communicate the medical decision for appropriate treatment goals of care for this patient. Choose A, B, C or D. If changes are made, this form must be crossed through, marked void and a new form completed.

**DIAGNOSIS:**

<table>
<thead>
<tr>
<th>NO LIMITATION OF TREATMENT:</th>
<th>Hospital</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. The goal of care is CURATIVE or RESTORATIVE. Treatment aim is PROLONGING LIFE</td>
<td>CODE BLUE</td>
<td>For full resuscitation</td>
</tr>
<tr>
<td>□ For CPR and all appropriate life-sustaining treatments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LIMITATION OF MEDICAL TREATMENT:**

| □ Patient has an advanced care directive and/or has requested the following treatment limitations: Please specify: |

**B. The goal of care is CURATIVE or RESTORATIVE with limitations:**

| □ NOT FOR CPR but is for all respiratory support measures | For CODE BLUE and MET calls |
| □ NOT FOR CPR or INTUBATION but is for other active management | For MET calls NOT for CODE BLUE and MET calls |

**C. The goal of care is PALLIATIVE. Treatment aim is quality of life:**

| □ NOT FOR CPR OR INTUBATION | Contact GP for planning |
| Specific notes: | MET call □ YES |
| | MET call □ NO |

**D. The goal of care is COMFORT DURING THE DYING PROCESS:**

| □ NOT FOR CPR OR INTUBATION | For terminal care NOT for CODE BLUE NOT for MET |

**Reason for limitation of medical treatment:** □ medical grounds □ patient wishes

**Discussed with:** □ patient □ person responsible

**PRINT DOCTOR'S NAME:**

**DESIGNATION:**

**SIGNATURE:**

**GP / consultant responsible:** PRINT NAME

**DATE:** DD/MM/YYYY

**This form is endorsed for ambulance transfer, and for the home or care facility.**

**Abbreviation key:** CPR = cardio-pulmonary resuscitation, GP = general practitioner, MET = medical emergency team
Australian Stats

- 2011 - estimated 298,000 people with dementia.

- Among Australians with dementia, in 2011 there was also an estimated 23,900 people living with younger onset dementia.

- In the absence of effective prevention or cure options, estimates suggest that by 2020 around 400,000

- by 2050 this figure it set to reach 900,000.
Alzheimer’s Australia: research and publications

Examples:

• Timely Diagnosis of Dementia: Can we do it better?
• Physical activity for brain health and fighting dementia
• Dementia care: person-centred, palliative and supportive
• Wrestling with Dementia and Death


Cognitive Assessment Measures, Dementia Collaborative Research Centres

References

- Australian and New Zealand Geriatric Society of Medicine Position Statement 2009. Driving and Dementia
- ReBOC Reducing Behaviours Of Concern. A Hands On Guide A resource to assist those caring for people living with dementia Alzheimer’s Australia 2012
- Wicking Dementia Research and Education. (2011) Talking about Dementia and Dying: A discussion tool for residential aged care facility staff.