Having the conversation

Identifying cognitive impairment and providing appropriate management and care planning in primary care

MARK YATES, CAROLINE GIBSON

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

BIRCH Ballarat Innovation & Research Collaboration for Health

Dementia Pathways Tool

I would like to acknowledge the traditional custodians of this land. I would like to pay my respects to their Elders, past, present and emerging.

Objective

To increase General Practitioners and Practice Nurses confidence, knowledge and skills in *discussing and managing* cognitive decline with their patients

1. background
2. recognising cognitive impairment and dementia
3. exploring the inkling
4. chronic disease management in the context of cognitive impairment
5. difficult conversations
6. Dementia Pathways Tool - https://www.dementiapathways.com.au/

Dementia in the community

- 70% of people with dementia live in the community
- 50% are undiagnosed
- 4+ co-morbidities and poor health outcomes

Can we support someone in primary health care if we do not identify and respond appropriately to the cognitive impairment

Delay in dementia diagnosis[3,4]

first inkling to talk to DR 1.9 years

to diagnosis 1.2 years

The person
- Lack of awareness
- Reluctance to get help
- Fear, worry, stigma
- Loss of independence
- Beginning of the 'slippery slope'

It is a difficult conversation

The Dr
- Futility of action
- 'nothing can be done anyway'
- Fear of damaging relationship
- Lack of knowledge, skills

The System
- Poor communication bn service providers
- Time limited consultations
- MBS does not cover carer consultations

Why is this delay a concern

- Early- moderate cognitive decline not being acknowledged
- No implementation of possible interventions to reduce decline in MCI
- The person and family lose opportunity to plan for future
- Risk of inappropriate management and care planning
- Risk of poorer quality of life/ health outcomes

Prevent progression

SPECIAL ARTICLE LEVEL OF RECOMMENDATION

Practice guideline update summary: Mild cognitive impairment

Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology

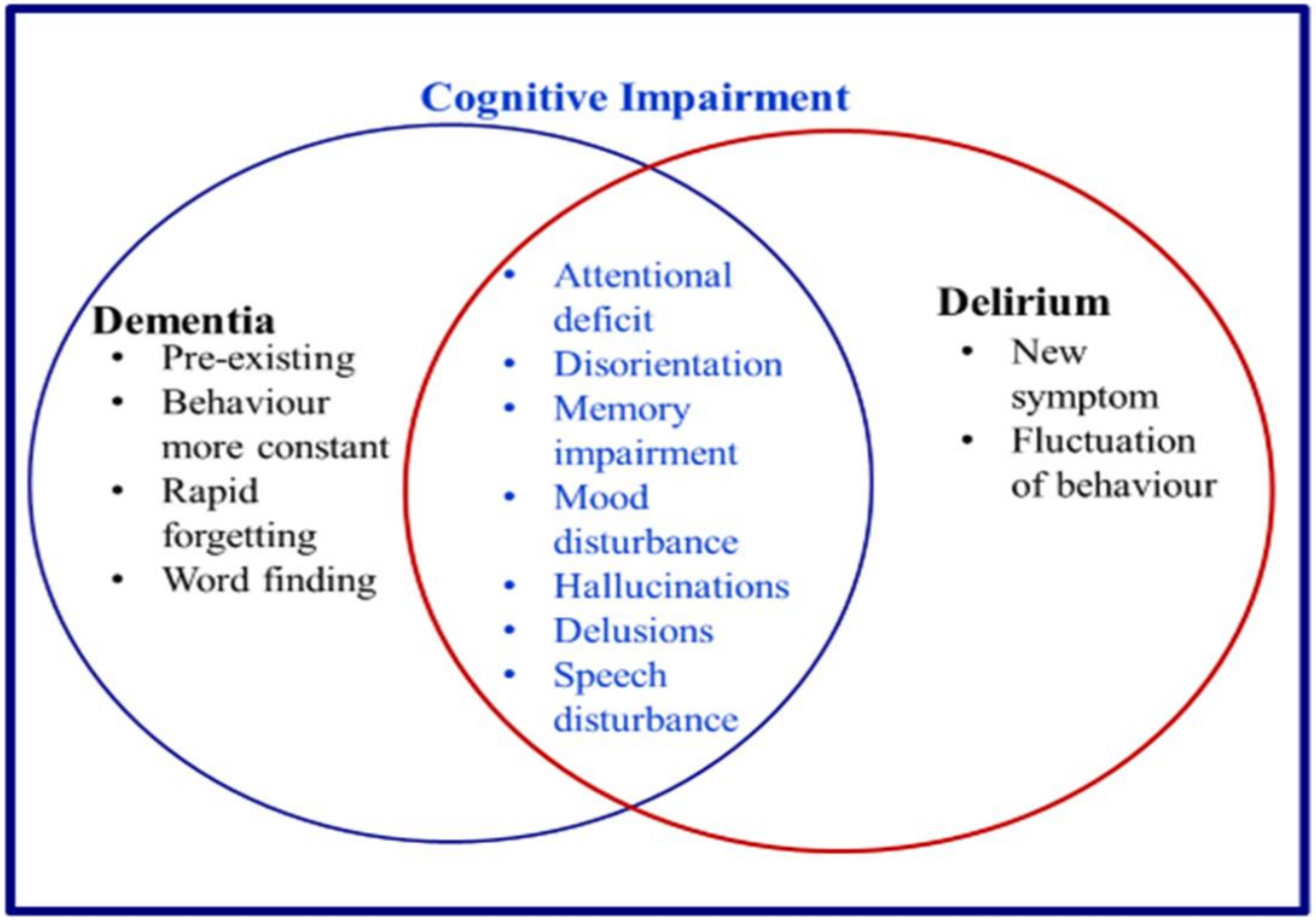
Ronald C. Petersen, MD, PhD, Oscar Lopez, MD, Melissa J. Armstrong, MD, MSc, Thomas S.D. Getchius, Mary Ganguli, MD, MPH, David Gloss, MD, MPH&TM, Gary S. Gronseth, MD, Daniel Marson, JD, PhD, Tamara Pringsheim, MD, Gregory S. Day, MD, MSc, Mark Sager, MD, James Stevens, MD, and Alexander Rae-Grant, MD

Correspondence
American Academy of Neurology
guidelines@aan.com

Neurology® 2018;90:126-135. doi:10.1212/WNL.0000000000004826

Results

MCI prevalence was 6.7% for ages 60–64, 8.4% for 65–69, 10.1% for 70–74, 14.8% for 75–79, and 25.2% for 80–84. Cumulative dementia incidence was 14.9% in individuals with MCI older than age 65 years followed for 2 years. No high-quality evidence exists to support pharmacologic treatments for MCI. In patients with MCI, exercise training (6 months) is likely to improve cognitive measures and cognitive training may improve cognitive measures.



CI a functional description and does not make a diagnosis. It is an acknowledgment of potential risk and the opportunity to support the patient

What is Cognitive Impairment?

Cognitive impairment is when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life.

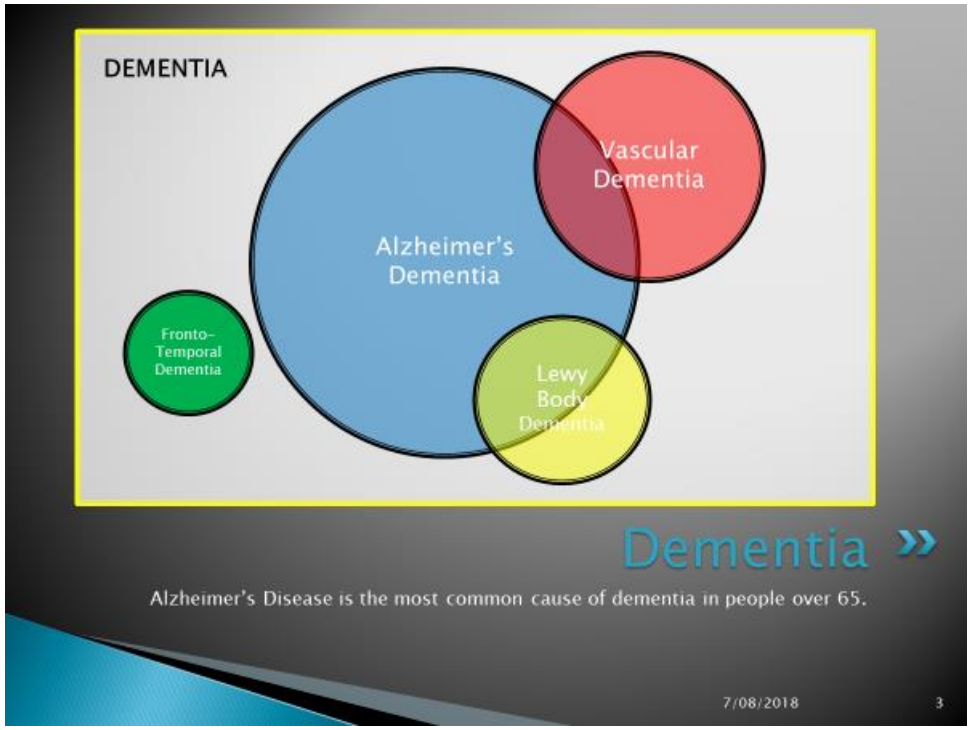
It can be mild or severe.

What is dementia

- is NOT a diagnosis
- does NOT indicate severity or level of function
- does NOT indicate prognosis

What is Dementia?

Multiple cognitive deficits, including **memory** impairment and at least one of:
Aphasia- Problems with language
Apraxia- Inability to carry out purposeful movements even though there is no sensory or motor impairment.
Agnosia - Failure of recognition, especially people
Disturbed executive functioning- Impaired planning, sequential organization and attention



What is the spectrum of MCI and Dementia?

- Modest cognitive deficits not sufficient to impair day to day function – adjustments manage the problem to allow independent action
- Cognitive deficits severe enough to interfere with occupational and/or social functioning
- Cognitive deficits represent a decline from a previously higher level of function
- These deficits do not occur exclusively during the course of delirium

Being cognitively aware – the nurse perspective

What triggers the inkling

Clues and early cues

Asking about cognition

Recent work with Practice Nurses indicated a lack of confidence/ skills in asking about cognition

Do not need to ask a confronting question

There are clues by conversation and clues by observation

The inkling

Note a change

- You say you do not cook so much any more
- I remember you were always busy knitting. I have noticed you have stopped this?
- You seem to be finding it a little difficult to remember where you put things?
- Peter says you no-longer go to Bingo

“Can you tell me more about that?”

Ask permission to ask support person their thoughts

The inkling

Observation

I notice that you are tapping your fingers?

I notice you appear frustrated?

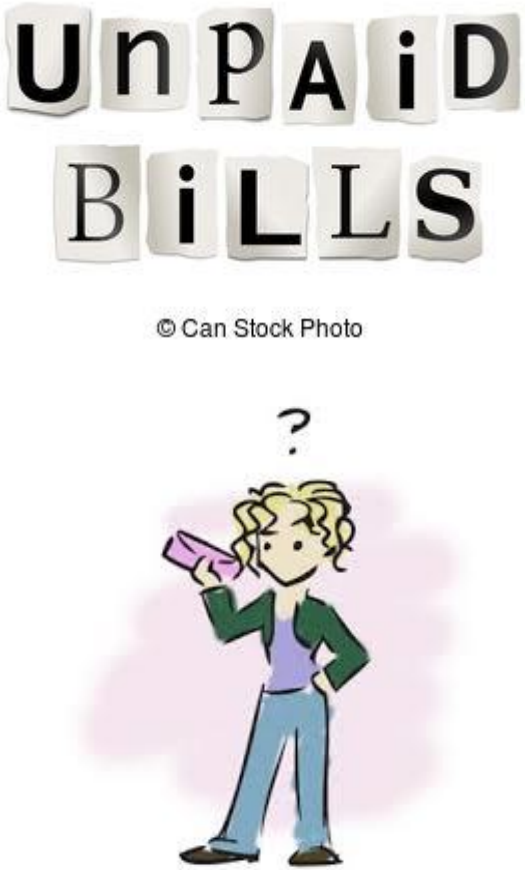
Can you describe to me how you are feeling?

Conversation

You say “this is too hard”

Can you tell me a bit more?

Early cues of cognitive changes



Change in chronic disease self management

BLOOD PRESSURE

Social withdrawal – an early sign of possible cognitive change

No longer doing activities that they previously enjoyed – golf, bowls

Ask why?

Be alert to “not interested any more” “cannot be bothered” “too hard to get there”

Mood change?

Depression?

Cognitively aware chronic disease management

- Be alert
- Be curious
- Listen, observe and ask better questions
- Look through a different lens

Social isolation

An access issue

- Community transport
- Encourage community groups
- Refer to Planned Activity Group

Or maybe a cognitive issue

Social isolation

Loss of confidence because forgetting peoples names
→ reassurance, buddy, community visitor

Inadequate nutrition

Lack of knowledge → dietician

Or maybe…

Complexity
Lost ability to use the stove
Change in hunger signals

Simple recipes
Alternative meal preparation/ provision
Sharing meals - PAG
Signs
OT referral

Hygiene and “resistive” behaviours

- Is the person being ‘difficult’
- Or frightened

Increasing incidences of “incontinence”

- Refer to continence clinic
- Pelvic floor exercises brochure

Or

- difficult clothing fasteners
- has person lost depth perception / changes in colour differentiation/ disorientated

- UTI

Visual Perception

As dementia progresses

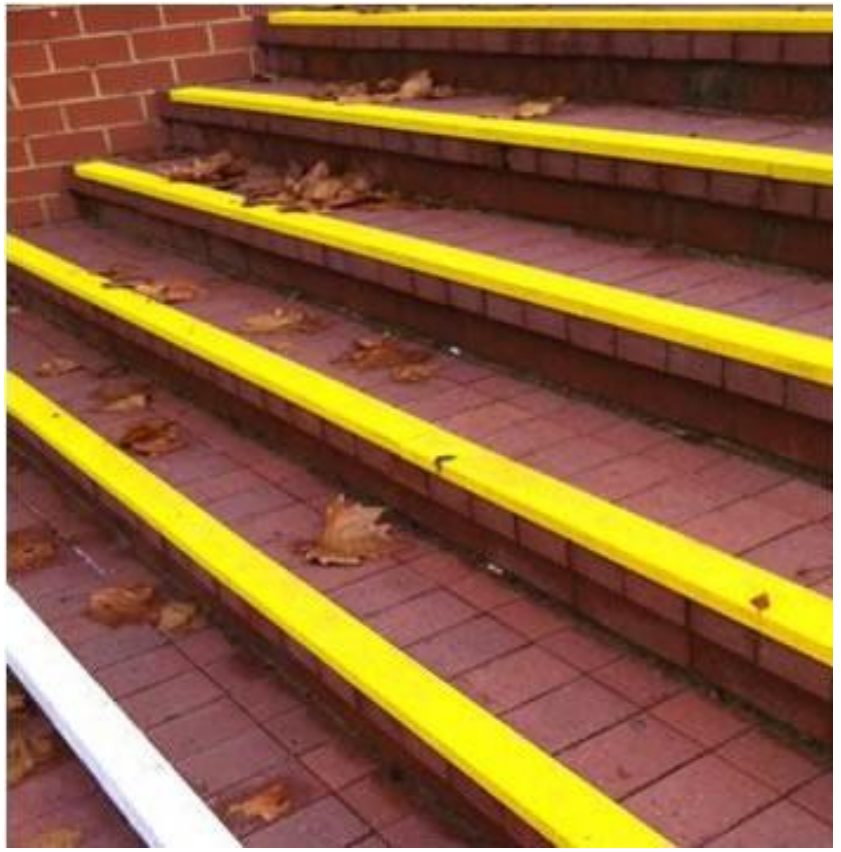
Changes in colour and depth perception

- Take care with multi focal, bifocal glasses

“Getting lost”

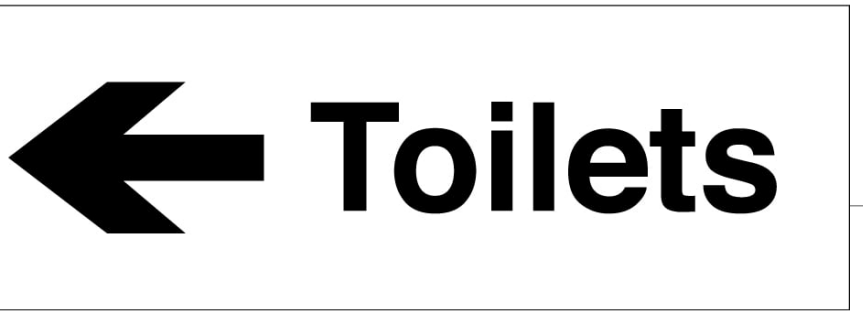
Or difficulty eating a meal…

Not going out/ scared of falling



Colour differentiation strategies


KITCHEN


Toilets


Bedroom


Coffee
and
Tea


Laundry
Room


PANTRY


TV Room

Supporting chronic disease self-management

MINIMAL INTERVENTION FIRST

MEDICATIONS

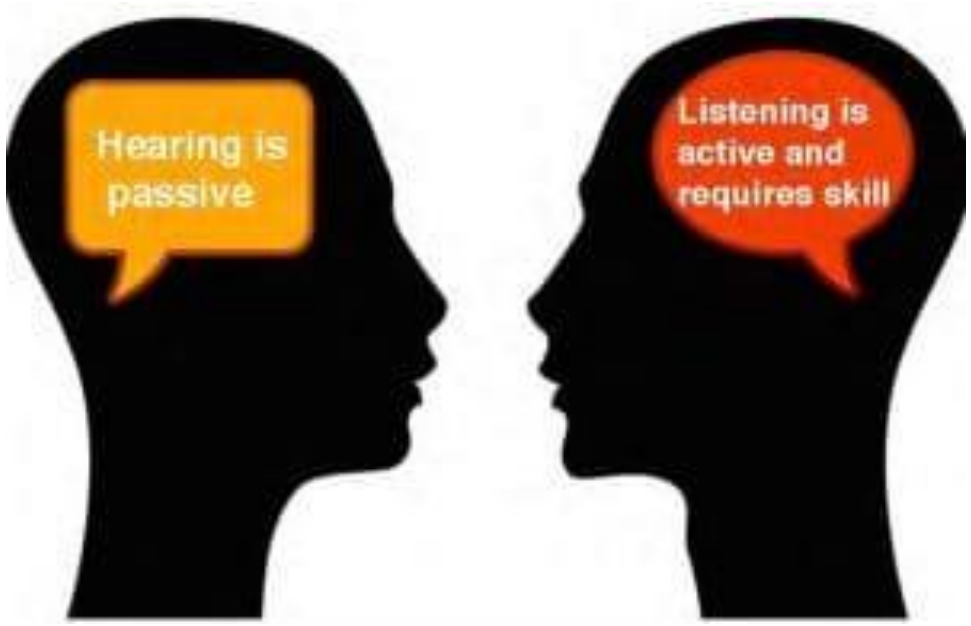
- medication administration aids
- can medications be reduced
- can BD medications be daily
- do not change administration aids or blood glucometers
- routines
- written instructions
- get partner/ family involved
- district nursing

LIFESTYLE

- reduce complexity of tasks
- familiarity – environment/ routines
- limit choices
- declutter
- contrasting
- shared meals
- supported exercise groups
- planned activity groups
- community visitors/ support workers
- occupational therapists

Key principles for cognitively aware CDM

- Active listening *you should be speaking less than the patient*
- Person-centred focus *who is this person, what gives their life meaning*
- Strength-based goals & strategies *build on what the person can do, strive for success*
- Health literacy *information provided is understandable, appropriate format*
- Be curious
- Be relevant


Hearing is passive
Listening is active and requires skill


Pay attention
Look at who is talking
Do not talk
ACTIVE LISTENING
Ask questions
Follow directions
Visualise what is being said

Difficult Conversations

Sharing the Diagnosis

- Graduated language
- Explore prior beliefs
- Emphasise the preserved skills
- Acknowledge preservation of wisdom – old tricks
- Diagnosis is knowledge and knowledge is power

Difficult conversations

Driving

- This can be very disruptive
- Be clear that only licencing authority can cancel a licence
- Cost of the car sitting in the garage

Difficult Conversations

Future Planning

- The prognosis question
- Complex families
- The role lawyers need to take

Supporting the primary care practitioner to provide appropriate care in the context of dementia

The Dementia Pathways Tool

A framework and on-line resource to guide CDM in context of dementia

- Cognitively aware chronic disease management pathway
- Dementia Pathways Tool

https://www.dementiapathways.com.au/

References

https://www.fightdementia.org.au/statistics

Ibrahim JE, Anderson LJ, MacPhail A, Lovell JJ, Davis M, Winbolt M. Chronic disease self-management support for persons with dementia in a clinical setting. Journal of Multidisciplinary Healthcare. 2017;10:49-58.

Phillips, J., Pond, D., & Goode, S. (2011) Timely diagnosis of Dementia: Can we do better? A report for Alzheimers Australia. Paper 24.

Speechly, C., Bridges-Webb, C. & Passmore, E. (2008). The pathway to dementia diagnosis. *Medical Journal of Australia,* Vol 189 (9) pp. 487-489