Dementia (Mild) - Management
Mental Health > Behavioural, developmental and other > Dementia

- Go to Advance Care Planning (ACP)
- Confirm EPA and ACP discussions
- Needs Assessment & Service Coordination (NASC)
- Assess presence of BOTH cognitive and non-cognitive symptoms
- Cognitive symptoms
  - Non-medication interventions for cognitive symptoms
    - Medication intervention for vascular dementia
  - Medication intervention for Alzheimer's Disease
    - Screen for frailty AND falls risk
    - Review in 6 months
- Non-cognitive symptoms
  - Non-medication interventions for non-cognitive symptoms
    - Medication interventions for non-cognitive symptoms

Information resources for people with dementia and carers
Information resources for clinicians
Updates to this care map
Hauora Māori
Pasifika

This map was published by MidCentral District. A printed version of this document is not controlled so may not be up-to-date with the latest clinical information.
1. Care map information

Scope:
- management of dementia including:
  - Alzheimer's Disease (AD)
  - vascular dementia
- pharmacological and non-pharmacological aspects of management including:
  - social care
  - person-centred care
  - palliative care and advance care planning
  - management of co-morbid emotional disorders
- recommendations and support for carers

Out of scope:
- management of:
  - Frontal-temporal dementia (FTD)
  - Dementia with Lewy Bodies (DLB)/Parkinson's disease dementia (PDD)
  - alcohol related dementia
- dementia due to other medical causes, e.g.:
  - HIV
  - head trauma

Definitions:
- cognitive impairment:
  - cognitive impairment may affect a number of domains in varying degrees:
    - difficulty with memory
    - language disturbances (receptive or expressive)
    - agnosia
    - apraxia
    - impairment of Executive Cognitive function
- dementia:
  - dementia is a progressive and largely irreversible clinical syndrome that progresses to widespread impairment of mental function and functional abilities
  - generally becomes associated with a decline in activities of daily living and impairment in social function

Aetiology:
- causes of dementia are not fully understood
- most common causes are:
  - AD:
    - usually insidious in onset
    - develops slowly but steadily over several years
    - predominantly affects older people
  - vascular dementia:
    - due to small vessel disease or multiple infarcts
    - other vascular risk factors often present
    - can have a gradual or a stepwise, fluctuating course
• DLB
• a proportion of people have mixed AD and vascular dementia, other dementias include:
  • FTD
  • other focal dementias, e.g. posterior cortical atrophy
  • mixed dementias – includes AD with vascular dementias, and AD with DLB
• young-onset dementia refers to dementia that develops before age 65 years

General risk factors include:
• Down's syndrome and other learning disorders
• history of head trauma
• genetic predisposition
• alcohol
• vascular risk factors

Prognosis:
• is a terminal illness
• young-onset dementia tends to progress more rapidly
• progression of cognitive function impairment in a number of different domains
• most people will eventually require assistance to perform even simple tasks

Incidence and prevalence:
• dementia affects about 48,182 (2011 stats)
• estimated to be 74,821 (in 2026)
• dementia is principally a disease of the elderly, affecting:
  • 5-8% of people over age 65 years
  • 15-20% of people over age 75 years
  • 25-50% of people over age 90 years
• AD accounts for about 60% of cases
• vascular dementia accounts for 15-20% of cases
• DLB accounts for about 15% of cases

2. Information resources for people with dementia and carers

Recommended resources for people with dementia and carers:

Advocacy and support:
• About Dementia
• Alzheimer’s New Zealand booklets and facts sheets
• Neurological Foundation
• Dementia Advocacy & Support Network International
• Memory loss and dementia
• Alzheimers disease and dementia support
• Communication
• Understanding behaviours

Legal:
• Advance care planning
• Enduring Power of Attorney (EPA)

Driving:
• dementia and driving
• National Dementia Cooperative

Firearm safety/gun licence:
• firearm safety

Te Ara Whānau Ora Brochure:
• Te Ara Whānau Ora Brochure

Patient version of Pathway
• patient version of Dementia Assessment Pathway

3. Information resources for clinicians

Recommended resources for clinicians

Cognitive screening:
• MoCA tool and instructions

Screening for depression:
• Geriatric Depression Scale

Medication:
• Rivastigmine transdermal patch doses and application

Legal:
• Advance care planning
• Enduring Power of Attorney (EPA)

Driving:
• consider if patient is fit to continue to drive
• dementia and driving
• medical aspects of fitness to drive (NZTA)

Firearm Safety/Gun licence:
• review access to firearms and whether this is still appropriate

Ministry of Health documents:
• support and management of people with dementia
• mental health and addiction services older people and dementia services
• improving quality residential care

Supportlinks referral:
• Supportlinks referral form or phone 0800 221 411 for information
Alzheimers Manawatu referral:

- Alzheimers Manawatu referral

4. Updates to this care map

First published: September 2014
Date of last publication: March 2016

This care map has been reviewed in line with consideration of evidenced based guidelines with no updates made. Below summarises changes made to the pathway following review:

- if donepezil is not tolerated due to adverse GI side effects, rivastigmine (Exelon) transdermal patch can be used in mild to moderate dementia of the Alzheimers type - special authority is required
- removed reference to palliative care and added screen for Frailty

Please see the care map’s Provenance for information on references, accreditations from national clinical bodies, contributors, publication schedule, and the editorial methodology.

5. Hauora Māori

Māori are a diverse people and whilst there is no single Māori identity, it is vital practitioners offer culturally appropriate care when working with Māori whānau. It is important for practitioners to have a baseline understanding of the issues surrounding Māori health. This knowledge can be actualised by (not in any order of priority):

- acknowledging Te Whare Tapa Wha (Māori model of health) when working with Māori whānau
- asking Māori clients if they would like their whānau or significant others to be involved in assessment and treatment
- asking Māori clients about any particular cultural beliefs they or their whānau have that might impact on assessment and treatment of the particular health issue (Cultural issues)
- consider the importance of whānaungatanga (making meaningful connections) with their Māori client / whānau
- knowledge of Whānau Ora, Te Ara Whānau Ora and referring to Whānau Ora Navigators where appropriate
- having a historical overview of legislation that has impacted on Māori well-being

For further information:

- Hauora Māori
- Central PHO Maori Health website

6. Pasifika

Pacific Cultural Guidelines (Central PHO) 6MB file

Our Pasifika community:

- is a diverse and dynamic population:
  - more than 22 nations represented in New Zealand
  - each with their own unique culture, language, history, and health status
  - share many similarities which we have shared with you here in order to help you work with Pasifika patients more effectively

The main Pacific nations in New Zealand are:

- Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu
Acknowledging The FonoFale Model (Pasifika model of health) when working with Pasifika peoples and families.

Acknowledging general pacific guidelines when working with Pasifika peoples and families:

- Cultural protocols and greetings
- Building relationships with your pasifika patients
- Involving family support, involving religion, during assessments and in the hospital
- Home visits
- Contact information

Pasifika Health Service - Better Health for Pasifika Communities:

- the Pasifika Health Service is a service provided free of charge for:
  - all Pasifika people living in Manawatu, Horowhenua, Tararua and Otaki who have long term conditions
  - all Pasifika mothers and children aged 0-5 years
- an appointment can be made by the patient, doctor or nurse
- the Pasifika Health Service contact details are:
  - Palmerston North Office - 06 354 9107
  - Horowhenua Office - 06 367 6433
- Better Health for Pasifika Communities brochure

Additional resources:

- Ala Mo'ui - Pathways to Pacific Health and Wellbeing 2010-2014
- Primary care for pacific people: a pacific health systems approach
- Tupu Ola Moui: The Pacific Health Chart Book 2004
- Pacific Health resources
- List of local Maori/Pacific Health Providers
- Central PHO Pacific Health website

7. Dementia management

This map includes the management of Alzheimer's Disease (AD) and vascular dementia management including:

- pharmacological and non-pharmacological aspects of management including:
  - social care
  - person-centred care
  - palliative care and advance care planning
  - assessment and management of co-morbid emotional disorders
  - recommendations and support for carers

8. Confirm EPA and ACP discussions

Discuss:

- Advance Care Planning (ACP)
- Enduring Power of Attorney (EPA)

9. Needs Assessment & Service Coordination (NASC)

For carer relief services and day care services
Consider referral to:
- **Supportlinks** (NASC): for assessment to organise carer relief services, day care services and respite for future urgent situations.
- complete [Supportlinks referral form](#) or phone 0800 221 411 for information

### 10. Assess carer stress

To assess carer stress consider asking the following:
- are you tired most of the time?
- have you given up doing things you enjoy?
- do you resent the person you are caring for?
- are you ever afraid of them?

**If carer stress/social issues are present consider the need for additional support.**

If required discuss services and interventions available to support carer and the person with dementia at all stages of the journey of care, including:
- **Supportlinks (NASC):** for assessment to organise respite/services for future urgent situations.
- **Alzheimers Manawatu:** for support, education and advocacy for all people affected by dementia

### 11. Alzheimer's Manawatu

**Alzheimer’s Manawatu** provides support, education and advocacy for all people affected by dementia, this includes those affected, their carers and family/whānau. Support is provided throughout the region through:

- **day program centres:**
  - for people with dementia, the opportunity to socially interact with others within a varied and stimulating program and respite for the carer to have time out
  - programs managed by trained staff are currently offered in Palmerston North, Levin, Dannevirke and Fielding

- **monthly carer support groups:**
  - held in Manawatu, Horowhenua and Tararua
  - give carers opportunities to discuss with each other day to day issues and enable them to support each other with a support facilitator

- **carer information sessions:**
  - provide carers with:
    - an understanding of dementia and the disease process
    - strategies to manage behaviours
    - empowers them to care confidently
    - educates them about the need to take care of themselves and also where to seek help and support

- **early stage group:**
  - provided to people with early stage dementia - is offered to:
    - enable social interaction
    - maintain regular exercise or creative expression. However the type of activity is dependent on time of the year i.e. walking group in the warmer weather and art in the winter

- **field officers:**
  - provide home visits for:
    - assessment
    - on-going support
    - education
Referral criteria:
• all persons diagnosed with dementia
• carers
• spouse
• family/whānau

Alzheimers Manawatu Referral

12. Assess presence of BOTH cognitive and non-cognitive symptoms

NB: people may present with both cognitive and non-cognitive symptoms, if this is the case both arms of the pathway need to be followed.

13. Cognitive symptoms

Cognitive symptoms can include problems with:
• attention and concentration
• orientation
• memory (short and long-term)
• comprehension
• learning capacity
• judgement
• functional ability
• language and communication
• eating and swallowing
• executive function

14. Non-cognitive symptoms

Non-cognitive symptoms may include:
• hallucinations
• delusions/abnormal beliefs
• extreme anxiety or agitation
• depression:
  • for assessment of depression use the Geriatric Depression Scale
• challenging behaviour:
  • aggression
  • wandering
  • social disinhibition
  • inappropriate communication

15. Non-medication interventions for cognitive symptoms

Initial approach:
• manage physiological needs, particularly those that trigger agitated behaviour:
• pain
• incontinence
• aim to simplify daily routines
• address any language or communication difficulties
• discuss the importance of regular exercise and well balanced diet

16. Non-medication interventions for non-cognitive symptoms

If a person with dementia develops distressing non-cognitive symptoms or challenging behavior, offer an early assessment to include:

• physical health
• communication abilities and suggest non-verbal forms of communication if required e.g.:
  • demonstrating
  • physically assisting
  • pictures
• possible depression and/or anxiety, especially if irritability is present
• unidentified pain or discomfort, especially behavioural signs
• side effects of medication, particularly noting any recent changes
• personal history, cultural, spiritual, or religious beliefs or practices that may impact
• psychosocial factors including role and relationship changes
• living environment factors that may contribute
• significantly distressing non-cognitive symptoms should be assessed by ElderHealth if initial interventions are unsuccessful

For co-existing agitation, consider interventions tailored to the person’s preferences, skills and current abilities. Consider the following:

• activities should provide stimulation and be achievable
• activities involving social interaction may be beneficial monitor for:
  • over stimulation or
  • presence of disinhibition
• rest and activity schedules
• regular exposure to sunlight
• therapeutic use of music and/or dancing
• animal assisted therapy or access to pets
• access to former hobbies or activities with modifications to allow achievement
• multi-sensory approaches e.g.:
  • aromatherapy
  • massage
  • exercise to music

Useful resources:

• Communication
• Understanding behaviours

17. Medication intervention for vascular dementia

Realistic expectations for treatment effects and potential side effects should be discussed.
Management primarily involves the identification and treatment of vascular risk factors and amelioration of behavioural and psychological symptoms of dementia (BPSD).
Risk factor management:
- people should be screened and treated for vascular risk factors, especially hypertension
- other considerations include:
  - diabetes management
  - statin therapy
  - antiplatelet agents.
- a healthy lifestyle should be promoted

Disease-modifying therapy:
Cholinesterase inhibitors and memantine have been studied in patients with vascular dementia (VaD). The data is limited and at this time these agents are not endorsed for patients with VaD. However, because of the shared risk factors and pathogenesis with Alzheimer's Disease (AD), these drugs are often used when there is difficulty differentiating AD from VaD on clinical grounds; consider a trial of cholinesterase inhibitor in this situation (Go to “Medication for AD node”).

18. Medication intervention for Alzheimer's Disease

Realistic expectations for treatment effects and potential side effects should be discussed.
Cholinesterase inhibitors increase cholinergic transmission in the brain, which is decreased in patients with Alzheimer's disease (AD). These drugs do not alter the course or progression of AD but for some people they improve symptoms related to:
- cognition
- behaviour and
- function

This can lead to:
- improved memory
- ability to perform daily tasks
- improved quality of life
- reduced need for care.

There are three cholinesterase inhibitors registered in NZ for the treatment of AD:
- rivastigmine
- galantamine
- donepezil

Only donepezil is funded.
Donepezil may be considered for any patient with mild to moderate AD but may also improve behavioural problems in patients with severe AD.

The most common adverse effects are vomiting and nausea. Other adverse effects may include:
- fatigue
- dizziness
- headache
- syncope
- bradycardia
- agitation
- confusion
- dyspepsia
- increased sweating
- tremor
All cholinesterase inhibitors have the potential to increase the risk of bradycardia with:

- beta blockers
- digoxin
- amiodarone
- calcium channel blockers

The actions of other anticholinergic drugs, e.g. oxybutynin and benztrapine may be antagonised.

Donepezil should only be considered when a clear diagnosis of AD has been made:

- check baseline ECG for no evidence of conduction abnormalities as Donepezil can exacerbate heart block
- start at 5 mg/day (once daily dosing, usually taken at night)
- review at 6 weeks to assess response to treatment and for adverse effects
- increase to 10 mg/day if no adverse effects
- review at 3 and 6 months
- reduce dose to 5 mg/day if adverse effects
- if no benefit at either dose, discontinue treatment with cautious downward titration

If donepezil is not tolerated due to adverse GI side effects, rivastigmine (Exelon) transdermal patch can be used in mild to moderate dementia of the Alzheimer's type - special authority is required. [Rivastigmine transdermal patch doses and application]

19. Medication interventions for non-cognitive symptoms

**Antipsychotic drugs:**

- use should be reserved for patients with severe and debilitating neuro psychiatric symptoms and when non-medication interventions have failed
- start at the lowest clinically appropriate dose and titrate cautiously according to:
  - symptoms
  - age
  - cardiovascular status
- use with caution as these drugs have been linked with an increase in significant side effects in people with dementia
- options with suggested starting doses include:
  - risperidone – 0.25mg b.d.
  - olanzapine - 2.5mg o.d.
  - quetiapine - 12.5mg b.d.
- review for adverse effects should occur at no later than 2 weeks
- provided there are no adverse effects cautious up-titration can proceed if necessary
- further review for response to treatment is recommended and should occur at 6 weeks or at the very latest 12 weeks
- if no benefit is apparent treatment should be discontinued in a cautious stepwise fashion
- even if benefit is achieved, discontinuation should be attempted, though for some patients this may not be possible

**Antidepressants:**

- selective serotonin re-uptake inhibitors (SSRIs) are preferred because of the anticholinergic effects of tricyclic antidepressants (TCAs)
- options with suggested starting doses include:
  - citalopram 10mg o.d.
  - fluoxetine 20mg o.d.
  - escitalopram 5mg o.d.
20. Screen for frailty AND falls risk

If frailty or additional co-morbidities exist refer to Frailty Pathway

People with dementia, particularly those prescribed donepezil and other like medications, are at increased risk of falls. Refer to the Falls in Older People Pathway for more information.

21. Review in 6 months

Review in 6 months to assess cognitive function and carer stress
Dementia (Mild) - Management

Provenance Certificate

Overview

This document describes the provenance of MidCentral District Health Board’s Dementia Pathway. This localised pathway was last updated in November 2014.

One feature of the “Better, Sooner, More Convenient” (BSMC) Business Case, accepted by the Ministry of Health in 2010, was the development of 33 collaborative clinical pathways (CCP).

The purpose of implementing the CCP Programme in our DHB is to:

- Help meet the Better Sooner More Convenient Business Case aspirational targets, particularly the following:
  - Reduce presentations to the Emergency Department (ED) by 30%
  - Reduce avoidable hospital admissions to Medical Wards and Assessment Treatment and Rehabilitation for over-65 year-olds by 20%
  - Reduce poly-pharmacy in the over-65-year-olds by 10%
- Implement a tool to assist in planning and development of health services across the district, using evidence-based clinical pathways.
- Provide front line clinicians and other key stakeholders with a rapidly accessible check of best practice;
- Enhance partnership processes between primary and secondary health care services across the DHB.

To cite this pathway, use the following format:

Editorial methodology

This care map was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of medicine editorial methodology. It has been checked by individuals with front-line clinical experience (see Contributors section of this document).

Map of Medicine pathways are constantly updated in response to new evidence. Continuous evidence searching means that pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the pathways through the quarterly publication cycle.

References

This care map has been developed according to the Map of Medicine editorial methodology. The content of this care map is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. This localised version of the evidence-based, practice-informed care map has been peer-reviewed by the CCP Executive Team and with stakeholder groups.

| 5 | Ministry of Health. 2011b. Mental Health and Addiction Services for Older People and Dementia Services: Guideline for district health boards on an integrated approach to mental health and addiction services for older people and dementia services for people of any age. Wellington: Ministry of Health. |
Contributors

MidCentral DHB’s Collaborative Clinical Pathway editors and facilitators worked with clinical stakeholders such as front-line clinicians and pharmacists to gather practice-based knowledge for its care maps.

The following individuals have contributed to this care map:

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This pathway was distributed widely for consultation and comments received have been acknowledged and taken into consideration in the final document.

Disclaimers

CCP Executive Team, MidCentral DHB

It is not the function of the CCP Executive Team, MidCentral DHB to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.