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Conference Abstract

Diagnosis and treatment of behavioural disorders in dementia: a the network of services in Modena according to the model ALCOVE

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Abstract

Introduction: Eighty % of people with dementia (PWD) in Italy live at home.

Psychological and behavioural symptoms of dementia (BPSD) occur in 50-90% of the patients in the course of their disease, considered the leading cause of institutionalisation, often anticipated compared to the phase of illness or of hospitalisation mostly improper with frequent adverse consequences for the patient and his family. According to the recent recommendations of Alzheimer Cooperative Valutation in Europe (ALCOVE, 2013), a network of services dedicated to dementia must be organised in such a way as to properly and promptly address BPSD whatever their underlying cause, even in emergency situations.The provincial network of structures and care organisations (SOC) dedicated to dementia is coordinated by the Dementia Programme of Local Authority for Health (Azienda Sanitaria Locale; ASL) of Modena which is set out to: i) uniform access to the SOC, the performance and activities of the Specialist Centres for Cognitive (CCD, geriatricians or neurologists), the Day Care Centres for Alzheimer patients (DCA), the Special Dementia Care Units (SDCU) and of the Special Hospital Unit (SHU) for Dementia, ensuring the appropriateness of interventions for diagnosis and treatment of major BPSD or crisis; ii) encourage a more organic integration of the existing SOC and among the health and social professionals and family associations; iii) to launch innovative services in a territory like Modena, with an already longstanding rich experience and expertise in Psychogeriatrics.Aims. To present the activities carried out in 2013 by the SOC for dementia (and BPSD) in the Province of Modena with a particular attention to the care of major BPSD and crisis.

Method and materials: The geriatric CCD provide home visits in “semi-urgency” (delay < 7 days) for non-ambulatory and/or uncooperative patients with persistent (for at least 10 days), worsening and severe BPSD (aberrant motor activity, persistent vocalization, physical aggression, delusional ideation with functional impact, insomnia), compromising the quality of care and quality of life of the patient/family). Patients with suspected Delirium superimposed on Dementia (DSD) due to organic causes such as an ongoing infection or uncontrolled (acute or chronic) pain or PWD with BPSD of non-organic genesis that result refractory to drugs and/or to tailored psychosocial interventions, are not eligible to this kind of home visits. In presence of severe BPSD and crisis

framed in a context of DSD, not requiring immediate hospitalisation, PWD can be referred to within a reasonable time, thanks to a direct link between the CDC and social health services to a special hospital services. First, the SCU, a special unit of a private psychiatric territorial hospital with 20 beds, in convention with ASL of Modena, is active since 2006. The main objectives of SCU are among others: the reduction or resolution of BPSD in comorbidity; the implementation of health preventive measures (e.g., malnutrition, dehydration, immobilisation, infection, falls, etc.), the maintenance of residual cognitive and functional skills and the definition of a post-discharge care project to be implemented in the context of a network of services dedicated to dementia. Secondly, the Day Service for Cognitive-Behavioural Disorders within the University Unit of Geriatrics, operating since September 2013, deals with PWD and elevated comorbidity in charge of the CDC and of other SOC dedicated to PWD, excluded GPs, with the aim to better understand the aetiology of cognitive impairment or of BPSD and to guide the CDC of origin, in choosing the most appropriate treatment (both pharmacological and non-pharmacological). The Day Service also sees PWD in the Emergency Department and from other sources, except from GPs, with severe BPSD that require timely and multi-dimensional assessment/treatment (and thus not only consultation) otherwise not feasible in the territory.

On the other hand, in the presence of dementia-related major BPSD refractory to (non)pharmacological treatment (NPI score > 24/144 or at least in one domain a score of 12, except for apathy, depression, and eating disorders) there is the possibility, in collaboration with the social services, to refer temporarily these PWD to a SDCU or to a DCA. PWD suitable for these two types of service are those who are excluded from the aforementioned geriatric home visits in "semi-urgency" both at home and in nursing homes and generic day care centres, or are those who have been admitted to the SCU or to the Day Service in order to monitor residual post-crisis BPSD before returning home whether or not supported by a day respite care (DCA, generic DC).

A network of services dedicated to dementia cannot not take charge of the family carers who often face an emotional or physical exhaustion contributing to the maintenance or worsening of BPSD. In addition to the presence of psychologists at the abovementioned hospitals with timely support to the family during the crisis, there is a protocol for sending to clinical psychologists with expertise in dementia and BPSD by the CDC or the GP informal carers, after an assessment of: a) the family context; b) the consequences of care-giving; c) physical and mental wellbeing of the carers; d) reasons for psychological group or individual support.

The strategic role of the GP has been protocolled by the ASL of Modena in 2007 with the following aims: a) to improve the integration and taking charge of the patient and his/her family favouring a greater dialogue with the GP; b) to play an effective role as a consultant, with particular reference to BPSD of acute onset (e.g., recognition of DSD); c) monitor the disease in terms of chronic integrated care; d) increase the use of home care for people with advanced dementia. Last but not least but nevertheless not less important, the Dementia Programme pays great attention to the role of Voluntary Organizations with this network that implement a range of (psycho-)educational programs in synergy with ASL and other local authorities, relating to the identification of the triggers of BPSD, the interpretation of symptoms and learning management strategies.

Conclusions. Sure some nodes of the network are still under development, in particular with regard to new technologies aimed at speeding up the flow and information collection and to the correct management of patients with DSD in the various hospital wards. Looking forward to these further developments, we can conclude that the current network of services dedicated to dementia ensures timely and proper management of BPSD in conformity with the recommendations of ALCOVE that emphasises its importance regardless of the stage of disease and its cause with the final aim to avoid as possible inappropriate emergency hospitalisation in generic wards.

Keywords

dementia; BPSD; services network

PowerPoint presentation

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