



DEMENTIA NEWSLETTER FOR PHYSICIANS

Sault Ste. Marie and Algoma District

Winter 2005

A Publication of the Dementia Care Network Algoma

In This Issue...

Non-pharmacological Approaches to Behaviour Symptoms in Dementia

Who Should be Assessed for Cognitive Problems?

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Your reference for community
resources in Algoma
www.dementiaalgoma.org

For More Info...

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Non-pharmacological Approaches to Behaviour Symptoms in Dementia

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Behavioural symptoms occur in up to 90% of patients with dementia. A structured approach can lessen physician and staff anxiety in assessing and trying to determine appropriate treatment.

1. **Who is agitated?** Lack of knowledge or understanding can make behavioural problems frightening to deal with. Sometimes successful resolution of a behavioural problem starts with teaching and possibly treating the caregiver.
2. **What is the behaviour?** Define and track target symptoms: This not only allows for tracking responses to treatment, but can also help staff and family members place some emotional distance between themselves and the behaviour, turning it into an object of inquiry rather than a personal attack. Tools such as the Cohen-Mansfield Agitation Inventory or the Neuropsychiatric Inventory (NPI) can help.
3. **What is going-on “inside”?** Establish or revisit medical diagnoses: Try to identify any medical condition that may be responsible in causing or bringing out the behaviour, especially delirium. Any sudden change in behaviour compared to the patient’s normal state should be considered a delirium so as not to miss this highly fatal problem. Possible causes include: infection, dehydration, metabolic abnormalities, medication side-effects, and pain (including that caused by constipation).
4. **What is going-on “outside”?** Assess and reverse aggravating factors: Cohen-Mansfield (Am J Geriatr Psychiatry 2001; 9: 361-81) identifies 3 theoretical models that provide a framework to formulating a treatment plan.

...continued on page 2

A. Unmet needs: such as sensory deprivation, boredom, and loneliness. Provision of stimulating activities and social interaction can help. Evaluate for hearing and visual deficits and try to correct these. Assessing quality of care (use of restraints, light levels, toileting and communication) is essential and can be addressed by ongoing staff training.

B. Learning/behavioural: This assumes a problem is a learned behaviour that is triggered or reinforced by others, such as increased attention when unwanted behaviour occurs. Tracking behaviour over the course of at least a week can sometimes identify patterns that can help point to a cause. Treatment is aimed at withholding the punitive trigger or reinforcer, or encouraging the expression of a desirable behaviour that will hopefully replace the problem.

C. Environmental Vulnerability/Reduced Stress-threshold: A dementia causes the patient to have a progressively lower threshold of tolerance to environmental changes, to the point that even normal levels of stimulation can be unbearable. Distracting the patient and provision of a calm surrounding, camouflaged exits, neutral colours, removal of TVs, radios or phones can help. An understanding of the progressive loss of skills and abilities (which in Alzheimer Disease is the reverse of child development) can allow assignment of an equivalent age and provide a teaching tool for staff and family members. For example, the patient who has lost

the ability to put clothes on unaided is operating at a similar functional level as a 5 year old and cannot be expected to be able to entertain him or herself alone.

5. What does the family know?

Identify relevant psychosocial factors. Emotionally laden memories are better preserved, even in dementias, than other types of memory. Some reactions may be understood by a careful psychosocial history. Family members may have insight into the patient's life that will help caregivers in dealing with situations that may trigger painful memories.



In general, it is preferable to manage these problems in the setting the patient lives in, especially if the patient lives in a nursing home, rather than admit them to an inpatient unit. This allows caregivers to learn how to approach and deal with problems so that they can more effectively help other patients with similar problems in the future. Some possible treatment modalities have been alluded to above, however, there are too many to discuss in this brief overview. The references below, which are easily found, provide a starting point.

References:

1. Allen-Burge R et al. Effective Behavioural Interventions for Decreasing Dementia-Related Challenging Behaviour in Nursing Homes. *Int J Geriatr Psychiatry* 1999; 14: 213-32
2. Cohen-Mansfield, J. Nonpharmacologic Interventions for Inappropriate Behaviours in Dementia. A Review, Summary, and Critique. *Am J Geriatr Psychiatry* 2001; 9: 361-81
3. Finkel, SI (Project Editor) BPSD IPA Educational Pack 2002 (can be obtained free of charge at www.ipa-online.org)
4. Raskind, MA. Evaluation and Management of Aggressive Behavior in the Elderly Demented Patient. *J Clin Psychiatry* 1999; 60 [suppl 15] : 45-9
5. Tariot, PN. Treatment of Agitation in Dementia. *J Clin Psychiatry* 1999; 60 [suppl 8] : 11-20

Conditional Approval of Ebixa®

Ebixa® for use to relieve the symptoms of Alzheimer Disease has been approved by Health Canada with conditions. This authorization reflects the promising nature of the clinical evidence and the need for a confirmatory study to verify the clinical benefit. This medication is used to relieve symptoms of Alzheimer Disease in the moderate to severe stages of the disease.

**For more information contact Marvin Irwin, B.A., D.D.S
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Who Should be Assessed For Cognitive Problems?

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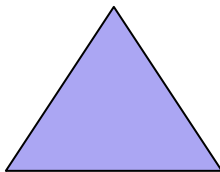
Certainly anyone with memory complaints or anyone whose family is concerned should have comprehensive cognitive assessment. However, think of urinary tract infection in the elderly; UTI may present with specific urinary complaints but may also present non-specifically with falls, dwindles, immobility, anorexia, fatigue etc. Similarly, you should assess cognition in elderly patients who present nonspecifically: falls, failure to thrive, not doing well and especially with any recent unexplained change in function or behaviour. Think ABC and have a “high index of suspicion” for cognitive impairment. It is easy to be fooled by good conversational skills and good “social graces”.

A=ADL's

Finances
Shopping
Driving
Cooking
Travel
Laundry

B=Behaviour

Anger
Irritability
Apathy
Depression
Agitation



C=Cognition

If Someone is Asymptomatic (no ABC complaints) When Should You Screen for Dementia?

In 1999, the Canadian Consensus Guidelines stated “there is insufficient evidence to recommend for or against screening for cognitive impairment in the absence of symptoms of dementia.”

In 2001, the American Academy of Neurology stated “General cognitive screening instruments (eg MMSE) should be considered for the detection of dementia when used in patient populations with an elevated prevalence of cognitive impairment due to age or presence of memory dysfunction.”

Screen High Risk Asymptomatic Elderly

- Age over 80 (prevalence of dementia > 25%) by age alone
- Age over 65 and other clinical factors
- Post CVA, delirium / depression / first onset over age 65
- Warning signs / behavioural flags
- “Vascular” risk factors (hypertension, CVA, TIA, CAD, DM, hyperlipidemia, atrial fibrillation)
- Family history positive

How Should You Screen?

You can do a full MMSE and further tests of executive function / visuospatial / language

- Clock drawing
- Naming 4-legged animals anywhere in the world (N is >12) in one minute
- Ramparts (continue the line)



- Trails B test

If this takes 20 minutes minimum, you can document start and stop times in your chart and bill K032 (specific neurocognitive assessment — \$52.50)

OR

You could do a Dementia Quick Screen (2-3 minutes)

- Year
- Clock drawing
- 3 item recall
- Name 4 legged animals in one minute

If any items incorrect, do full cognitive assessment.

**Have a look at:
www.dementiaeducation.ca**



This site has been developed as part of the Physician Education Initiative of Ontario's Strategy for Alzheimer Disease and Related Dementias. This multi-faceted education program was developed to inform and promote practice change in regards to Alzheimer Disease and

related dementias. Registered users of the site will have access to clinical tools, educational materials and teaching resources. The website hosts casebased interactive learning modules, clinical practice guidelines, various educational resources and information on community resources.

Take a look...be informed!

Katherine L. Punch Resource Centre

For current information on Alzheimer disease and related dementias refer your patients to the free resources at the Alzheimer Society. Books and videos on topics such as the progression of Alzheimer disease, communication techniques, coping strategies, community resources, making the long term care decision and research are just a few of the issues covered.

**For more information call:
The Alzheimer Society of Sault Ste. Marie
& Algoma District at 942-2195**

Safely Home Alzheimer Wandering Registry

Help to keep your patient with dementia safe by referring him to the Safely Home Program. Safely Home™ is a nationwide program designed to help find the person who is lost and assist in a safe return home. Developed by the Alzheimer Society of Canada in partnership with the Royal Canadian Mounted Police, a registry stores vital information confidentially on a police database. The information can be accessed by police anywhere in Canada and the United States.

Registrants will receive an identification bracelet and identification cards. Wearing the bracelet and keeping the cards in places such as wallets and coat pockets aid in quickly identifying people should they become lost. The program is designed to assist police officers in the safe and timely return of individuals with dementia.

The Alzheimer Society will update the registrant's file annually.

**For more information on the program
including the registration form contact:
Alzheimer Society of Sault Ste. Marie &
Algoma District at 942-2195
or visit
Alzheimer Canada website
www.alzheimer.ca**

The Dementia Care Network Algoma would like to thank the Dementia Network of Ottawa for allowing the reproduction of this newsletter.