DEMENTIA CARE
QUICK REFERENCE GUIDE

Consider the C.A.U.S.E. of the behaviour. What factors are impacting the behaviour?

Cognition
Abilities
Underling Illness/injury
Social
Environment

7 As – represent the losses a person may experience.

Amnesia – loss of memory
Apathy – loss of initiative
Aphasia - loss of communication
Apraxia – loss related to executing tasks
Agnosia - loss of recognition
Anosognosia – loss of insight
Altered Perception – change to senses

Signs of Depression (SIGECAPS)

Sleep changes (increase during day or decreased at night)
Interest (loss of interest in usually pleasurable activities)
Guilt and/or low self-esteem (devalue themselves)
Energy (loss of energy, low energy, or fatigue)
Concentration (reduced cognition and/or poor concentration)
Appetite (usually declined, occasionally increased)
Psychomotor changes (agitation or slowing of movement)
Suicide ideation or preoccupied with death.

Dementia Observation System (DOS)

An observational tool used to:

- Provide objective data on behaviours
- Identify potential causes or triggers so appropriate interventions can be put in place

1. Use the standardized DOS tool, have staff record periods of rest/calm as well as behaviours of concern in 30 minute increments for 5-14 days.
2. Colour code and analyze when concerning behaviours are occurring looking for patterns and possible causes.
3. Plan interventions based on the analysis and communicate the plan to the health care team.

November 2023

What are the RISKS? Think I.S.S.U.E.

Injury/Illness (physical causes, pain, rule out delirium)
Suicide ideation
Safety (substance use, self-neglect, elopement, conflict, etc.)
Us (relationships with others, harm by person, or to person, including neglect or isolation)
Environment (disruption, damage to property)

When considering interventions for Behavioural and Psychological Symptoms of Dementia (BPSD), assess the **7Ds**. Monitor, observe, and document:

1. **Dangerous –** how dangerous or threatening is the symptom?
2. **Distressing -** how distressing is the symptom to the person?
3. **Disturbing –** does the symptom have a disturbing quality to the person or others?
4. **Direct action –** is the person acting on a delusion or hallucination?
5. **Decline in independence or social interactions**- is this affecting quality of life?
6. **Distant vs Present** – is delusional thought content occurring in the past or present?
7. **Definite (fixed) –** does the person have full or partial insight

Social Connection Plan

An intervention tool that aims to provide a resident with regular brief periods of 1:1 attention apart from the provision of care. Goal is to ease behaviours that might arise from loneliness, boredom, communication difficulties, or general sadness.

1. Using a template sign-up sheet, staff members sign up for a date and time to spend 3-5 minutes with the resident. At least 5 team members preferred (e.g., nurse, HCA, housekeeping, rehab, social worker, recreation, spiritual care, etc.). Each staff member signs up for a visit a minimum of 1/week, maximum 7/week.
2. The resident will direct how the 3-5 minutes is spent (e.g., talking, reading, walking, holding hands, etc.)

Clock Drawing:

1. Provide person with a blank page or a pre-drawn circle
2. Ask them to make the circle look like a clock
3. Then ask them to make the clock show 10 after 11

Mini Cog: Quick screening tool often used in conjunction with the Clock Drawing test:

1. Have them repeat 3 words after you.
2. Name as many 4-legged animals as possible in one minute
3. Recall the 3 words from #1.

Delirium: Use Confusion Assessment Method (CAM)

1. **ACUTE ONSET AND FLUCTUATING COURSE** Does the abnormal behavior: • come and go? • increase/decrease in severity?
2. **INATTENTION** Does the patient: • have difficulty focusing attention? • become easily distracted? • have difficulty following a conversation?
3. **DISORGANIZED THINKING** Is the patients' thinking • disorganized? • incoherent? Does the patient have: • rambling speech? • Illogical flow of ideas?
4. **ALTERED LEVEL OF CONSCIOUSNESS** What is the patient's level of consciousness? • Vigilant (hyperalert) • Alert (normal) • Lethargic (drowsy, easy to arouse) • Stupor (difficult to arouse) • Coma (completely unarousable)

KEY: Presence of features 1& 2 plus either 3 &/or 4 is positive for delirium – use **PRISME** if positive for Delirium

Hallucination - a sensory perception in the absence of a corresponding external or somatic stimulus. Can be auditory, visual, olfactory, tactile, gustatory, command, somatic, or multimodal. (e.g. seeing bugs, hearing children)
Delusion - fixed beliefs that are not amenable to change in light of conflicting evidence and are inconsistent with the culture and education of the person. Can be persecutory, jealous, somatic, erotomaniac, grandiose, or mixed. (e.g., people stealing from them, spousal affairs, etc.)
Illusion - a false mental image produced by misperception of real external stimulus. (e.g., call bell as doorbell or phone, fans as car motor)

Use PRISME to identify & address physiological reasons for delirium:

PAIN / **P**SYCHOSOCIAL
RESTRAINT/ **R**ETENTION
INFECTION
SLEEP DISTURBANCE / **S**ENSORY CHANGE / **S**OCIAL ISOLATION
MEDICATION / **M**ETABOLIC / **M**OBILITY
ENVIRONMENT

Medications for Behavioural and Psychological Symptoms of Dementia (BPSD)

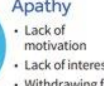
Behavioural and Psychological Symptoms of Dementia[1]

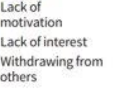
Psychosis
- Delusions (false beliefs)
- Hallucinations (hearing/seeing things that aren't there)

Reactions
- Defensiveness
- Resistance to care
- Severe verbal reactions
- Severe physical reactions

Agitation
- Dressing or undressing
- Pacing
- Repetitive actions
- Restlessness/anxiety

Depression
- Anxiety
- Guilty thoughts
- Hopelessness
- Irritablity
- Sadness/tearfulness
- Suicidal thoughts





Apathy
- Lack of motivation
- Lack of interest
- Withdrawing from others

Mania
- Intense excitement
- Irritability
- Fast speech

Other: • Hiding or collecting things • Getting lost • Disinhibition (e.g., sexual)

BPSD Likely to Respond to Antipsychotic[2]

Cluster	Likely to Respond	Unlikely to Respond
Psychosis	• Delusions • Hallucinations • Misidentification • Suspicious	
Reactive Behaviour	• Defensive • Physical	• Verbal • Resistance to care
Agitation	• Restlessness • Anxious	• Dressing/undressing • Pacing • Exit seeking • Repetitive actions
Mania		• Euphoria • Irritable • Pressured speech
Apathy		• Amotivation • Lack of interest • Withdrawn
Other		• Hiding or hoarding • Wandering without reactive behaviour • Disinhibition (e.g. sexual)

Medications for BPSD[2]

Behaviour	Drug Therapy
Psychosis, Aggression, Agitation (severe)	• Atypical antipsychotics (such as risperidone, aripiprazole, olanzapine, quetiapine as discussed in detail on **page 6**)[10,14]
Agitation (severe), unlikely to respond to antipsychotics	• SSRIs such as citalopram or trazodone (however, evidence is lacking for trazodone)[15,16,44]
Agitation (severe) in Lewy Body Dementia or Parkinson's	• Possible cholinesterase inhibitors • Very low dose quetiapine[15,16]
Anxiety (short term/ intermittent)	• A short-acting benzodiazepine such as lorazepam prior to anxiety provoking events such as bathing[17]
Anxiety (chronic)	• Antidepressants (such as SSRIs, SNRIs) • Buspirone[10]
Depression (severe)	• Antidepressants such as SSRIs (e.g., citalopram, sertaline), SNRIs (e.g., venlafaxine, duloxetine), other antidepressants (bupropion, mirtazapine, moclobemide) • Secondary TCAs (nortriptyline or desipramine) may be suitable if coexisting indication like neuropathic pain, etc., but caution regarding anticholinergic load, etc.[10,16,18]
Mania	• Addressing any possible drug causes is of primary importance • Evidence for specific recommendations lacking • Mood stabilizers are an option, but take caution regarding tolerability and drug interactions
Apathy	• Limited role for drug therapy but sometimes cholinesterase inhibitors may be helpful • Methylphenidate also sometimes used, but limited by concerns such as stimulant effect on behaviour and risk of diversion[15,18]

First-line Antidepressants[3]

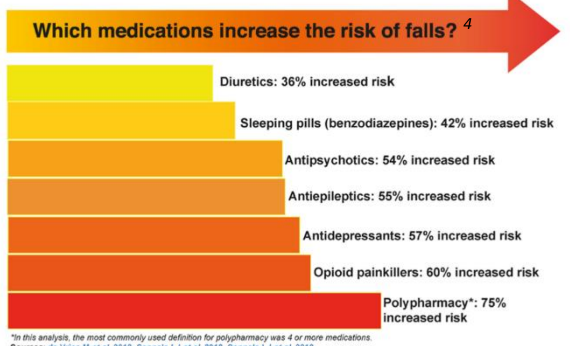
Psychopharmacology

- Duloxetine or sertraline are recommended as first-line
- Escitalopram or citalopram are alternatives
- Consider anti-cholinergic effects and drug interactions

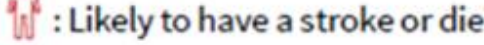
- **If you are considering initiating antipsychotic therapy, first ask:** [2]
  a. Are symptoms likely to respond to antipsychotics? (see below right)
  b. Is there imminent risk of harm to self and/or others?
  c. Are symptoms particularly disturbing, distressing or dangerous?
  d. Have you weighed the potential benefits and harms?

Antipsychotics: Potential Benefits	**Antipsychotics:** Potential Harms [2]
Limited benefit: modest improvement seldom observed • **effect size:** 0.12-0.2 • **NNT variable:** ~5-14 (ie. at best, compared to placebo, antipsychotic therapy results in targeted behaviour benefit in 1 out of 5 people treated)[20,21]	**Side effects:** sedation, falls, postural hypotension, QT prolongation, confusion, EPS (rigidity, stiffness, akinesia), tardive dyskinesia, diabetes, weight gain[22,23] **Stroke:** increased risk **Death:** possible increase Health Canada Advisory noted a 1.6 fold increase in mortality (mostly related to heart failure, sudden death, pneumonia). Some data suggests that there will be 1 extra stroke or death for every ~100 people treated (NNH=100).[24,25,26]

KEY: **EPS:** extrapyramidal symptoms (Parkinson's-like); **NNT:** number needed to treat to see one extra benefit; **NNH:** number needed to treat to see one extra harm



Antipsychotic Benefits and Harm[1]



Tips for Reassessing Antipsychotics for Possible Deprescribing [2]

- Stopping or tapering antipsychotics may decrease "all cause mortality"[27]
- Deprescribing may not be indicated where symptoms are due to psychosis, or where behaviour is especially dangerous or disruptive
- Evaluate reason for use and any recent changes in targeted behaviour
- Ensure suitable non-pharmacological measures for BPSD are optimized
- Due to the nature of responsive behaviours and the usual course of dementia, antipsychotics can often be successfully tapered and/or discontinued.[28] As some may worsen, approach cautiously, and monitor behaviour[29]
- Taper gradually, often by 25-50% every 2-4+ weeks and look for any resulting behaviour changes. Once on lowest dose, may discontinue in 2-4+ weeks
- Continue to reassess for emergence of responsive behaviours

References:

1. *Centre for Effective Practice. (2019). How Antipsychotic Medications are Used to Help People with Dementia.* https://cep.health/media/uploaded/CEP_BPSD_Discussion_Guide_ENG_RFCq_Updated2019.pdf
2. *Centre for Effective Practice. (2016). Use of Antipsychotics in Behavioural and Psychological Symptoms of Dementia (BPSD) Discussion Guide. LTC 2nd edition.* https://cep.health/media/uploaded/UseofAntipsychotics_LTC2016-2.pdf
3. *Canadian Coalition for Seniors' Mental Health. (2021). Treatment Guidelines for Major Depression in Older Adults.* https://ccsmh.ca/wp-content/uploads/2020/03/depression_laminate.png
4. *Medication and Falls. (2023).* https://www.deprescribingnetwork.ca/medications-and-falls