

GP Masterclass: Memory Clinic Services, 10 July 2013

Expert panel discussion – Q&As

Panel members:

Dr Adrian Treloar, Consultant in Old Age Psychiatry, Clinical Director Older People’s Mental Health Services and Senior Lecturer, Oxleas

Dr Jo Cook, Head of Older People’s Psychology, Oxleas

Dr Ana Saiz, Consultant in Old Age Psychiatry, Oxleas

Dr Abi Fadipe, Consultant in Old Age Psychiatry, Oxleas

Dr Sylvia Nyame, Clinical Project Lead in Mental Health, Greenwich CCG

Dr Sid Deshmukh, Lead Informatics and Dementia, Bexley CCG

Question	Answer
<p>What sort of help is given to carers looking after patients at home?</p>	<p>We provide a person centred service, assessing the needs of the patient and carer.</p> <p>Advanced disability care is a contract with patients and our service/GP, that when the time comes, we’ll be there to support.</p> <p>Our Advanced Dementia Service:</p> <ul style="list-style-type: none"> • commitment to support care to end of life • ongoing assurance, advice and support • care packages in place • right equipment in the home • right medication/treatment • palliative care towards end of life • with excellent feedback from carers and also GP’s as to outcomes.
<p>What do you mean by ‘carer’s burden eases as disease progresses’?</p>	<p>The pathway varies for different carers. The diagnosis can cause real shock and terror of what lies ahead for a carer and can be really daunting. We support people and if they accept help, they can find a form or meaning or value in providing care, appropriately supported to live a bit of their own life too.</p> <p>In addition to the process of adjusting to living with someone with dementia, there are also phases in the illness when the challenge to carers is greatest. Therefore at a time when wandering is prominent, or other forms of distress or psychosis are especially bad, carer burden may be greatest. Therefore, as dementia progresses and distress or wandering/agitation/challenging behaviour settles, carer burden may in fact reduce as the illness progresses.</p> <p>The importance of this is that it can give some hope to carers at times when things seem especially bad and they have been told to expect the dementia to progress (ie get worse).</p>

Question	Answer
<p>Do you find a large overlap between vascular dementia and Alzheimer's, and what do you do in terms of treatment?</p>	<p>Yes, the majority of people we diagnose have mixed dementia, often vascular dementia and Alzheimer's co-exist. People with vascular dementia who have high cholesterol are more likely to develop Alzheimer's. We would talk to these patients about vascular risk factors and how to control them.</p> <p>The key in terms of treatment is a trial of appropriate medication. Most therefore will benefit from a trial of antidementia drugs. Some of the people with a very strongly vascular picture who are also on multiple other medicines (eg for hypertension, heart failure and also diabetes) are less likely to receive such drugs because of the harmful effects of polypharmacy.</p>
<p>When a person's in crisis, how can they access support, where do they go?</p>	<p>Firstly though, by an assessment by GP and others, as to why they are in crisis. Are they ill, do they have a UTI, is this delirium, etc., are the first things to check. And if the crisis is due to acutely low mood or psychosis then of course the CMHT will be needed. So first and foremost the response to a crisis is to try and work out what has triggered this crisis. Some will need help from social services, some assessment in A&E and some assessment at home or in clinic by our CMHTs.</p> <p>For respite care, contact Social Services. It really depends what the crisis is.</p>
<p>What about ongoing care packages? Social Services advise contacting the Memory Clinic.</p>	<p>When someone is in crisis, we need to ask why they are in crisis. Check there are no infections, deliriums, etc, what's the nature of deterioration? What's going on? Do we need to add in treatment as well as social care?</p> <p>In different boroughs routes of access to social care differs. In Bromley, social workers are placed within teams and that helps to link up with social care. Referrals will either be via existing CMHT CPN's etc, or when someone is not known to that team via the usual social service route.</p> <p>In Bexley, sadly, social workers no longer work within our CMHT's and so access to care packages is via the access teams in social services.</p> <p>In Greenwich, people under the Memory Clinic and who are not known to our services, access care via the usual social service routes. Those under the CMHT will have their care commissioned via a one stop service jointly run within the CMHT at the Memorial by health and social services.</p>
<p>Do all Memory Clinics depend on neuro imaging? What percentage of patients end up having a scan?</p>	<p>We don't have to do a scan on every patient. If we don't suspect other neuro problems, it isn't necessary. In the Memory Clinic we are seeing patients earlier and earlier and tend to request neuro imaging. If we see patients later, a clinical diagnosis is sufficient.</p> <p>Differential diagnosis – not just dementia causes memory problems.</p>

Question	Answer
What percentage of referrals turn out not to be dementia?	<p>Not very many. Some are the worried well, concerned about ageing. We tend to see those people only once. We are seeing people earlier with diagnosis of mild cognitive disorder, but not all of those will go on to develop dementia – we do a cognitive baseline assessment, and will review these people in one year’s time. We do see the ‘worried well’.</p> <p>Dementia has a serious impact on life, with mild cognitive disorder, people can get on with their lives.</p>
Can you give a quick overview of cholinesterase inhibitors, how effective they are?	<p>They are not curative. But they do help. The average gain on SMMSE is about 1.7 points so it’s a small but significant gain. Some patients do not respond at all and others do much better. As a result of that effect progression of the illness is slowed, with delays in entry to institutional care of 6 months to one year. And carers really do find the gains in function very valuable.</p> <p>Finally, these drugs do give hope. Hope of some help in what is otherwise a sad illness. Of course we also give hope by the other aspects of care that we offer, including support, treatment of pain depression and psychosis and also just by the promise of on-going support. But these drugs offer hope of a real improvement in function. That is a very valuable thing, even though the effect size is small.</p>
What evidence is there of their effectiveness?	<p>1.7 average gain. For some people they work well, really well for a few. They give hope to the carer and patient - that something can be done to improve their condition.</p>
Can these be used in treatment of behavioural problems? What’s the impact?	<p>They’re not always useful. Case example, a patient with severe dementia at home with his wife, drug reduced and stopped, causing no difference in cognitive functions, but patient stopped recognising his wife. They don’t have a great effect on behavioural problems. There is better evidence that Memantine may have some effect in reducing agitation in dementia.</p>
When GPs see patients and carers in surgery, they can provide support to carers. However, when patients are at home and not visiting surgery, what support is there to carers? Is there a carers line?	<p>There is a dementia advisers line in Greenwich which the CCG are trying to promote to GPs. The Alzheimer’s Society has a national dementia helpline. MindCare in Bromley and Alzheimer’s Society are a good place to start. Each borough has a Carer’s organisation.</p> <p>The services vary between boroughs. If carers have their own mental health needs, the Memory Clinic can support, or they can be seen in the CMHT in their own right.</p> <p>We run carers’ education groups which can give carers a range of skills to help them care better.</p>

Question	Answer
<p>What's the best way to deal with wanderers? Locked doors?</p>	<p>Firstly, perhaps by enabling wandering to occur. Either in the back garden or by accompanying someone on a walk etc.</p> <p>Secondly if they are depressed or psychotic, by treating that effectively.</p> <p>Thirdly, assessment of the issues by the CMHT.</p> <p>A Just Checking kit (telecare type of system) can be put in a home for a couple of weeks to monitor activity. It really depends on the risks the family are willing to take.</p> <p>But finally, in the end, for some who will be at risk if they do go out, it is sometimes appropriate to lock the door. Doing that is a form of restraint. That is allowed under section 6 of the Mental Capacity Act which allows (or even gives a duty to restrain) so as to avoid harm to the patient, provided the restraint is proportionate to the harm to be avoided. So its another analysis of risk and benefit. But it is not universally illegal to use locked doors to protect people with dementia from harm. We do lock the doors of many care homes and also our wards.</p>
<p>I've got a long standing dementia patient who is becoming more aggressive and exhibiting sexualised behaviour</p>	<p>Refer patient to the Community Mental Health Team for assessment. Anti-dementia drugs may be causing agitation.</p>
<p>Any plans for training carers, HCAs, etc in care homes?</p>	<p>It is the responsibility of the care home to train staff. Each care home should have this in place.</p>
<p>Packs need to be developed for relatives, to help them when patient goes into a nursing home, so relatives can understand what's happening right from the beginning.</p>	<p>We do have information packs in the Memory Service.</p>

<p>I was asked to write a covert treatment document yesterday re a patient coming out of hospital with crush and dissolve all medication. Is this related to DoLS?</p>	<p>We did a study in Bromley and Kent a while ago, asking nurses ‘Do you put medicines in people’s food?’. 75% said ‘Yes’. Nurses interviewed said they had to do it or patients suffered, but felt their registration was put at risk if they did it. We asked carers the same question, 96% felt it was the right thing to do.</p> <p>The Royal College and NMC guidance was developed, which states where people lack capacity and may come to harm, it is legitimate to do, in discussion with family, etc.</p> <p>Under the Mental Capacity Act, it is a form of restraint. You need to justify under Section 6 of the Act, it needs to be done with care, around harm (distress).</p> <hr/> <p>The discussion on the use of medication within foodstuffs at this GP Masterclass has some references that you might like to read for further reflection upon the issue. It is an issue that does lead to great anxiety, but nonetheless, can support the important principle that those who lack capacity should be able to receive appropriate treatments even though they are unable to consent to them.</p> <p>If you would like that topic covered in any of our practice based seminars, this could be done at your request.</p> <p>References</p> <p>http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(00)03578-9/fulltext and http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1298081/pdf/10983501.pdf and http://apt.rcpsych.org/content/7/6/444.full</p> <p>There is guidance at http://www.rcpsych.ac.uk/pdf/covertmedicine.full.pdf (R C Psych) and http://www.nmc-uk.org/Documents/Circulars/pre%202002%20circulars/Registrars%20letter%2026-2001%20annexe.pdf (NMC)</p>
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