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GP CME

EPOA'S AND CAPACITY

4 BASIC TENETS OF ETHICS

Autonomy

Beneficence

Non-Malificence

Justice

AUTONOMY

Requires that the patient have autonomy of thought, intention, and action when making decisions regarding health care procedures

Therefore, the decision-making process must be free of coercion or coaxing

In order for a patient to make a fully informed decision, she/he must understand all risks and benefits of the procedure and the likelihood of success

HDC CODE OF RIGHTS

The Code of Rights gives you 10 rights. These are:

1. To be treated with respect.

2. To be treated fairly without pressure or discrimination.

3. The right to dignity and independence.

4. To receive a quality service and to be treated with care and skill.

5. To be given information that you can understand in a way that helps you communicate with the person providing the service.

6. To be given the information you need to know about your health or disability; the service being provided and the names and roles of the staff; as well as information about any tests and procedures you need and any test results. In New Zealand, people are encouraged to ask questions and to ask for more information to help them understand what is going on.

7. To make your own decision about your care, and to change your mind.

8. To have a support person with you at most times.

9. To have all these rights apply if you are asked to take part in a research study or teaching session for training staff.

10. The right to complain and have your complaint taken seriously.

COMPETENCE

Everyone is considered competent to make their own decision unless there is reason to doubt it

At law only appropriately qualified medical practitioners can assess competence and declare a person not competent

Competency assessments are issue based

People are allowed to make bad decisions

PPPR ACT 1988

The Protection of Personal and Property Rights Act 1988

Purpose is to help people who lack capacity to make or understand decisions about their own personal affairs or property OR who are no longer able to communicate to other people their decisions

Act was revised in 2005

KEY PRINCIPLES

Presumption of competence

Capacity is decision specific

Can fluctuate over time or in different situations

An assessment of persons decision making ability NOT the decision that they make…

Least restrictive intervention

ESTABLISHING AN EPOA

Lawyer or Public Trust

User Pays

Two forms so generally charged twice (Personal care and welfare, can appoint one person; Property and Finance can appoint two)

Everyone is assumed competent so only need a capacity assessment to sign the paperwork if you are concerned they aren't even competent to sign EPOA!

Capacity assessments are for activating already signed paperwork

ORDERS AND POWERS UNDER ACT

Competent person can give an EPOA to one (or more) others, for when/if they become incompetent

Personal orders for decisions for a person's care and welfare → welfare guardian

Property orders to appoint a property manager to look after persons financial affairs

So needs a capacity assessment by expert medical opinion to activate

CAPACITY/COMPETENCY

Communicate choice

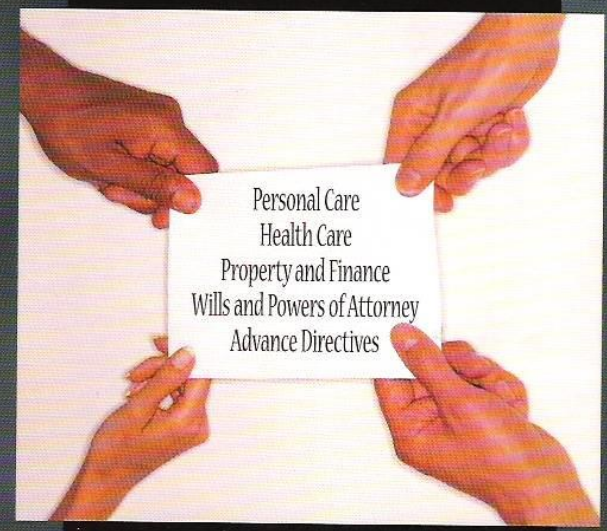
Understand relevant information

Manipulate information

Appreciate the situation and its consequences

Who Can Decide?

The six step capacity assessment process



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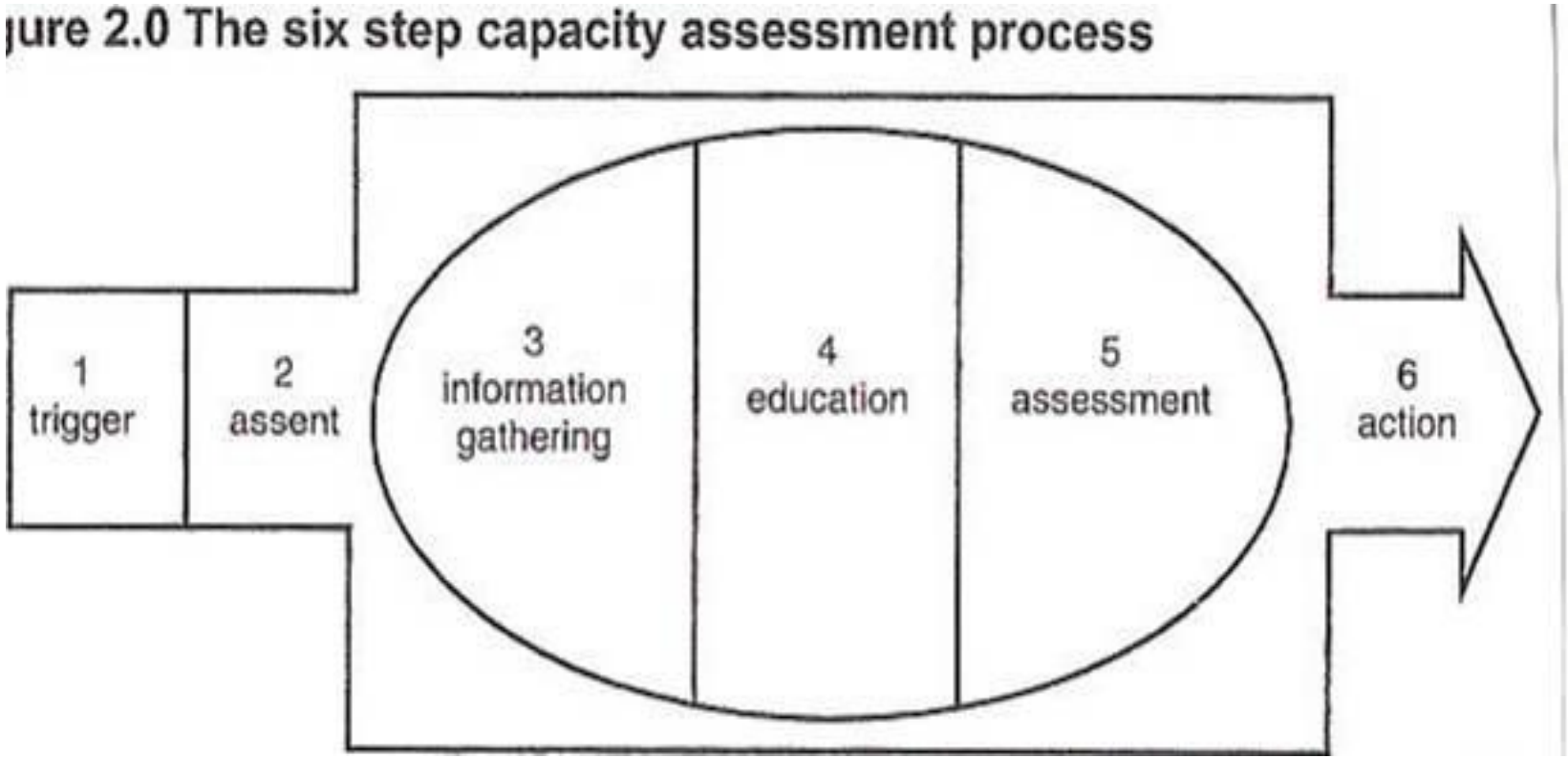
jure 2.0 The six step capacity assessment process



COMPETENCE ASSESSMENT

Validity of assessment in law

Understand the nature of the decision

Foresee the consequences of decisions or of any failure to make such decisions

Communicate decisions

BASIC PRINCIPLES OF CARE

Prima facie is that every person has right and capacity to accept or refuse medical treatment

If there is doubt resolve in favour of preservation of life

LIMITATION ON POWER OF EPOA OR WG

Welfare guardian cannot consent to

- Administration of ECT
- Brain surgery
- "refuse consent to administering to that person any standard medical treatment or procedure intended to save that person's life or to prevent serious damage to that person's health"
- Medical experimentation, other than an experiment to be conducted for purpose of saving the person's life or preventing serious damage to person's health

WHAT IS NORMAL

Need to contrast this with what is normal forgetfulness

Normal forgetfulness	Problem memory
Where you left things	Forgetting what credit card is for
Using lists to remember	Not understanding what a list is for
Worried about memory	Lack of awareness of memory problem, forgetting what you have done

DRIVING

Important to decide as dementia is linked with unsafe driving.

Useful guideline is the Dementia and Driving guideline – and there is a table in the guideline to advise on when to restrict driving (multi-coloured table).

Moderate to severe dementia – must stop driving

MCI – usually fine as by definition there is no functional impairment.

Medical aspects of fitness to drive

A guide for medical practitioners

NZ TRANSPORT AGENCY
WAKA KOTAHI

New Zealand Government

Dementia and Driving Safety

A Clinical Guideline

Driving with Dementia Working Group
Auckland, Counties Manukau, Waitemata and Northland DHBs –
Revision - 2014

COUNTIES MANUKAU HEALTH

NORTHLAND DISTRICT HEALTH BOARD

Waitemata District Health Board
Te Wai Awhina

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Dementia Stage	Driving Recommendation
No Dementia	May continue to drive Check for Other Medical Conditions
Mild Cognitive Impairment	Most people Safe to Drive Consider OT driving assessment, Restricting or stopping driving if: • Family concerns • Recent accidents or near-misses • Functional impairment in some complex tasks • Behavioural disinhibition – "risk-taking" • (Notify NZTA)
Mild Dementia	Driving Safety is Uncertain: Some people safe, others unsafe to drive Safety not predicted by Cognitive testing / Dementia Stage Person needs further investigation / review: • OT Driving Assessment ** (Preferred and Recommended) • Further Collateral History • Clarification of Function level in other areas • Driving Questionnaires • Further cognitive testing • Alternative on-road driving assessment • Second Opinion Clinical Decision needs to be made! • Continue Driving – Review Date, • Restricted Driving – Review Date, or • Stop Driving Immediately • Notify NZTA
Moderate Dementia	**Must Stop Driving!** **Notify NZTA**
Severe Dementia	**Must Stop Driving!** **Notify NZTA**

DRIVING

Mild dementia is harder to decide –

- take collateral history about driving, would they let grandchildren go in the car with patient? (Beware of unreliable history due to different agenda)

-Can do another test e.g. trails test

-Functional review – if difficulty working phone/microwave , paying bills then probably can't drive either

-Some restrict driving to daytime, close radius e.g. 5km

-AA driving test may help but this is not the same as OT driving test.

-Get AA to Inspect car – has there been any damage

-Some specific situations to consider e.g. hemianopia from stroke, risk taking with FTD

DRIVING CONT

Usually if ACEIII <76 and MoCA <17 or RUDAS <22 or concerns with other issues they should do OT driving test, but don't recommend this if certain to fail (waste of money). Can do it if "second opinion" is needed.

Write letter to NZTA cc patient

Consider other options for driving – Age Concern/Dementia Auckland referral for total mobility subsidy

Driving Miss Daisy

POWERS OF PERSUASION

We have to be at the peak of our game to drive a car

In a car you only have seconds to avoid a catastrophe

It's not about your driving skills but your reaction times, being able to think under pressure and cope with multiple stimuli

If you are struggling to cope with complex tasks like cooking or paying bills then driving is the most complex skill you do and it is the most dangerous

If a doctor said your eyes were not sharp enough to drive anymore how would you react?

In the end if we have the good luck to live long enough we will all have to hang up our driving keys at some point

Imagine the legacy you could leave if you had an accident and killed someone else

You may be a really careful driver but what if someone else does something stupid in front of you – could you react fast enough?

It's better to hang up your car keys with dignity than wait till you have your licence removed

OSTEOPOROSIS

Not a ‘normal part of ageing’

Develops from a combination of factors

Age

Genetics

Lifestyle

Hormones

Medications

Medical conditions

CALCIUM IN DIET

Estimated that around 20% of older adults don't have enough dietary calcium intake per day

In NZ postmenopausal women and men 70+ have a RDI of Ca of 1300mg/day

Calcium is most easily absorbed from dairy sources

Some products are now Ca fortified

VITAMIN D

People with light skin need 15-20 mins of sun a day

Found in some foods but usually diet is inadequate to get enough a day

Darker skin needs 3-4x the amount of sunlight to get their Vit D

More likely to be deficient if you are older in residential care, admitted to hospital, hip fracture, dark skin, an other reason you can't get enough daily sun

Monthly Calciferol is or if on Fosamax use the Alendronate + Vit d prep

BISPHOSPHONATE TREATMENT

Currently if you've had a fracture you don't need a DEXA if you are

Over 75, had two fractures or on steroids

Alendronate no longer needs SA but do check P1NP to see if it's working and change to Zol if it's not

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Note)

or

- ☐ History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age

or

- ☐ History of two significant osteoporotic fractures demonstrated radiologically

or

- ☐ Documented T-Score less than or equal to -3.0 (see Note)

or

- ☐ A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note)

or

- ☐ Patient has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) prior to 1 February 2019 or has had a Special Authority approval for raloxifene

and

- ☐ The patient will not be prescribed more than 5 mg of zoledronic acid in a 12-month period

BE AWARE PRIOR TO IV ZOL

Need to know the eGFR is > 35 ml/min

Check Ca and PO4 normal

Patient needs to be 'Vit D replete'

Warn patient about common Flu like illness for 24 hours

Recheck renal function/Ca/Po4 within a few days

WHAT IF THEY FRACTURE ON ZOLEDRONATE?

We do have Teriparatide

Beware it's daily injections subcut, patient can learn to do it but has less patient acceptance, for 18 months!

Can't be used in patients with eGFR < 35 ml/min

Once they come off it they should have consolidatory treatment with Bisphospohnate

Teriparatide

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 18 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has severe, established osteoporosis

and

☐ The patient has a documented T-score less than or equal to -3.0 (see Notes)

and

☐ The patient has had two or more fractures due to minimal trauma

and

☐ The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes)

WHAT IF THEIR RENAL FUNCTION IS TOO POOR?

Denosumab

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has severe, established osteoporosis

and

- ☐ The patient is female and postmenopausal

or

- ☐ The patient is male or non-binary

and

- ☐ History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Note)

or

- ☐ History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons

or

- ☐ History of two significant osteoporotic fractures demonstrated radiologically

or

- ☐ Documented T-Score less than or equal to -3.0 (see Note)

or

- ☐ A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note)

or

- ☐ Patient has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) prior to 1 February 2019 or has had a Special Authority approval for raloxifene

and

- ☐ Zoledronic acid is contraindicated because the patient's creatinine clearance is less than 35 mL/min

and

- ☐ The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes)

and

- ☐ The patient must not receive concomitant treatment with any other funded antiresorptive agent for this condition or teriparatide

ROLE OF DEXA

Practical point of view if they are younger than 65 and you are concerned about osteoporosis/risk of fracture

They have had a fall, had a fracture (osteoporotic or not)

Consider more in females, low BMI, premature menopause, family history of maternal hip fracture pre 75 yrs, those on steroids, conditions associated with osteoporosis such as rheumatoid arthritis

PROBABILITY OF FRACTURES CALCULATIONS

FRAX https://www.sheffield.ac.uk/FRAX/tool.aspx?country=23

Garvan https://www.garvan.org.au/promotions/bone-fracture-risk/calculator/

Helpful not just for getting medications funded but can help you and patients understand their risk for fractures

FRAILTY

Difficult to define but easy to know it when you see it

A large number of Frailty scores around

Increasing frailty is associated with poor health outcomes and poor prognosis

ROCKWOOD FRAILTY SCORE

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

CHSA FRAILTY SCORE

Box 1: The CSHA Clinical Frailty Scale

1 *Very fit* — robust, active, energetic, well motivated and fit; these people commonly exercise regularly and are in the most fit group for their age

2 *Well* — without active disease, but less fit than people in category 1

3 *Well, with treated comorbid disease* — disease symptoms are well controlled compared with those in category 4

4 *Apparently vulnerable* — although not frankly dependent, these people commonly complain of being "slowed up" or have disease symptoms

5 *Mildly frail* — with limited dependence on others for instrumental activities of daily living

6 *Moderately frail* — help is needed with both instrumental and non-instrumental activities of daily living

7 *Severely frail* — completely dependent on others for the activities of daily living, or terminally ill

Note: CSHA = Canadian Study of Health and Aging.

POLYPHARMACY AND DE-PRESCRIBING

Stopping medicines is as important as prescribing them

Always need to be looking at lists of medicines and questioning if they are all needed

Often medications are started in hospital or by colleagues with a view to stopping/weaning down but it just doesn't happen

MEDICATION RECONCILIATION 1

Is the original condition which the medicine was prescribed for still present?

Are medicines initiated for symptomatic management providing adequate relief?

Are there any medicines which do not have a clear indication for use?

Has there been a change in the patient's health status, e.g. frailty or falls, which alters the balance between the benefits and possible harms of a particular treatment?

Are there any duplications in the patients prescribed medicines, e.g. two medicines from the same class initiated to treat the same condition when one is sufficient?

Are any simplifications in their prescribed regimen possible? For example, once daily medicines or combination tablets.

MEDICAL RECONCILIATION 2

Were any medicines initiated to treat an adverse reaction to another medicine, i.e. a prescribing cascade? If so, could both medicines be stopped?

Is there a risk of medicine interactions, including with any over-the-counter medicines or supplements?

Is the dose appropriate? For example, declining renal function may mean a lower dose is required in an older adult.

Could a non-pharmacological treatment be used instead? For example, exercise or physiotherapy for patients with osteoarthritis, instead of non-steroidal anti-inflammatory medicines.

Does the patient have any concerns regarding their prescription regimen?

deprescribe.org

CONSIDER PROGNOSIS AND HOW THAT IMPACTS

Sometimes can be easier to do when an event prompts a revision of treatment because the patient has moved to PH or is now palliative

Or a new diagnosis has come in clearly indicating a poor prognosis

Then we can focus on symptomatic treatment rather than preventative treatments that may never yield a positive result

MEDICINES TO HAVE A SECOND THINK ABOUT

Medicine class	Potential harms, particularly in older patients
Anticholinergic medicines	Increased risk of falls, delirium, cognitive impairment and urinary retention
Antihypertensive medicines	Increased risk of hypotension and falls
Antipsychotics	Increased risk of mortality in patients with dementia, increased risk of falls and postural hypotension when used as sedatives or hypnotics, e.g. quetiapine
Aspirin	Increased risk of gastrointestinal bleeding, limited evidence of benefit for CVD prevention[12]
Benzodiazepines or zopiclone	Increased risk of falls, cognitive impairment and possible association with Alzheimer's disease
Bisphosphonates	Increased risk of atypical fractures with prolonged treatment.
Diabetes medicines	Intensive glucose lowering is unlikely to benefit older patients; risk of hypoglycaemia with some medicines
Hypnotics	Cognitive effects the following day, increased risk of falls, possible increased risk of Alzheimer's disease
NSAIDs	Greater increase in absolute risk of bleeding than in younger patients, acute kidney injury
Opioids	Constipation, delirium, sedation, increased risk of falls or unintentional overdose[13]
Proton pump inhibitors (PPIs)	Increased risk of fractures, *Clostridium difficile* infection and renal adverse effects such as interstitial nephritis
Statins	Risk of adverse effects, e.g. myalgia, new onset diabetes mellitus, limited evidence of benefit for CVD prevention[14]
Tricyclic antidepressants	Cognitive impairment, urinary retention, postural hypotension, increased risk of falls