



# Dementia in residential care: Valuing everyone's quality of life

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Australia faces an explosion of people living with dementia. Dementia is the commonest medical problem affecting older people in residential care facilities (RCF). Residential care is important for them and their families, particularly when there is advanced dementia, which can make care difficult and stressful for everyone involved. Improving the care delivered to people with dementia living in Residential Care Facilities is an urgent imperative.

In our DIRECT study of the needs and preferences of general practitioners in relation to dementia education, certain learning priorities emerged: behaviours of concern; communication; knowledge regarding dementia; aspects of person-centered care; system factors; and the multidisciplinary team. The GPs surveyed emphasised the need for flexible, case-based and sustainable educational programs.

There are some key messages around dementia care in RCFs (which form part of our current educational intervention trial).

### Working efficiently and effectively with RCFs

Many GPs who work in aged care facilities can be financially sustained by working smarter, not harder in these ways:

- Limit the number of facilities visited.
- Establish a regular visiting schedule.
- See patients regularly and complete Comprehensive Medical Assessments when due.
- Arrange regular team meetings and case conferences (which is best practice, supported by corresponding MBS items).

Simple ideas make the GP's life easier and are valued by staff and families. For example, a single conference with staff and family soon after admission can yield many dividends in the months ahead. Care planning, including end-of-life care planning, establishes clear guidelines for staff and increases the chances that a resident's wishes will be followed. Checklists RCF staff can refer to before phoning a GP can make life more pleasant for all. Time spent in organising is often a sound investment because RCF staff are generally keen to work efficiently with GPs.

### Working with behaviours of concern

GPs are often approached by nursing home staff for assistance to reduce behaviours of concern (BOC), such as calling out repeatedly, verbal or physical outbursts in response to staff approaches around personal care and trying to leave the facility in a risky way.

Many behaviours of concern are in response to unmet needs of the residents involved. The behaviour may indicate opportunities to improve the service being provided to other residents as well. Simple early interventions and changes in work practices may better meet individual needs and prevent these behaviours. Thus time invested by GPs in planning preventive strategies is usually time well spent.

Staff will tend to repeat those strategies in the future. The problem of poor staff continuity can sometimes be overcome by alternative rosters and by identifying the staff "dementia champion" at the RCF.

Sometimes behaviours of concern are more persistent. GPs are able to refer to services such as the Commonwealth funded Dementia Behaviour Management Advisory Service for a more detailed individual analysis and

intervention plan. Judicious use of psychotropic medications to address identified psychiatric conditions such as anxiety or depression, are usually an adjunct to the key components of intervention, identifying the causes of the BOC and reviewing the way staff provide care. This is distinct from larger doses of a drug to sedate ("chemically restrain") a person with dementia.

### Communication with residents, staff and families

People with dementia experience changes in their communication abilities that make it harder for them to stay connected in relationships with other people. These changes in understanding and expression include:

- Finding it harder to follow a conversation
- Being more sensitive to background noise and distraction
- Needing more time to take their turn in a conversation
- Talking around a subject or word
- Being less likely to start a conversation

GPs, staff, family and others need to take increasing steps to compensate for these progressive changes – to bridge the ever-widening communication gap that threatens to socially isolate residents with dementia.

When conducting an interview with a resident with dementia, GPs may try to bridge the communication gap by reducing background noise, clearly facing the person with their own face well lit, being positive with their body language, speaking clearly in short sentences supported by gesture, and giving the person plenty of time to reply. Writing down information for the person to take away may also be useful.

In ordinary conversation staff and families may use the same techniques and focus on the communication strengths of people with dementia, such as:

- Personal history – talk about significant life events
- Reading – people with dementia may want to keep up their routine of reading the daily newspaper,
- Recognition of faces, things (but not naming) – have photographs of family and friends on the wall or handy
- Memory for routines – try to keep showers or baths at the same time of day
- Tone of voice & body language – how you say something is more important than the words used
- Emotions – respond to the emotions displayed and be reassuring

It is also important to remember that many people with dementia retain a degree of insight

and awareness. Studies reveal that common themes relating to their understanding of their situation include ideas like:

- Nothing is right now
- I'm alright, I'll manage
- I am still somebody
- It drives me mad (living here)

Understanding probable perspectives of family members will help communication. For most families their caring role changes, but does not stop, after their relative moves to a care facility. Family members commonly want to:

- Restore aspects of their relationship that suffered while they cared for them at home.
- Monitor their relative's care and advocate for them.
- Help in personalising the care their relative receives.

Sometimes families are relieved when their family member goes into care and want to have a break.

Busy staff often feel there is not enough time to talk to residents. GPs can be important in supporting culture change in facilities, so that staff come to see all communication with their residents as important.

### The 3Ds

Depression and delirium are common causes of excess suffering and disability in people with dementia. It is critical that depression and dementia be detected and treated because of the burden of morbidity and mortality associated with under-treatment.

The symptoms of depression (which include loss of motivation, loss of pleasure, thoughts of

low self-worth and low mood) can sometimes be hard to separate from the symptoms of cognitive impairment. Intervention for depression typically includes a combination of three important elements: lifestyle change to re-engage the person with more pleasant events and the experience of pleasure; talk-based therapy to challenge the depressive thinking style and resolve inter-personal issues, and anti-depressant medication. Anti-depressant medication may best be thought of as a short-term intervention to facilitate the effectiveness of the other two elements, but may play a bigger role when communication issues interfere with talk-based therapy.

In people with a subcortical element to dementia (common in people with vascular dementia) cognitive slowing can be prominent, making depression even harder to recognise. If there is uncertainty, a trial of anti-depressant therapy is sometimes warranted.

Delirium is easily missed, especially in the HYPOactive form. Someone who is more withdrawn may actually be delirious. Fluctuation is a core feature of delirium, which can also make it difficult to recognise. This is another area where collaborative preventive work by a GP and RCF staff may help staff to better record changes in behaviour that come and goes, and to bring this to the notice of the visiting GP.

If delirium is suspected a thorough search for underlying causes (such as sepsis, metabolic derangement and medication adverse events) is mandatory. ■

