Introduction: This summary is to provide a brief overview of the GNABC Conference. Some learning gems are shared along with some links to resources.

April 12 – Meet & Greet: Caring for the Caregiver using Alternative Therapies

- Fun networking opportunity, space packed with people booking appointments with the various therapists. All for free!
- Alternative therapies: card reading, reflexology, massage, brushing, reiki
- Drink ticket & appetizers also provided.

April 13 – full day of presenters.

1. **BC Seniors: Issues & Priorities** by Heather Cook (BC Seniors Advocate rep.)
   - Role of advocate is to: monitor (25 programs); Analyze; Provide info & referral; and write Reports for government (2009 & 2012)
   - www.seniorsadvocateBC.ca quick facts directory, RCAL sites survey results
     - 28,000 living in BC RCAL, 30% with severe cogn. Impairment & 60% with mild to mod cogn. impairment.
     - Residents living shorter time in RCAL from 2.5 years now at 18 months
     - Looking at NP role in RCAL for coverage
     - Need to focus more on making life more meaningful and with loneliness
     - How to give time to converse with residents everyday
     - Just got $548M to increase direct care hours for residents
     - Home Health report coming soon

2. **Anxiety, Depression & Loss by Dr. Jane Saunders (Geriatric Psychiatrist)**
   - Society losing our sense of community – do you know your neighbours??
   - Get to know older adult personality (introvert vs extravert) and food preferences (+ reinforcement), they go a long way
   - Anxiety – common in women, poor health, cogn. impair, decrease coping abilities, trauma and isolation which usually stems from depression
     - Harder to recover from stress, bell curve with optimal function decreasing with trigger and recovery
     - Panic attacks rare, more subclinical symptom/somatic complaints with impending doom
     - Begins with anticipatory anxiety…become housebound d/t anxiety
     - Tool to try: Geriatric Anxiety Inventory
   - Bereavement – death of a loved one, normal to hear them, no time period as each person grieves their own way
   - Complicated bereavement – intense, intrusive thoughts, constant yearning, avoid reminders

- Mourning – working through the loss
- Grief – response to death of loved one, 2 stages:
    - 1. Loss – orientated coping– yearning, denial, avoidance of triggers to memories
    - 2. Restoration orientated coping-forging new relations, activities & roles
    - Screening/Assessment Tool : Brief Grief Questionnaire by Shear
- Depression affects: 10-15% community; 20% with dementia; 45% of hospitalized older adults (OA)
    - OA features of depression – mood less affected, anxiety, negative, grumpy, somatic complaints (2/3 have), psychosis (delusions), pseudo-dementia – easily distractible, tired have deceased concentration
    - Vascular depression (post stroke) – apathy, decreased insight & exec. function
    - Increased isolation d/t: ageism, physical limitations, losses, home function, independence, cognitive changes, societal structures changing

Loneliness	Isolation
-subjective – sense of isolation	-social decreased interactions, connections
-unable to make a connection	-lack a sense of friendship
-affects 1/3 to 2/3 OA	
Rx adaptability of community, group therapy	
"Compassionate Gaze" book	

        - <u>Depression with med. (e.g. metformin)</u>
    - Treatment – still SSRIs & SNRI if change anything do it one at a time, monitor with Geriatric Depression Scale or Cornell
        - In combination with psycho education (UK using Personal Illness Model)
        - Meds take time to work, sometimes 6-12 weeks
    - Side Effects – watch for hyponatremia, QRT prolongation, falls

3. <u>Reflections in MAiD, (an update)</u> by Dr. Roseanne Bethune

- BC data, MAiD completed at: VIHA-422; VC 223; FH 146;
- Patients with frailty meeting criteria (++ comorbidity)
- Have oral preparation available with secobarbital – used in Oregon, does not require a doctor present, can do it when patient decide, e.g. on the beach
- Couples dying together, story in the news recently romanticized the procedure, but a retraction describing the situation came out later
- Frailty – more complex decision but coming more, utilizing Frailty Scale score

4. **Providing inclusive and affirming care to LGBTQ2 Seniors** by Nicole Tremblay, SW
   - Sexuality continues into old age
   - Person Centred Care ≠ Equal human rights
   - LGBT experiences from the past: Mental illness, criminal pervert/immoral, and is threating to the family
   - In Residential Care: What will it be like for these people? Invisible (keep it quiet), embarrassed & fear (non-acceptance)
   - Unique challenges: financial security with many female couples living below poverty line
     - Loneliness – aging alone, no kids
     - ↑ risk abuse/neglect
   - Respecting LGBTQ2 Seniors: be kind, be curious, assume nothing, e.g. heterosexual.
     - Challenge those that negatively look upon this vulnerable group
   - VIHA – working on tool kit for RCAL

5. **Cultural Considerations: First Nations Elders"** by Tania Dick, ARNBC Pres.
   - Very moving and emotional reflection given on elders, their experiences and challenges over the decades
   - Elders role in band – contribute to the greater good, they are the connection to the past
   - Challenges – jurisdiction issues – health care workers, ambulances, etc. unable to access some reserve lands.
     - Lack of opportunity & access to community events, leading to loneliness, no $$ for transportation
     - Loosing language & culture – seniors dying; if survived residential care likely did not learn their language or cultural practices
     - 1st nation person had to give up status to go to war, unable to return to reserve after serving his country of Canada??
     - Hard to find a safe place for elders to gather
     - Elders having difficulty understanding other generations
     - Past residential schools & Indian hospitals may trigger memories when they hear "residential care"
   - What's needed for healing
     - Need Health Authority nurse to support band not federal
     - ↑ opportunity for community engagement
     - Bands need to participate in traditional ways, merge medicines
     - Utilize trauma informed practice
     - "Walk with us", form of reconciliation…new govt dept. of Reconciliation forming
     - There is forgiveness, some are there, others not so much
     - Nurses best positioned to work on reserve clinics, first & last person they see
     - **Cultural training program, Provincial Health on-line program 6 weeks**

April 14, 2018 – ½ day of presentations

6. **Polypharmacy: Is your pt. taking too many meds?" by Lanai Vek, Pharm.**
   - Definition: unnecessary meds; any unwanted side effects, ranges from 5 to 10 meds
   - 26% of OA in community take 10 or more; 50% in Residential Care
   - Most common ER visit: bleeding and hypoglycemia
   - Common meds linked to increased ER visits: HCT/gout; amlodipine for high BP/ edema; Cipro/hallucinations;
   - Rx "De-prescribing" www.deprescribeing.org - provide a plan & supervised process of dose reduction or stopping meds. www.choosingwiselyCanada.org
     - Why de-prescribe? ↓ appetite, swallowing difficulties, weight loss, crushed pills taste bad! Or taste perversion as med side effect, finances, take less pills, dementia/cognitive decline in function; ↓ life expectancy, side effects, can't monitor (e.g. warfarin); become less beneficial after 1st year, no longer sure why prescribed, ↓ kidney/liver function
     - What good are they anymore? What are the risks/benefits?
     - www.chd.bestsciencemedicine.com Cardiovascular risk calculator, plug in risk factors and see the benefits of each interventions (est. ± 5%)
     - www.sparctool.com benefits of anticoagulants on A. fib.
     - Fracture risk: Google "frax risk assessment tool"
     - www.thennt.com % of benefit for various therapy
     - www.medstopper.com
   - Where to begin? "Taper is safer"
     - Comfort care vs all possible intervention; Dignity vs longevity
     - Frailty scale – stage 9 terminal
     - Patient wishes
     - Current symptoms – look at adverse drug effects: nausea, balance, fatigue, bowels
     - BEERS criteria
   - BP recommendations: target less than 140/90 for everyone, diabetes 130/80
     - High intensive treatment 120/80 for high risk people

7. **Parkinson's Disease** by Dr. John Coyle, Geriatrics & Int. Medicine
   - Prevalence 2% Elderly & 10% in RCAL but this is likely higher
   - Causes: Parkin gene (rare), TAU protein, affects the alpha-synuclein in Lewy bodies
   - Risk factors: smoking, toxins MPTP (bad lot of drugs), trauma
   - Patho: 70-80% loss of dopamine affecting subsstantia nigra
   - Diagnosis: no longer recommend levodopa trial

- 5 Stages of PD:
    - Prodromal – one side mildly affected, even face, no function loss. Tremor & rigidity – sow as being more clumsy. Depression, frozen shoulder, REM sleep disturbance, e.g. fragmentation, restless leg (check iron/Fe), hyposmia – loss of smell
    - Early – bilateral, loss of facial expression, decreased blinking, speech abnormalities, soft/monotonous/fading voice, stooped posture & slowness with ADL. If tremor present than can diagnose, fatigue (15-50% excessive daytime sleep)
    - Mid stage – loss of balance and slowness of movement, falls (unable to move fast enough to protect self), Dx usually, living in own home
    - Disabled – sometime can stand and walk unassisted, likely used a walker, needs assist for some Activities of Daily Living (ADLs). ++ supports needed at home
    - Advanced – unable to get out of bed on own, falls, stumbles, freeze when walking, 24 hour assistance needed, may be hallucinating or delusional.
- Unusual Signs & Symptoms: swim in circles, ROLEX sign - ↓ arm swing, faulty dance steps, resting tremor post yawn, micrography (small handwriting), drooling, shuffling, rigidity with cog wheeling
- Treatment: Levadopa only works for 5 to 10 years, forms free radicals, take with food but avoid protein

  0 years _____5_____12 _____15 y
  Onset Honeymoon Motor complications, freezing, dyskinesia Cogn ↓

- Not PD: Essential Tremor – worse on action (can be vocal & head, too), NPH (apraxia, inc.)
- Medications
    - Levadopa – started 1960s + 1970s
    - Dopamine Agonist (Bromocriptine, Requip) – used for severe, last resort type movement or unusual beh. (e.g. gambling)
    - MAOI – B Selegiline
    - Amantadine – good for dyskinesia, not PD, tablets best preparation
    - Anticholinergics – good for tremors but not recommended in older age
    - COMT inhibitors – increase "on" time & function
        - Misc. treatment: Mirtazipine, Aricept, Enzyme Q10
        - Tai Chi, boxing, dancing (ballroom)
- Deep brain stimulation – used for young, no cognitive impairment with severe motor fluctuations, waitlist of 5 years, cost $60K
- Surgery – transplants, guided by MRI
- NEW. Duodopa - $60K drug goes through infuser to stomach (dopamine almost intolerable)

8. **"What really matters: Older Adult Voices"** by 3 Van. Island University students 2 & 4 year
   - What matters?
     - Family, health, connections with others, music, moving (walking, 10 steps), social (clubs, coffee group, classes, lunches), handywork, jigsaw, routine/schedule, gardening, reading
     - Purpose/meaning in life
     - Staying current
     - Remain in own home, still in control
     - Accepting of aging…adapting
   - Fears?
     - Losing independence or overly dependent on others
     - Not being heard
     - Living alone
     - Pain – don't want others to see me in this shape
     - Finances
     - Don't call me "Deary"

Upcoming Gerontological Conferences

Oct 18-20, 2018 Cdn Assoc. of Gerontology presenting "Making it Matter: Mobilizing aging Research, Practice & Policy" www.CAG2018.ca

April 5 & 6, 2019 GNABC 2019 at Executive Inn in Coquitlam, looking for volunteers. Please consider volunteering, it's fun!! Check out the GNABC website for more information.

May 2-4, 2019 CGNA Conference in Calgary. Entitled: "Older Persons Climbing Mountains: Journeys & Transitions" www.CGNA2019.ca

Most presentations available on the GNABC Website:

www.gnabc.com/gnabcAdmin/?page-id+116