Changed behaviours associated with dementia Webinar

Q&A

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| Question | Response |
| Would symptoms be worse in the late afternoon compared to early morning | “Sundowning” where symptoms are worse in the late afternoon, is common in dementia |
| In the field of dementia care, is there a preferred model of support for problematic behaviours: e.g., Newcastle model, Positive Behaviour Support? | I don’t know that there is a preferred model but rather finding a model that you are familiar with and comfortable using is the way to go |
| Is one model "better" than the other to use? |
| What can you tell us about the interactions of medications which have side effects that are then medicated for? | Each medicine is different and has a different side effect in different people. Whether to use it or not is a choice which requires a balance between benefits and harms. |
| I would like to ask if Drs are visiting residents living with dementia in aged care if they request or enquire about the inclusion / recommending a Diversional Therapist be consulted to assist in meeting social, leisure , recreation , cultural and spiritual needs. As many RACFS. Do not employ degree qualified DTs and or Cert 4 Recreation Activity Officers. Again, I only ask as even the aged care commission has not listed DT as a allied health profession even though we are and exist..." | I can’t really answer that but feel that diversional therapists would be ideal to assist in the care of people living with Dementia |
| Would Michael have younger onset dementia which if he is under 65 would he get assistance to help the family adjust under the NDIS | Yes, that is correct he would be eligible for support under the NDIS |
| How to manage escalated behaviours when the patient is in danger to themselves/ fellow patients/ care staff. If diversion methods, reassurance, redirections, and reproaching with different staff members not effective in de-escalating those behaviours. This patient has high tolerance to pain medications and anxiety/ antipsychotic. If PRN medications given, this will impact their safety. | As above, medication choice is often a balance between benefits and harms. This needs to be discussed also with family members, if it involves psychotropic medication. Remember to document start date/efficacy and review date. |
| Do you support a functional integrated medicine to keep with complex chronic issues including dementia well? | I am unclear exactly what is meant here |
| I have noticed that my some of my bilingual patients tend to lose their second language. Is this common? | Yes, it is common for people to revert to the language of their childhood and forget language that was learned later on. |
| Could a person like Anna just be just feeling lonely isolated and a bit scary in the flat at the bottom of the garden when she wakes up in the dark in the middle of the night? | She definitely could be feeling like that! |
| Do you support an person being sleep tested as a routine-- to find if sleep apnoea is an issue - it can be centrally driven sleep apnoea in people with dementia -- oxygen sats plummet to average 83% down to 70% without snoring -- with nightly nasal CPAP I have improved cognitively now average 94% --but only have spinal anaesthesia as my O 2 Sats. -plummet with even a twilight dose | The guidelines do not recommend screening for sleep apnoea as this suggests. However, it certainly should be looked for if there are symptoms such as daytime sleepiness which suggest it is a possibility. |
| Is hyper sexuality and/or inappropriate language a sign of dementia? | With dementia, people often lose their inhibitions and may express their sexuality or use language in ways which are inappropriate to the social setting. |
| Have you researched the possibility of taking most of the medications away and using non-pharmacological methods instead? | We have not researched this but- research has been done to look at deprescribing medications and trying non-pharmacological approaches and this is the preferred option  We should always view pharmacological treatment as an adjunct to non-pharm and as short-term options |
| Why are aged care facilities usually quick to use medications like risperidone to control the residents because the staff say they don’t have enough time to try other methods | This is a very complex question which probable needs a royal commission to answer!!  Often this can be the case or not having the familiarity with tools – I think more education/training/funding/staff are needed to really improve the management of behavioural changes |
| Can we use picture that describe pains a patient experience if she doesn’t too talk | The Abbey Pain Scale is a tool specifically developed for non-verbal people with dementia |
| I have noticed that most of elderly in aged care has mild to moderate cognitive impairment and as well as dementia. Could you please differentiate cognitive impairment and dementia? Will there be different behavioural approach for the cognitive impairment and the dementia? | Mild cognitive impairment does not meet the criteria for dementia, which is more severe. For example, people with mild cognitive impairment are generally still able to look after themselves in basic ways, whereas this may not apply to people with dementia. |
| Are there medications that have a risk of causing dementia? | Anticholinergic medicines and psychotropics may cause the person to look as though they have dementia, but this reverses if the medications are ceased. |
| What do you do when a wife will not let you remove or even consider reducing risperidone. the risks including death are explained and she doesn't want the Dr to ever cease it or reduce it or even review it | The doctor would need to explain that reviewing it is a requirement for ongoing prescription of the medication. |