



Fiona Wood Public Lecture Series

Transcript for 'Making a difference in the dilemma of delirium and dementia'

Presented by Consultant Geriatrician Dr Hannah Seymour and Specialist Aged Care Nurse Unit Manager Anthea Crawford

Dr Amanda Boudville

My name is Dr Amanda Boudville and I am a member of the South Metropolitan Health Service board. It is my pleasure to welcome you to what is the fifth session of the Fiona Wood Public Lecture Series. I would also like to respectfully acknowledge the past and present traditional owners of the land on which we meet today, the Noongar people and it is a privilege to be standing on Noongar country.

I happen to also be a geriatrician like Hannah and a stroke physician, so I am particularly pleased to be here this evening to be part of the conversation about the impact of delirium and dementia on our health system in our community. It's an important conversation we need to be having as healthcare providers, as a community and as families.

The statistics around dementia are sobering. An estimated 250 people join the dementia population each day with this number expected to increase to 318 by 2025 and to be more than 650 people a day by 2056. Dementia is now the second leading cause of death of Australians and has overtaken heart disease as the leading cause of death amongst Australian women.

While dementia develops over time with a slow progression of cognitive decline in general, delirium tends to occur abruptly, acutely, often in the setting of acute medical illness and people with dementia can also get delirium. Anywhere between 10 to 18 per cent of people aged 65 years or older who present to our hospitals have delirium at the time of admission and another 2 to 8 per cent will develop delirium during their hospital stay.

So what do all these statistics add up to? A huge challenge for healthcare services such as Fiona Stanley and Fremantle Hospitals to ensure people with dementia and delirium receive appropriate care. It is also a challenge for our community and in particular the families and carers of older people experiencing delirium and dementia. Tonight our experts will look at what we can do here and now to prevent delirium and dementia and how we can better care for those living with these conditions already.

Dr Hannah Seymour is a consultant geriatrician and medical director at Fiona Stanley Fremantle Hospitals Group and she works clinically in orthogeriatrics where she has a passion for falls prevention and improved outcomes in aged care. Anthea Crawford is the Nurse Unit Manager for the Specialist Aged Care Ward at Fremantle Hospital. Anthea brings decades of nursing experience, compassion for patients and their families and a practical focus to delirium and dementia. It is now my pleasure to hand over to Hannah and Anthea. Thank you.

Dr Hannah Seymour

Thank you and thank you so much for coming this evening, it's a real honour to have so many members of the community come to hear what we have to say. So, why are we here? Well, we're all getting older and that's actually a really, really good thing. None of us want to die young, I don't, I'm sure you don't. So the fact that we talk about the ageing tsunami as if it's a really awful thing that we don't want in our society is a real shame, because this is actually a reflection of the success of our society. We have a very low infant mortality rate, we have very low rates of death from infection now which is what used to cause us to die. We are getting better and better all the time at treating cancer. So, the fact that we're ageing is a good thing and it's a marker of our success as a society, but it leads to some different problems and that's what we're going to talk about today.

Who here has someone in their family, a parent or a grandparent who has or has had dementia? Yep, so that's a reflection I think of how common dementia is and it's going to get more common as we age. So this is the population in 2016 by age group and the blue bars are 2031. So we're going to have more and more older people in our community, and again that's a good thing if we're all well and we're all independent because that's what most of us want.

So, I learnt when I was preparing for this that there are currently 270 women over the age of 100 in Western Australia. By 2030 that will be 590. So, that's a doubling. So the very old are going to increase but it's this group of older people around 80 to 90 that's really going to increase and that's the group who we're about to see are much more likely to get dementia. So if we have four grandparents then two of them are women and women are more likely to get dementia mainly because we live longer, sorry to the men in the audience, but you have about a 20 per cent chance if you're between 85 and 89 of having dementia. That's an 80 per cent chance of not getting dementia.

So let's, you know, turn it around the positive way. It is not certain that we will get dementia. We have 100-year-old ladies who come in who don't have dementia, but the chance goes up as you get older. So, in Western Australia currently there are over 41,000 people living with dementia and that's going to double by 2060/2058 and that's purely just because people are getting older and we have more people of the age groups who get dementia around at that point in time.

So, is there any good news? There is actually evidence that for the number of people of any age group the number of people who will get dementia is going down, in Australia. That's not true everywhere in the world. So there is some good news about the number of people who are going to have dementia. I guess the question is why is that happening? It isn't because of any revolution in anything, it's because probably, we think, that we've been much, much better at targeting blood pressure in midlife, so people my age 40s/50s/60s, if you control your blood pressure there is really good evidence that you will reduce your chance of getting dementia along with many other illnesses and also improving cardiovascular risk factors.

So there was a really lovely study actually published last week that confirmed exactly what is on this slide, that there isn't any magic cure coming at the moment, there's a lot of research going on to look for things that may help people who are developing dementia, but ultimately at the moment the best advice that you can get is to be healthy. It's the boring stuff, it really is. So, not smoking. If you don't smoke you reduce your chances of dementia and again I think lots of people talk quite fatalistically about I want to enjoy my life, I don't mind if I drop dead of a heart attack, but if you actually talk to people about well you're going to reduce your chance of dementia by stopping smoking, that's powerful because that's something that no-one wants to get and it isn't something that just comes one day and you die from the next day, it's something that you live with for a long time.

Living a healthy life, so being a sensible weight, not being overweight, having well controlled blood pressure, having a healthy diet and not drinking too much. Along with exercise. Exercise is coming out time and time again, that midlife we need to continue exercising, we need to do as much as we can. I think the message, you know there are very specific guidelines around this, but essentially doing anything is better than doing nothing. So doing little bits of exercise is better than doing no exercise. Doing a bit more exercise is better than doing a little bit of exercise. So again, every day, let's think about that, let's think about where we can walk, where we can do a bit more, where we can go to some of those living longer living stronger classes, following the advice and stay on your feet, getting out into your community.

The other big thing that is coming out as reducing your risk of dementia is staying engaged, and that sounds really simple but it is that getting out there every day and doing something and having purpose every day. So retiring sounds like a great thing, especially to me some days when I'm very busy, but I'm sure many of you know that can lead to you becoming quite isolated, not getting out there, not stimulating your brain and not having things to do every day and that, it turns out, is really, really important at preventing decline as you get older. So, if there isn't a cure, what can we do? It sounds, you know, pretty negative but there are lots and lots of things we can do. Our focus has to be on maintaining independence and on quality of life and dignity and that has come out time and time again as to be the really important things to people as they get older or if they get dementia.

Technology might be able to assist us quite a lot, there is quite a lot of interest in this space. When there are a lot of people going to get a problem then people see that as an opportunity, a business opportunity. There are lots of things that are being developed to see if they can aid people to maintain their independence if they have dementia. Very simple clocks that prompt people about the time. Monitoring – there is very clever stuff coming with sensors in your house that you don't even have to ... they don't have something that you press, they sense that you haven't moved for a while or that the humidity in the room has changed because you haven't been in there breathing and they can then send alarms to other people. So there's very, very clever stuff coming that will allow us to be more confident about leaving someone with dementia in their own environment. Tracking - so my watch, my children, I don't know who else tracks their children but I track my children when it's school holidays and I'm not sure where they are, turn on the tracking see where they are. So, that's really useful for me as a mother but it also gives us more confidence. If we can let someone go out to the shops, maintain their independence but know that we've got a backup plan if they do get lost or if something happens, that can be a really positive thing. There's some clever stuff coming with robots. Medication management, can people remember to take their tablets? Really clever little devices coming that are, and around already, that pop out the tablets that you need at a certain time, and I think they are only going to get more and more sophisticated. So I think again, clever things coming that will help people.

I also encourage everybody, and I do this so I encourage everybody to do this, if you can't speak for yourself, if you can't tell us what you want it makes discussion really difficult for everybody else. We should all talk about what quality of life is for us, and identify who we want to speak for us knowing that they will understand what we wanted and discuss as a family what you want. There's some quite good evidence out there that health care workers actually talk about this more and actually make different decisions at the end of their lives to people who are not necessarily involved in health care, and I think that is because we obviously understand what that means, what that looks like. But the more that people talk about this in the community then if for whatever reason you're not able to speak for yourself, it makes it so much easier for your family to know what it is that you wanted and what your attitudes were to life.

That is something that GPs and health care workers can also assist with, so I really do encourage you to talk about some of those taboo subjects.

So we've talked a bit about dementia, we wanted today to also talk a bit about delirium because if I come into hospital or my relative comes into hospital, what I want to know is that the team that are looking after them are passionate about looking after them the best that they can and that they understand what is going on. Delirium is one of those things that is very difficult for a family member to see their loved one come into hospital and just look so different to normal. I get asked this all the time in the patients that I look after, "So why are they not quite right? What's going on? They're not normally like this? What is it that you've done to them that's made them like this?"

When we at least give a name to it and we talk to families about this is delirium, that at least helps because it says that at least we understand what's going on. It's a medical problem that develops when people are unwell. So I look after mainly hip fracture patients. The hip fracture itself, the pain that you get from that is one aspect of the cause of delirium, but the fact that you've come into hospital, you've gone through an emergency department, you're now in a ward bed, then we give you some opiate medication to try and reduce your pain; all of those things together contribute to delirium. Then we give you an anaesthetist and operate on your leg and that also contributes to delirium. It's often not one single thing that cause delirium but it is the combination of all those things together that can make somebody appear very different to normal. It is that acute deterioration that's really important.

The other thing that's really important to understand is it fluctuates. So, people can be okay in the morning when I pop in as the doctor on the ward round, for that five minutes or ten minutes of the day and I ask my questions and someone seems fine, and it's only when I read the notes from the nurses overnight who say, "Well, actually they were really confused overnight, they were agitated trying to get out of bed", and yet the next morning they can look fine again to me. So that's where we have to work as a team and listen to what other people are telling us about those fluctuations. Delirium is much, much more common if you have a pre-existing dementia. So if you have a pre-existing dementia and you come in to hospital for whatever reason, it's much more likely that you will get a delirium and become more confused than normal.

Again, there's no cure for delirium. There isn't a tablet that you can give that will make it go away. Often we actually try and stop medication to try and help, but again it's this idea that lots of small improvements can lead to better outcomes. So I'm going to just explain one of those and then Anthea is really going to take over and tell you some of the things that we're doing across the group of hospitals that we work in to try and improve our outcomes for older people.

So, if you think you've got dementia which is this chronic, longer term syndrome where you get gradual change and then you've got delirium which is an acute change, and if you put those two things together you've got cognitive impairment.

We're going to a model of talking about cognitive impairment in hospital because the care needs of those patients are the same. So we're trying to get across to all of our staff that someone has got cognitive impairment therefore we need to care for them in certain ways. So, in our organisation; this was a survey done this year, 55 per cent of people over 65 didn't have any evidence of cognitive impairment, but 45 per cent did. Of those, 19 per cent likely had some form of dementia or were developing dementia but 26 per cent likely had delirium. So you're starting to see how common this is in our hospital. This isn't something that just comes occasionally, it happens on every single ward no matter what the speciality, no matter what the average age of that ward, but obviously is more common in wards that look after the very older population.

So we're doing lots of things in this space. We've just set up something called a Frailty Unit which is really targeting older, frailer people as they come into hospital and trying to really adjust our care to meet their needs, but we're also looking around the world and we had someone come from the UK who gave us a very inspiring talk about how we should be trying to reduce the number of people who get admitted to hospital wherever we can.

So it sounds like hospitals are a safe place but actually for lots of reason they can lead to deterioration in people. So what we're now working on is a programme called CHOICE which is 'Consider Home Care Over Inpatient Care Every time', and it really is about trying to put in the services that you require at home to get you back to your environment where you're much better adapted as soon as it's safe to do so. That's really relating to this thing that there is so much more value, meaning and accuracy when someone can be assessed.

So the idea here, I don't know if anyone here has had a kitchen assessment in a hospital, but I get confused when I go to someone else's house and try and make a cup of tea and I have to open every cupboard to try and find the mug and the teabags and work out how the kettle works. Traditionally that's what we've done, we've assessed people in hospital in a kitchen they don't know to see if they can function and make a cup of tea, for example. That's much, much more accurate to do in someone's own home because they know everything in their own home and they're much more likely to succeed in that environment. That's where we're starting to see some improvement in that area with us being able to safely assist people to go home as soon as they possibly can.

So I mainly look after people with hip fractures. So of our 500 hip fractures a year about 200 of those people will have cognitive impairment. So it's one of the commonest reasons that people fall over and break their hip is because they have pre-existing cognitive impairment. It does not take a doctor to tell you that having a fracture like that really, really hurts. It's no wonder that if you've already got existing dementia that really sets you off, you can become very agitated, much, much more confused and really distressed.

So just one of the things that we've done here to address that is that we have, as soon as someone with a hip fracture comes into the hospital, we have a page that goes out so that everybody knows there's a patient coming. One of the things that we're leading Australia in is nerve block. So we have an absolute pathway across Western Australia actually where we've really managed to get everybody in the team, so the emergency doctors in particular are key to this part, to giving a nerve block as soon as you come in and we know that you've got a hip fracture. That means that you actually stop the nerve that transmits the pain doing that and you immediately control someone's pain without needing to give strong drugs which further confuse and distress people.

So the reason I know that we're doing that really well is because we're passionate about the care that we provide, we measure it and we compare it with other people. So I know that this year we're the top hospital. So it's almost unheard of now for someone to come into hospital with a hip fracture and not get a nerve block, and that wasn't the case even 10 years ago, and it isn't the case in other places in Australia now.

So I think again it comes back to that idea that we're passionate about what we're doing, we're trying everywhere that we can to improve the care for our frail older people when they come into hospital, particularly those with dementia.

So, now I think Anthea is going to come up and Anthea is going to talk about her passion which is caring for people at Fremantle and providing them the best chance that they can to get back home.

Anthea Crawford

Thank you for having me and good evening to you all. I'm just going to give you a brief overview of what Fremantle Hospital has done and is doing in this space and hope that I peak some interest. Hannah's touched a little bit on what the behaviours are in delirium, but the typical behaviours are these – poor thinking skills; and I'll just go through them briefly, various behaviour changes.

A lot of patients actually have hallucinations which are very distressing for the people watching on. They might be very restless, they might be calling out, they might be very quiet and withdrawn and that is often overlooked as a delirium because people don't realise that there's both hyperactive delirium and hypoactive delirium, can often be missed.

They might have slowed movements, there might be disturbed sleep habits, there might be reversal of the night and day sleep/wake pattern which is every nurse's delight. There are often emotional disturbances and this again can be very distressing for people looking on. The change in a person's personality can be quite frightening and you actually think that they've had personality changes. They often develop a reduced awareness of the environment and that is again what Hannah's been referring to – get them home into their own environment as soon as possible because being in an unfamiliar environment actually throws them completely.

Why are these behaviours problematic in hospitals? I think that anyone who has had any contact with patients with either dementia or delirium or a combination can just begin to imagine when you've got a cohort of people that are that unwell and having to be accommodated in normal environments, it's very, very difficult.

At Fremantle Hospital we actually decided to make the environment as dementia friendly as possible; and we use dementia in the broad sense that basically cognitive impairment, as cognitive impairment friendly as possible. We see some very unfortunate behaviours in hospital. There is a lot of antisocial and violent behaviour, there's a lot of aggression. There's a lot of sexual disinhibition which again is very distressing for young nurses particularly and for the relatives. There's great confusion, there might be a lot of noise, vocalisations and this is all dangerous and distressing for staff, other patients and visitors.

What can it result in? We have an enormous amount of abuse. Staff are abused on a regular basis. They might get injured, there's a lot of, as I say, with the violent behaviour, people get incredibly strong in these circumstances. You'd think that the little frail old man that you saw yesterday becomes this herculean person once they develop delirium. You can get an element of job dissatisfaction amongst carers and you get patient/carer dissatisfaction at the patient being in hospital.

Can anything be done to improve these outcomes? Okay, as I say we took the bull by the horns about three years ago and decided we'd make a concerted effort to get Fremantle good in this space. Specialist training was provided for the staff using resources from Dementia WA and Alzheimer's Australia. We're in the process of introducing many, many cognitive impairment assessment tools. There's a violence and aggression project in progress and this is including support from our colleagues in the psychiatric area of Fremantle Hospital, and we've modified the environment to improve the ambience for these people. Remembering that patients at Fiona Stanley, Hannah put up the length of stay there, it was about six or eight days - the length of stay at Fremantle Hospital because we are getting the people who have to stay in hospital for various reasons for an extended period of time, ours is about 26 days, which is quite a lot in terms of cost.

So, how did we make the area conducive to these folk? It was very hard to measure the efficacy of all this but it was all done with a lot of research into what is best for people. First of all we put in security doors wherever it was necessary to prevent escaping. There is nothing like a person intent on getting out of hospital to see them get out. The fire escape doors were made tamper proof. Reception areas were redesigned, resurfaced and painted. The door frames have all been painted in different colours to actually define the door space and the doors that we don't want patients to go through are left neutral so they actually choose the colour over the neutral and hopefully go through the right door. All the lighting was changed to LED lighting and that has actually improved the ability of patients to walk down passages without seeing shadows and dips in the floor and so on which they mistake for obstructions. We put very good downlights for night use and the underbed lights have been changed from green lights, which they used to be for some reason or another, to white lights to improve people's ability to get round at night.

There's been a lot of work done across both sites in the cognitive impairment area and each ward now has got an information folder. We use things like the 'Sunflower tool' which if any of you ever have a patient in hospital if you see it hanging up on the wall it's actually for your use to put in information on that sunflower. It's got little questions already pre-written and then you just give us the answers and this is a conversation starter for patients that you don't know what else to talk about. If you know that they've had a dog called Ben some years ago it actually encourages the conversation between carer and patient and makes them feel more at home.

We've developed a bedside identifier which you will have seen outside perhaps on the table out there, I have a picture of it earlier and when you see it you will think what does it actually show. We all consider it angel wings and I think that's nice for people to be looked after by the angel wings. The bedside curtains have all had mesh surveillance panels put in them so we can actually unobtrusively watch patients when we have to. All the toilet seats have been changed to another colour, one ward has got red toilet seats, most of the rest have got blue and this actually improves depth perception and prevents people, or reduces the chance, of falling at the toilet.

We put universal signage up everywhere, very specifically black on yellow because that has been seen to be the best colour combination for people's eyesight. There's a no falls project in progress, another area of great difficulty. As Hannah said, many, many people who fall have actually got an element of cognitive impairment, and there's been an avalanche of documentation developed. Again, great joy for the nurses. Just a few samples there of what we've done and the arrow pointing to the toilet roll there is actually significant because so many people over the age of say 70 or 75 have never seen a round thing like that delivering toilet paper. So we actually put up a picture of what they would have known as a toilet roll rather than these so-called modern ones now. There's our sunflower tool and just one of the many delirium screens that Jane if she's here has developed. A lot of work has gone into that.

We sourced, these are little things and again very difficult to measure the efficacy, but we've sourced coloured crockery and colour coded serviette and cutlery pouches and we have a yellow diet feeding program going on so that, again it's for eyesight. It's also for the nurses to know that when they're on a yellow diet and feeding program they know to actually give each course of the meal separately so the person does not get overwhelmed with a large tray of different types of food, different containers, lids that they have to open, things that they have to tear back. It's all really confusing so we find that if we actually separate each course it's actually much more effective for them.

We've got all the usual fiddle blankets and mitts and things for people to play with when they're bored and not knowing what else to do with their hands. Their activity boxes, their puzzle games, all those sort of things.

A little bit of a problem because for a long time we had all these things but because nursing staff were so busy, pretty difficult to often sit and play with patients and it's just been fantastic now, they've recently implemented the volunteer program that was already established at Fiona Stanley, we've now got it established at Fremantle Hospital and it's going extremely well. We've implemented things like aromatherapy particularly at end stage of life. We have music therapy and we're working on a whole lot of things in that area. We have visiting pet therapy, I sometimes think it's a bit of a zoo there, there are more animals than nurses sometimes but it's great. We employed extra OT assistants a couple of years ago and then the existing AINs that we have to help care for these patients were specifically, well they were already employed but they were specifically educated in the care of cognitive impairment.

Where do we go in the future? We're hoping to develop some green areas because it is very important for people to be able to get to gardens, they get a bit stir crazy when they've been locked up in what they consider a prison for days at a time, so we're going to hopefully develop an area and make a sensory garden there. We're going to trial various bits of assisted technology already referred to by Hannah, but there's a thing called a Nordic chair which is using weighted blankets on folk who are very distressed and I'm about to trial that.

The most important aspect I think throughout this very challenging area of nursing, and it's probably one of the most challenging areas that I've ever experienced and I've been around the block a while, is education. People, the public, the patients if they can be and the staff need continual education and we finally got a certificate in aged care available at university level here and I'm encouraging my staff, certainly – and a couple have taken it up – to in fact enrol and get their ticket to say that they are qualified to look after these people.

I'm just going to give you a very brief case history of a patient and really to demonstrate communication. We will call him John, I think Hannah had Elizabeth but we will call this fellow John.

Dr Hannah Seymour

John is the most frequent name that you get in someone across Australia with a hip fracture. So, John is the most frequent name.

Anthea Crawford

There you go, hands up, Johns in here. So let us assume he's come to us following a fractured femur and they usually arrive on day two or day three, and usually because they are not going home early, by the time they get to us they're often in quite a state of delirium.

This particular gentleman had delirium superimposed on a background of diagnosed dementia. He had a known micro-alert, so he had to be nursed in a single room. He was a diabetic on insulin and while he was with us, or from the time of his admission, his demeanour and behaviour escalated enormously to include very aggressive and combative behaviour. Again, if you could see the size of my average nurse, I could point one out to you here in the audience but I won't, but they're tiny, they're small people and this combative behaviour can be quite disconcerting. He was probably delirious due to pain, dehydration possibly, constipation, potentially erratic blood sugars and the change of environment. So there are a whole lot of factors that we actually have to look at, have to prioritise and decide which ones we can treat and which ones we just have to manage.

On day four John's behaviour remained agitated and combative despite his pain being treated, his intake being adequate, his bowels are moving; all important of course, most nurses most important question and his mobilisation was improving using a Zimmer frame as an aid.

It did become a useful weapon. At about 2pm one day a commotion was heard coming from his room. Okay. So, I heard this commotion emanating from his room and thought it may be necessary to investigate it. The sight that met me was of a furious old man yelling expletives while standing in water with one arm in the sink and the taps on full blast. The other arm was waving his Zimmer frame around while he was yelling abuse at the bloody fools emptying the water. Several nurses were indeed endeavouring to mop the gushing torrent with numerous towels and not making much impact. They were pleading with him to switch the tap off which he was refusing to do. He dropped the frame and lurched towards me, grabbing at my spectacles while asking me in an exasperated tone, "Can't you see what these clowns are doing?"

At that point he suddenly removed his arm from the sink and asked me why it was so red, and I realised that he hadn't felt a thing but to my horror he had actually had it under the boiling hot tap. At this point I asked everyone to stop what they were doing, quieten down and give him space.

I appealed to him to allow me to move closer so that I was able to subtly switch taps and he promptly replaced his arm in the sink acting as the plug and thus inadvertently administering his own first aid under the cold tap. In the meantime he continued yelling about the emptying of his pool and when I stopped and actually looked at him and actually took time out, I realised that in his mind he was standing on the blue floor of the hospital looking at the dark blue skirtings around the base of the wall and truly believed he was in his swimming pool and was trying to fill it and all these fools were preventing him filling it, and he was furious. He was really, really frustrated.

I suddenly realised that perhaps we needed to attack this from a different point of view and not just tell him not to do it. So I said to him, "What is your usual occupation, sir," and he stated that he worked for the council and he was still working for the council. I then appealed to his sense of citizenship and asked what a council worker would think of such a waste of water in our dry, desert of a city. There was a moment of clarity which I seized at and suggested he come with me and we could perhaps go and speak to the authorities to see how best to deal with this water crisis. His mood changed instantly and he waded out with me to dry land and we wandered off down the corridor chatting about the state of the world and where we would find the best cup of tea, thereby averting further disaster in the water.

So my point about that little story, which is true, is that I think one of the most important things is communication with these folk and I continually try and, we're all learning, it's a learning curve for all of us, but we continually emphasise the fundamentals of communicating with a person suffering from delirium and dementia and there are a few very common sense things, but not everyone thinks about it.

I think we tend to crowd people who are confused, and that confuses them even further. So you have to give the person space, stand back, don't get in their face. Get level and make eye contact. Ensure one's body language is confident but not overbearing. Speak clearly and calmly. Be in the moment with them. I think that's a very important issue. Don't argue their reality, what they say is truth and you won't convince them that it's not true. It is true. Ask questions that can be easily answered with a yes or no. Don't ask open-ended questions because they can't think in that complex fashion. Don't give them multiple choices, if you're going to offer to feed them food give them two choices. If you're going to let them choose which clothes to wear give them two choices, don't give them a wardrobe of clothes to look at. Certainly do not take offence at abusive or aggressive statements or actions. Use humour appropriately. Certainly do not endanger one's self or others and most importantly walk away if necessary. It's very hard for carers to walk away because you feel that you've got to be there helping but it's actually better to step away for a few minutes, let everyone catch their breath and then go in for the fray again.

I guess that's basically the summary of my story, but I just want to give a shout out to my colleagues out there who come in day after day after day with smiles on their faces and continue to cop an enormous amount of difficulty in their day's work and they do it with a smile, and to quote Fiona Woods from a lecture that I went to of hers, "They bring their A-game to work," and I certainly appreciate it and I think that a lot of the relatives and carers of people with dementia appreciate it as well. So thank you to them. Cheers.

This document can be made available in alternative formats on request.

South Metropolitan Health Service, Locked Bag 100 Palmyra DC WA 6961

Telephone (08) 6152 2222

www.southmetropolitan.health.wa.gov.au

Compiled: South Metropolitan Health Service 2018

© State of Western Australia, South Metropolitan Health Service 2019