Primary Care Dementia Projects

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Projects

- Screening
- Pathway
- Referral to Memory Assessment & Treatment Service
- Annual Review
- Education
- Carers Workshop

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Who should be screened?

- Not the general population
- Increased risk
  - Downs syndrome
  - Learning disabilities
- CVA patients
- Parkinson’s disease
- Concern expressed by relatives
- Concern expressed by receptionists

When should we suspect dementia?

- Head turning sign
- New or deteriorating signs or symptoms
  - Cognitive symptoms
  - Challenging behaviours
  - Neurological symptoms
  - Difficulties with Daily Living

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Cognitive Symptoms

- Forgetfulness
- Repetitive questioning
- Naming difficulties
- Misunderstanding
- Disorientation

Challenging behaviours

- Withdrawal
- Depression
- Anxiety
- Agitation
- Social withdrawal
- Disinhibition
- Psychosis – delusions, hallucinations

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Neurological

- Gait disturbance
- Apraxia

Difficulty with Daily Living

- Orientation
- Getting lost
- Taking prescribed medication erratically
- Trouble with money
- Neglecting hygeine, self care
- Making mistakes

- None of these symptoms are specific for dementia

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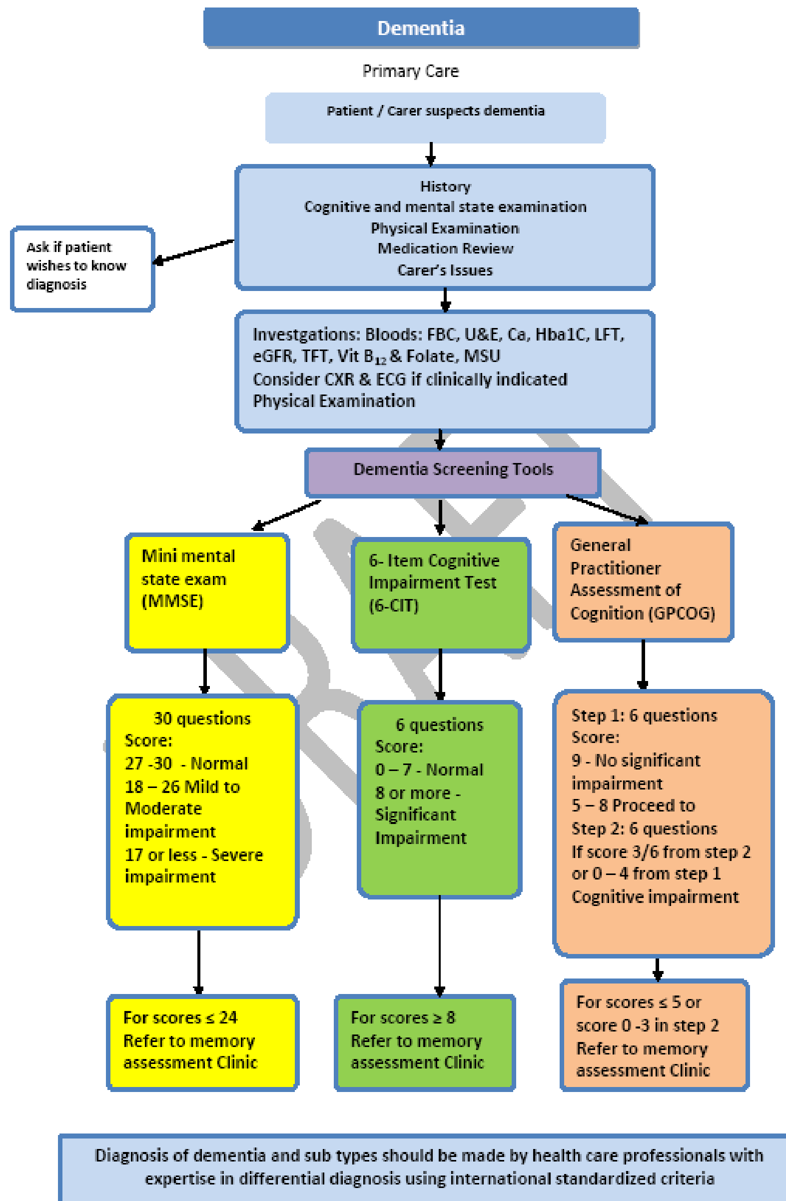

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Screening tools

- Six item Cognitive Impairment Test
  - 6-CIT
- General Practitioner Assessment of Cognition
  - GPCOG
- Mini-Mental State Exam
  - MMSE

6 CIT

- To administer the six-item cognitive impairment test (6-CIT)
  - **Ask:** *What year is it?*
    - Score 4 if incorrect.
  - **Ask:** *What month is it?*
    - Score 3 if incorrect.
  - **Say:** 'Repeat after me: John / Smith / 42 / High Street / Bedford'
  - **Ask:** *About what time is it?*
    - Score 3 if more than 1 hour wrong.
  - **Ask:** *Count backwards from 20 to 1*.
    - Score 2 if one mistake; score 4 if two or more mistakes.
  - **Ask:** *Say the months of the year in reverse*.
    - Score 2 if one mistake; score 4 if two or more mistakes.
  - **Ask:** *Repeat the address phrase requested earlier.*
    - Score 2 for each mistake; maximum score 10 for five mistakes.
- Assess the test as suggestive of dementia if the total score is 8 or more.
- A computerized version of the 6-CIT with automated scoring is available on some general practice computer systems.

GPCOG

- The General Practitioner Assessment of Cognition (GPCOG) test is available to do online. It is also available in online files suitable for printing in English (pdf), French, Italian, Greek, German, Spanish, Mandarin, and Cantonese; see the GPCOG website www.gpcog.com.au.
- GPCOG test scores are interpreted as:
  - Score of 9 — no significant cognitive impairment and further testing is not necessary.
  - Score of 5–8 — more information is required. Proceed with Step 2, the informant section.
  - Score of 0–4 — cognitive impairment is suggested.
- Step 2, the informant section. If the score on Step 1 is 5–8, this part of the GPCOG should be completed by an informant who has known the person well for some years. It has six questions that assess how the person is now compared to when they were well, for example 5–10 years ago.
  - If the informant's score is less than 4 (out of 6), cognitive impairment is suggested.

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GP COG Patient Examination

- **Name and address for subsequent recall**
  "I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington"
  Allow a maximum of 4 attempts but do not score yet)
- **Time Orientation**

  1. What is the date? (accept exact only)
- **Clock Drawing (visuo-spatial functioning)** *use a paper with a printed circle.*

  2. Please mark in all the numbers to indicate the hours of a clock (correct spacing required). *For a correct response (above), the numbers 12, 3, 6, and 9 should be in the correct quadrants of the circle and the other numbers should be approximately correctly placed.*

  3. Please mark in hands to show 10 minutes past eleven o'clock (11:10). *For a correct response (above), the hands should be pointing to the 11 and the 2, but do not penalise if the respondent fails to distinguish the long and short hands.*
- **Information**

  4. Can you tell me something that happened in the news recently? (recently = in the last week) *Respondents are not required to provide extensive details, as long as they demonstrate awareness of a recent news story.*
  If a general answer is given, such as "war", "a lot of rain", ask for details.
  If unable to give details, the answer should be scored as incorrect.
- **Recall**

  5-9. What was the name and address I asked you to remember?
  Score for each of the 5 components - John, Brown, 42, West Street, Kensington. GPCOG Patient Score = /9

Score 9 normal
5-8 proceed to second part
0-4 cognitive impairment

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GP COG Informant

GPCOG Informant Interview

Ask the informant: ….Compared to a few years ago…..

- Does the patient have more trouble remembering things that have happened recently?
- Does he or she have more trouble recalling conversations a few days later?
- When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?
- Is the patient less able to manage money and financial affairs (e.g., paying bills, budgeting)?
- Is the patient less able to manage his or her medication independently?
- Does the patient need more assistance with transport (either private or public)?

Score 1 point for each "no" answer.

Score out of /6

0-3 cognitive impairment

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Mini Mental State Examination MMSE

Instructions : Ask the questions in order listed. Score one point for each correct response within each question or activity. 11 questions or activities

Question / activity	Score
"What is the year? Season? Date? Day of the week? Month?	5
"Where are we now: State? County? Town/city? Hospital? Floor?	5
The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number correct on first attempt	3
"I would like you to count backwards from 100 by sevens." (93, 86, 79, 72, 65,….) Stop after five answers. (Alternative : "Spell WORLD backwards." (D-L-R-O-W))	5
"Earlier I told you the names of three things. Can you tell me what those were?"	3
Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.	2
"Repeat the phrase : 'No ifs, ands, or buts."	1
"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)	3
"Please read this and do what is says." (Written instructions is "Close your eyes.")	1
"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)	1
"Please copy this picture" (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.)	1
	Total 30

Adapted from Rovner & Folstein, 1987

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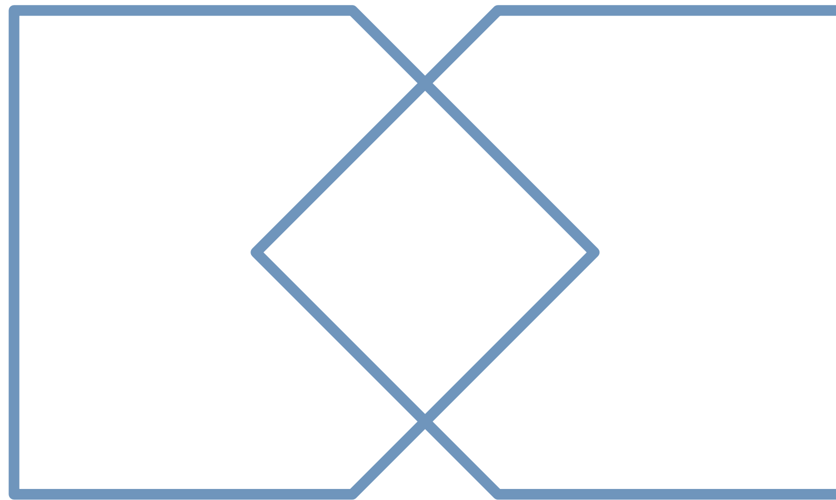
Diagram



Dementia and QOF

- DEM 1 A register 5 points
- DEM 2 % of patients reviewed in the past 15 months 70% 15 points
- DEM 4 % of patients with a new diagnosis of dementia in the last 15 months, with a record of FBC, Ca, Glucose, renal and liver function, TFTs, B12 and folate recorded 6 months before or after entering the register 80% 6 points

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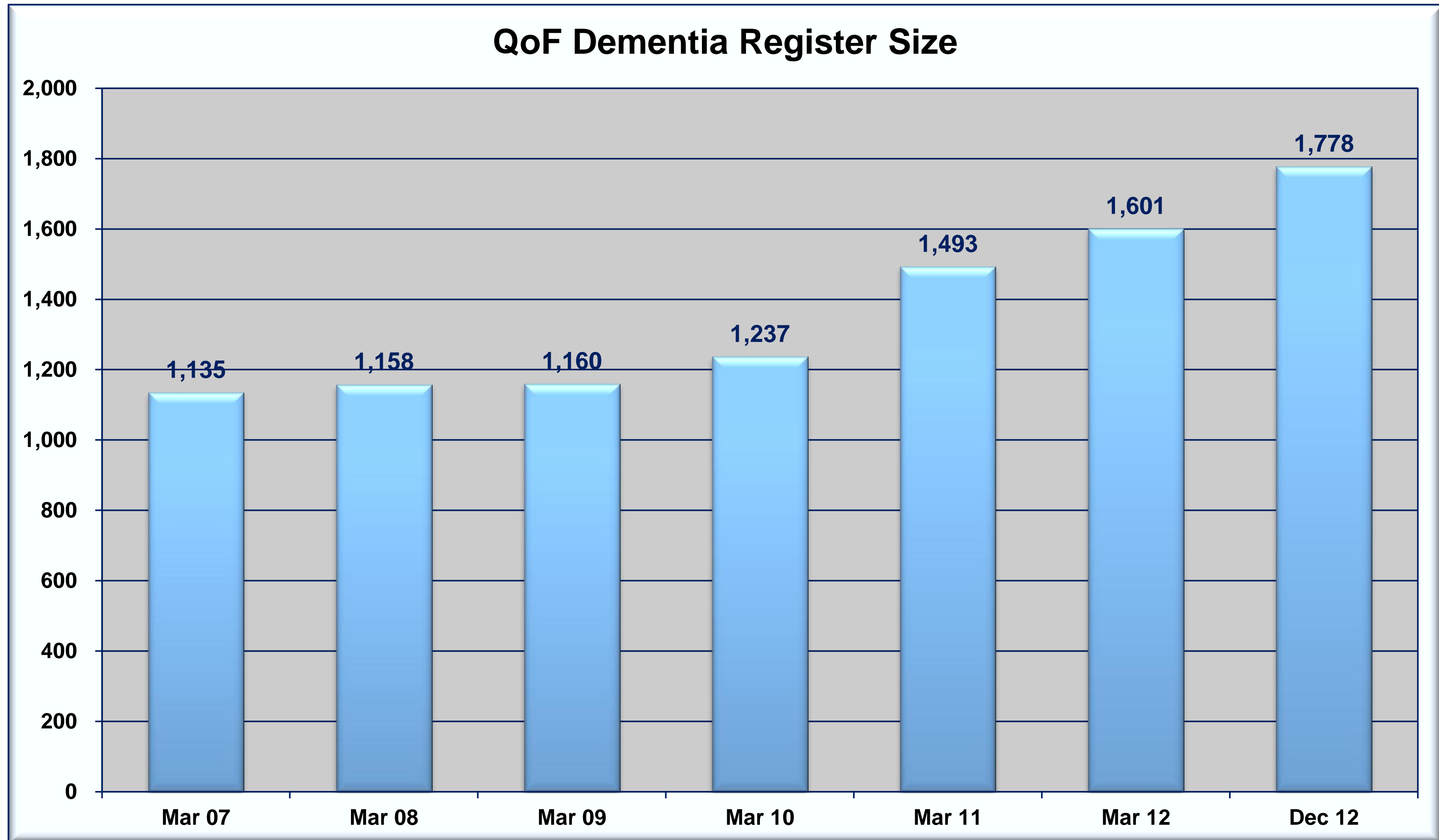
Registers - numbers



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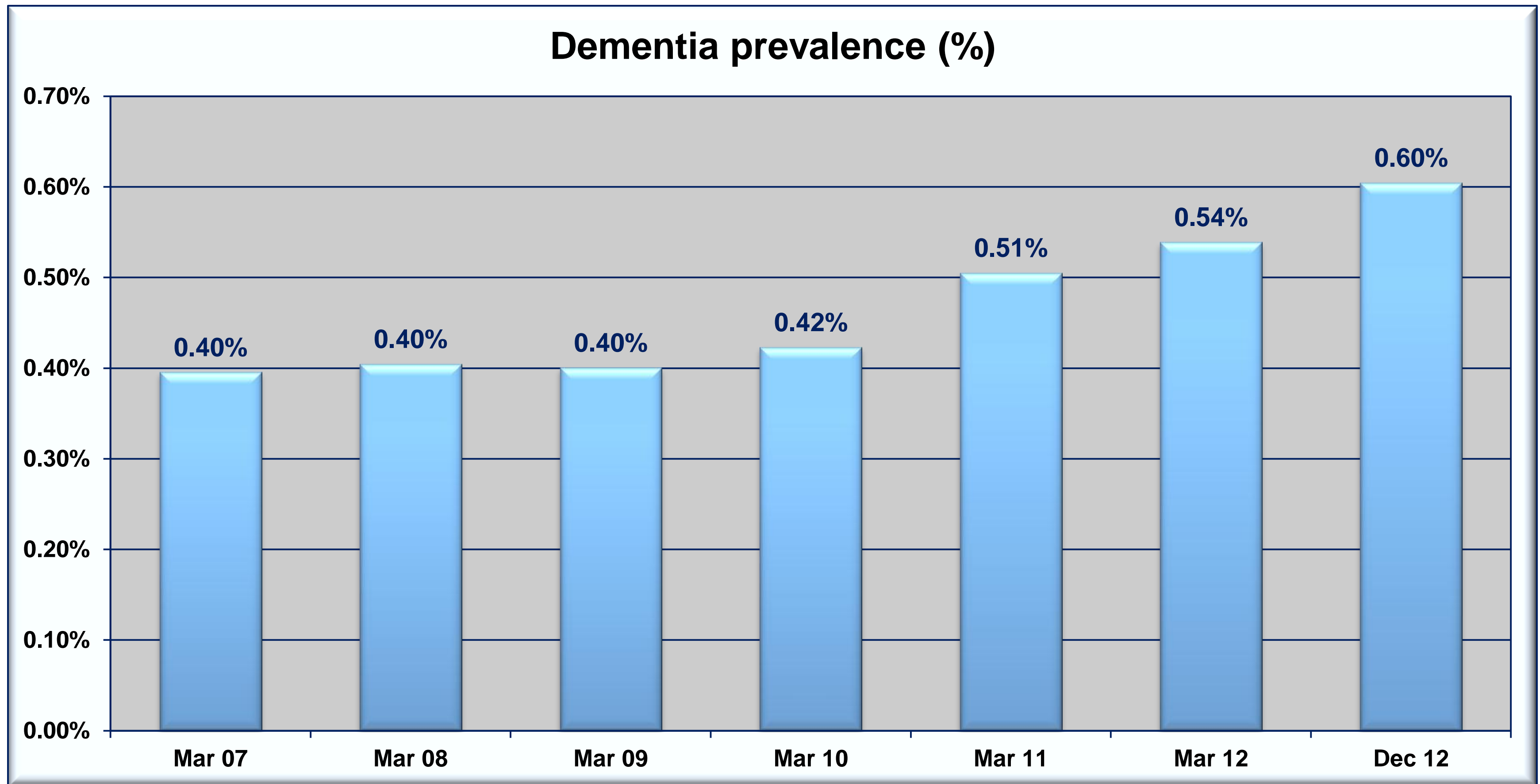
Registers - Prevalence



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DEM 2

- An appropriate physical and mental health review
- The carers needs for information commensurate with the stage of the illness and the patients health and social care needs
- The impact of caring on the care-giver
- Communication and Co-ordination with Secondary Care
- Concurrent physical conditions
- New appearance of features intrinsic to the disorder
    - Wandering
    - Hallucinations
    - Delusions

Mental Health Assessment (#38C1)

Symptom	Coding	Prompts
Wandering	Wanders during the day Wanders at night Wanders day and night	Are there underlying causes to changes in behaviour such as hallucinations or delusions
Agitation	Yes No	Is the patient in pain?
Aggression	Verbally abusive behaviour Physically abusive behaviour Argumentative behaviour	Think of underlying causes such as hallucinations or delusions
Sleep	Good sleep pattern Poor sleep pattern	Potentially a big impact on the carer
Patient aware of diagnosis	Yes No	Degree of knowledge and awareness will help you pitch the review at the right level
Repeat of depression screening test	Yes No	6CIT (#3AD3) GPCOG (#38Dv) Mini mental state (#ZRaA)
Depression screening	Yes No	Geriatric depression scale (#ZRL6)
Fit to drive	Fit to drive Unfit to drive	DVLA have to be notified of the diagnosis of dementia
At risk of financial mismanagement	Yes No	Power of Attorney applied for or held
Vulnerability assessment	Text	Is the patient at risk from others? Physical, verbal, psychological, or neglect

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Physical Health assessment (#38C2)

pSymtoms	Coding	Prompts
Appetite	Appetite normal Appetite increased Appetite reduced	
Hearing	Hearing normal Deteriorating hearing	Poor hearing has an impact on cognitive function
Vision	Normal Vision Deteriorating vision Partially sighted Registered blind	Impact of poor vision needs to be distinquished from the effects of hallucinations
Mobility	Fully mobile Mobile outside with aid Mobile in home Confined to chair Bedridden	
Urinary continence	Bladder incontinent Bladder occasional accident Frequency of micturition Nocturia Bladder fully continent	Find out if patient is aware of incontinence. This has an impact on intensity of management by the carer
Faecal continence	Bowels incontinent Bowels occasional accident Bowels fully continent	Is patient aware?
Needs help with self care	Text	Is patient dependent, independent, or needs help?
Number of falls in the past year	Text	? Refer for falls assessment
Risk of accidents at home	Text	Burns a significant risk Safety using stairs? Is home environment as safe as it can be?
Weight	Linked	

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Medication Review (#8B3S)

Current medication	Text	
Use of dementia specific medication	Yes No	Anti cholinesterase inhibitors? Memantine?
Use of antipsychotics	Yes No	
Use of anti-depressants	Yes No	
Use of sedatives	Yes No	
Mental health medication review (#8BM0)		
Medication review		

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Impact on carer/Carers needs (#29MQ)

Carers details	Name Address Telephone No	
Relationship to patient	Text	
Proximity		Does the Carer live with the patient?
Carers needs assessed	Text	
Carer coping	Text	
Carers needs for information	Text	Literature provided? To whom?
Carer assessment required		Carer can have a separate Social services assessment of their needs

Communication with / Referral to other services

Care co-ordinator (#918D)
Memory assessment team
Social services
Voluntary agencies
District Nurse
Intermediate care
Care management plan agreed

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Education

- Bridge Education Event – 3rd October
- Practice Nurse Education Event – 24th October
- HCA/Health Trainer Education Event – 12th December
- Ad hoc education in GP practices

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Carers Workshop

January 2013

- Practice Manager Workshop – assess approach to carers in GP practices
- Develop action plans e.g. identify carers leads in practices, write carers policy etc.
- Follow-up event March 2013

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