Dementia prevention priorities in General Practice

If the average age of dementia onset could be delayed by five years, the number of newly diagnosed people with dementia would be halved by 2050 (Access Economics 2004).

Attention to vascular risk factors, improving physical and cognitive leisure activities, and a healthy diet may improve cognitive function and/or reduce dementia risk (Ackermann et al 2013; Barber et al 2012; Loel & Walach 2012).

Nurses and doctors in General Practice have a critical role to play as some risk reduction strategies are supported by sufficient evidence for GPs to recommend changes in behaviour to their patients (Travers et al 2009).

However, there are barriers to implementing a dementia prevention program in primary care. We set out to identify key knowledge translation (KT) opportunities for doctors and nurses in primary practice around dementia risk reduction.

Focus groups

Input from focus groups of Registered Nurses (RNs) and GPs will help us identify which evidence is ready to implement into clinical practice or public health promotion, and where appropriate, to offer suggestions on ways forward for implementation. We recruited people from two key areas of primary practice and invited them to join separate focus groups: one for GPs (n=5; QLD) and the other for RNs who worked in General Practice (n=6; NSW). Participants first read a literature summary about dementia prevention, then partook in a facilitated discussion around three questions relevant to dementia prevention:

- What evidence are you already implementing in your practice?
- What evidence is ready for implementation if it were presented in a suitable format (define the format)?
- What evidence requires strengthening before you think it is ready to influence practice (define the specific area that needs strengthening to improve adoption)?

Each group was asked to identify three or four primary suggestions for research that was ready to be implemented now or suggestions for complementary research which would lead to implementation of current promising concepts in the next decade. The task was to think of specific suggestions which would guide future work in the area of dementia prevention.

Dementia risk reduction priority activity

While the nurse and GP focus groups met independently, each identified that their top priority, in terms of readiness for implementing in General Practice, was the inclusion of dementia prevention information in general risk reduction/lifestyle discussions with their patients.

They also recognised that many of the risk factors for dementia overlap with those for other chronic conditions (eg heart disease) that are currently addressed in preventative health (Farrow 2010). We know that many people are unaware of the full range of potential ways to reduce their risk of dementia (Farrow 2008).

There is evidence that GPs can assist patients to modify their lifestyle to reduce the risk of chronic disease (such as cutting down or quitting smoking and increasing physical activity). In a General Practice environment, clinicians can also be involved in educating patients about the risk factors associated with dementia, helping them make appropriate lifestyle changes, and treating medical risk factors (Farrow 2010).

The GPs and Practice Nurses (RNs) in our study recognised the opportunity to highlight to patients that making lifestyle changes to lessen their risk of chronic disease would also reduce their risk of dementia. This could encourage more people to heed the lifestyle improvement message.

Researchers (including the author, far left) and RNs from one of the focus groups

GPs and Practice Nurses looked at the evidence for dementia prevention and opportunities for getting the message to their patients. Melinda Martin-Khan and co-investigators* outline the primary recommendation arising from the experience.

Participants identified that the best opportunity for moving evidence from theory to practice in General Practice is to include dementia prevention messages in patient education about the effects of smoking, poor nutrition, alcohol use, physical inactivity and obesity on vascular health. Explaining that improved physical fitness, mental health and social well-being will help to decrease dementia risk can be highlighted as yet another benefit of the lifestyle changes already being promoted to prevent chronic disease.

Future action

The doctors and nurses in our focus groups suggested that future KT activities and research in this area needs to focus on:

- Strategies to improve clinicians’ understanding of the potential for dementia risk reduction.
- Effective messages for communicating with at-risk patients which result in modified behaviours and changed risk levels.
- A public health approach which continues the lifestyle improvement message but incorporates dementia risk reduction as a key motivator, along with reduction of chronic disease.

A focus group is also planned with community stakeholders in the prevention target age group to discuss the strategies suggested by GPs and RNs. The group will be asked to discuss perceptions of community readiness to respond to interventions with this focus, and to recommend action steps.

Based on the recommendations of these focus groups in primary care, a knowledge translation strategy will be developed to influence General Practice and public health messages with the aim of increasing the number of Australians willingly participating in dementia risk reduction activities.

GPs or the Alzheimer’s Australia’s website (www.fightdementia.org.au) have...
Four warning signs of nursing care issues

Kasia Bail explains how four common, but potentially preventable, complications experienced by older patients with dementia in hospital can be useful indicators of quality of care.

We know that hospital services account for most of Australia’s public health expenditure, with a large proportion of the costs going towards the treatment and care of older patients with complex medical conditions and care needs, including dementia. What we tend not to notice is that most of the costs of caring for older people in hospital are for nurses. Nurses account for about a third of hospital expenses — more than for operating theatres — but we don’t actually know very much about what society receives for this money.

Sensibly, there is an increasing focus on ‘efficiency’ and ‘productivity’ in the public health system to make the most of taxpayers’ money. But how can we aim for ‘cost efficiency and effectiveness’ if we don’t know what we are getting for our money — what quality, as well as quantity, of nursing care is being received?

Nursing care for older people

In order to better understand and analyse quality, the context of nursing care for older people, including those with dementia, needs to be understood.

People over the age of 65 account for 30% of hospital admissions and 48% of bed days (AIHW 2015) and the problems of older patients in hospital are increasingly complex. For example: half of people aged 65-74, and 70% of those over 85 have five or more comorbidities (ABS 2010); 10.4% of people in hospital have dementia (Bail et al 2013) and 30% have cognitive impairment (ACSSQH 2010); almost all people in hospital need assistance for daily living (Barnes et al 2013); and the enormous functional variability between older people even of similar ages can make predicting needs, workloads and costs more difficult.

Patients with dementia provide a classic example of the complexity of the care needs of older people in hospital. Their care is complicated by the fact that dementia is usually an accompanying comorbidity, rather than the reason for hospital admission; it’s often poorly diagnosed and poorly documented (Laurila et al 2004; Rodwell et al 2010); and people with dementia have longer lengths of stay (AIHW 2013).

The problems in hospitals are also increasingly complex, with the number of available beds decreasing in relation to the population, bed occupancy usually over 90% when 85% is considered safe (Kuntz et al 2015); simple surgery goes elsewhere, leaving only the most complex cases (Sammut 2009); a lack of senior staff (Garling 2008); an increasingly casualised workforce (Alameddine et al 2012) and less experienced nurses caring for patients, as more senior nurses take on administrative and academic roles (Garling 2008).

Nurse sensitive outcomes

My research interest is in improving sustainable acute care health delivery for an ageing population. In particular, my DCRC-funded PhD examined a range of patient outcomes demonstrated to be sensitive to nursing (‘nurse sensitive outcomes’); that is, “changes in health status upon which nursing care has had a direct influence, acknowledging other variables also influencing those outcomes” (International Council of Nurses 2010).

Key outcomes examined in this nursing research field are complications that could have been prevented.

However, there’s been limited analysis of nurse sensitive outcomes for people with dementia in hospital, despite the