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Hong Kong Psychogeriatric Association Newsletter
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MESSAGE FROM THE NEWSLETTER COMMITTEE

The upcoming issues of the HKPGA Newsletters will focus on a hot topic in psychogeriatrics- BPSD. We have invited a number of local and international experts to share with us the different aspects of BPSD and the articles will be published in two consecutive issues. In this issue, Mr. Samuel Kong gives us a comprehensive review on non-pharmacological interventions for BPSD. Then, we are honored to have Prof. Wendy Moyle, editor of the IPA Bulletin, to brief us on a few recent examples of the psychosocial interventions for BPSD. Lastly, Ms. Doreen Ho shares her experience on using the Montessori Method in Hong Kong so that our readers can learn from both the local and international perspectives. To save a tree, please send us your latest contact email address at *info@hkpga.org* and visit *www.hkpga.org* for upcoming events.

NON-PHARMACOLOGICAL INTERVENTIONS FOR BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD): A NURSING PERSPECTIVE

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Behavioral and Psychological Symptoms of Dementia

Caring for people with dementia is often of vital importance in psychogeriatric settings. Dementia is a complex, multi-symptoms, multi-factorial, heterogeneous process in which there is a gradual decline in cognitive, behavioral and emotional functioning (American Psychiatric Association, 2000; Wilkinson, 2011). It is associated with progressive cognitive disability, with a high prevalence of behavioral and psychological symptoms of dementia (BPSD) (International Psychogeriatric Association, 2002). BPSD refers to symptoms of disturbed perception, thought content, mood and behavior (Kozmanet et al., 2006; NICE, 2007). The symptoms are further delineated into 2 subgroups (Finkel, et al., 1996):

Behavioral symptoms:

Usually assessed on the basis of observation, including physical aggression, screaming, restlessness, agitation, wandering, culturally inappropriate behaviors, sexual disinhibition, hoarding, cursing and shadowing.

Psychological symptoms:

Usually identified based on interviews with patients and carers, including anxiety, depressive mood, hallucinations and delusions. These symptoms largely affect the patients themselves, as well as their caregivers (Donaldson et al., 1997) and impose additional burden to the community resources.

Ninety percent of people with dementia will experience BPSD as part of their illness and about two-third of dementia patients experience some BPSD at any one time point, and for one-third of community-dwelling dementia cases the level of BPSD will be clinically significant (Lyketsos et al, 2000). Therefore recognition and treatment of BPSD results in a positive impact to alleviate patients' suffering, improve their quality of life, reduce carers' stress and lower societal costs in the management of dementia patients.

Assessment of BPSD

The starting point in devising a nursing management plan is nursing assessment. Recognition of BPSD can be done by identification of respective causes of disorders, characteristics of the symptoms, together with the frequency, severity and impact on the patients by using of standardized rating instruments like Neuropsychiatric Inventory (NPI), Cohen Mansfield Agitation Inventory (CMAI); Geriatric Depression Scale (GDS); Behavioural Pathology in AD (BEHAVE-AD) (Cummings et al., 1994; Frisoni et al., 1999; Sutor et al., 2001). In practice, an explicit recording of challenging or risk-creating behavior, such as aimless wandering, hoarding, refusing to bathe, is crucial to continuous assessment and monitoring. The assessment results facilitate the clinicians to understand the causes of such behaviors and design appropriate interventions to manage the risk associated with cognitive impairment.

In addition to the standardized rating instruments to monitor BPSD, Sutor et al. (2001) summarize that environmental, social and redirection issues are the potential exacerbating factors to the development of BPSD. Comprehensive assessment should be made with regular review. They include:

- one's own physical health
- possible undetected pain or discomfort
- side effects of medication
- individual biography, including religious beliefs and spiritual and cultural identity
- psychosocial factors
- physical environmental factors
- behavioral and functional analysis conducted by professionals with specific skills, in conjunction with carers and care workers

Management of BPSD

Medications are commonly used in the management of BPSD. They include antipsychotics, antidepressants, anticonvulsants, benzodiazepines, adrenergic beta-blockers, acetylcholinesterase inhibitors, memantine and hypnotics. However, the potential benefits of these drugs must be weighed against the potential risk of side effects and serious adverse events such as confusion or worsen cognition (NICE, 2007). For example, the use of antipsychotic drugs in the management of agitation and psychosis seems to be associated with increased cognitive decline in Alzheimer's Dementia cases (McShane et al., 1997) and extra-pyramidal side-effects (Lonergan et al., 2001). Also use of a few atypical agents may increase the risk of stroke in elderly dementia patients (CSM, 2004; Schneider et al., 2005). Therefore non-pharmacological interventions should be considered as the first-line treatment for the people with BPSD.

In psychogeriatric settings, environmental manipulations are foundation of work to manage people with cognitive impairment. A quite atmosphere, good lighting, clear orientation signs and familiar objects in patient's immediate environment are optimal to all patients in clinical areas. Besides, arranging chairs around tables rather than set in lines has been improved the level of social interaction among the elderly.

Another best known and best validated intervention is reality orientation. It is based on the notion that a key problem in those with dementia is that they become disoriented for time, place and person. There is good support that certain aspects of cognitive functioning are enhanced by reality orientation. In spite of this, the effect of reality orientation is short-lived after the program has been discontinued and the benefits are limited.

Clinicians should sensitively handle BPSD by different approaches. Sometimes, reality orientation may be too confrontational to the dementia patients, which would possibly lead to withdrawal or hostility. Validation therapy emphasizes on the validation of feelings in whatever time of place appears to be real to the individual, despite the reality. For example, a widow talks about her husband is still alive may be responded to not by denying this but by pointing out the listener is aware that she loves her husband very much.

Apart from the above, other non-pharmacological approaches that may be considered to use for management of BPSD:

- Acupuncture
- Animal-assisted therapy
- Aromatherapy
- Behavior management
- Cognitive stimulation therapy / cognitive training
- Counseling
- Light therapy
- Massage / touch therapy
- Music therapy
- Physical activity / exercise
- Reminiscence therapy
- Snoezelen / Multi-sensory stimulation
- Transcutaneous Electrical Nerve Stimulation (TENS)

The efficacy of each non-pharmacological management is not significant since it is individualized and based on specific features of patient and therefore very few randomized controlled trials (RCTs) are available compared with the traditional pharmacological treatment. Researchers (Livingston et al., 2005; Hulme et al., 2010) have revealed the effect of specific non-pharmacological interventions. Most of the sample sizes were small and evidence was modest. The majority of the interventions fell into 'might work' category. Therefore conclusions on their efficacy are limited because of the paucity of quality research (Duedon, et al., 2009). NICE (2007) has concluded that, after meta-analysis from several research findings, there is no evidence that standardized approaches, such as validation, cognitive stimulation and reminiscence, reduce the degree of BPSD, even some improvements in mood have been noted. Meanwhile little research is yet available regarding music-based approaches, multi-sensory stimulation and bright light therapy. Aromatherapy has been evaluated in 2 RCTs with some evidence of benefit in terms of reduced agitation and general neuropsychiatric symptoms. However, data supporting the efficacy of aromatherapy is scarce whilst the side-effect profile of commonly used oils is virtually unexplored (Nguyen & Paton, 2008).

Behavioral Management

Meanwhile, Livingston et al.(2005) has suggested that behavioral management is effective to handle the BPSD. It is useful in responding to problematic behaviors such as aggression, un-cooperation and disruptive verbal abuse (Bird et al., 1995; Moniz-Cook et al., 2001; Buchanan & Fisher, 2002). Therefore relevant training and support are required. Carers and health care personnel should identify, monitor and address environmental, physical health and psychosocial factors that may increase the likelihood of violence, aggression, and the risk of harm to self or others. Management of these behaviors includes de-escalation techniques and methods of physical restraint. There is evidence that behavioral disturbances may be reduced by using behavioral management largely derives from single case series (NICE, 2007).

Conclusion

BPSD is a wide array of distressing psychological and behavioral problems that imposes physical and emotional burdens to the caregivers, clinicians and the patients themselves but most BPSD will stop after four weeks without pharmacological treatment. In view of the nature of these symptoms, non-pharmacological interventions are considered as the cornerstone approach under the careful and comprehensive assessment of environmental, medical and psychiatric facets of the patient presentation. In addition, BPSD can be recognized as a form of communication. Identification of the message behind the symptoms enables the clinicians to manage the problem behaviors by changing the patient to modifying causative or exacerbating factors (Sutor, et al., 2001). Therefore clinicians should not view the symptoms only, but understand the symptoms in the context of the patient's life. With understanding of the demented patients, tailored made management with both medication and non-pharmacological interventions can be formulated to reduce or eliminate difficult behavior from the client so as to improve their quality of life.

References:

American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association.

Bird, M., Alexopoulos, P. & Adamowicz, J. (1995). Success and failure in five case studies: use of cued recall to ameliorate behaviour problems in senile dementia. International Journal of Geriatric Psychiatry, , 305–311.

Buchanan, J.A. & Fisher, J.E. (2002). Functional assessment and non-contingent reinforcement in the treatment of disruptive vocalization in elderly dementia patients. Journal of Applied Behavior Analysis, , 99–103.

Committee on Safety of Medicines/CSM (2004). Atypical antipsychotic drugs and stroke. Available at www.mhra.gov.uk/SafetyInformation/GeneralSafetyInformationandadvice, Retrieved *14/7/2011.*

Cummings, J.L., Mega, M. & Gray, K. (1994). The neuropsychiatric inventory: comprehensive assessment of psychopathology in dementia. Neurology, , 2308-2314.

Deudon, A. , Maubourguet, N., Gervais, X. Leone, E. , Brocker, P., Carcaillon, L., Riff, S. Lavallart, B. & Robert, P.H. (2009). Non-pharmacological management of behavioural symptoms in nursing homes,International Journal of Geriatric Psychiatry, 24, 1386–1395.

Donaldson, C., Tarrier, N. & Burns, A. (1997). The impact of the symptoms of dementia on caregivers. The British Journal of Psychiatry, , 62–68.

Finkel, S.I. (2002). Behavioral and Psychological Symptoms of Dementia (BPSD) Educational Pack. International Psychogeriatric Association.

Finkel, S.I., Costa e Silva, J. & Cohen, G. (1996). Behavioral and psychological signs and symptoms of dementia: a consensus statement on current knowledge and implications for research and treatment. International Psychogeriatrics, (suppl. 3),497-500.

Frisoni, G.B., Rozzini, L. & Gozzetti, A. (1999). Behavioral syndromes in Alzheimer's disease: description and correlates. Dementia and Geriatric Cognitive Disorders, ,130-138.

Hulme, C., Wright, J., Crocker, T., Oluboyede, Y., & House, A. (2010). Non-pharmacological approaches for dementia that informal carers might try or access: a systematic review. International Journal of Geriatric Psychiatric, 25,756-763.

Kozman, M. Wattis, J. & Curran S. (2006). Pharmacological management of behavioral and psychological disturbance in dementia. Human Psychopharmacology: Clinical and Experimental, 21, 1–12.

Livingston, G., Johnston, K. & Katona, C. (2005). Systematic review of psychological approach to the management of neuropsychiatric symptoms of dementia. American Journal of Psychiatry 162, 11,1996-2021.

Lonergan, E., Luxenberg, J. & Colford, J. (2001). Haloperidol for agitation in dementia (Cochrane Review). The Cochrane Library, issue 4. Oxford, Update software.

Lyketsos, C.G., Steinberg, M. & Tschanz, J.T. (2000). Mental and behavioral disturbances in dementia: findings from cache county study on memory and aging. American Journal of Psychiatry, 157, 708-714.

McShane, R., Keene, J & Gedline K. (1997). Do neuroleptic drugs hasten cognitive decline in dementia? Prospective study with necrosy follow up. British Medical Journal, 314, 266–270.

Moniz-Cook, E., Woods, R.T. & Richards, K. (2001) Functional analysis of challenging behaviour in dementia: the role of superstition. International Journal of Geriatric Psychiatry, , 45–56.

National Institute for Clinical Excellence/NICE (2007). A NICE–SCIE guideline on supporting people with dementia and their carers in health and social care. Clinical Guideline No. 42.

Nguyen, Q. & Paton, C. (2008). The use of aromatherapy to treat behavioural problems in dementia. International Journal of Geriatric Psychiatry, 23, 337-346.

Schneider L.S., Dagerman K.S. & Insel P. (2005). Atypical antipsychotic drug treatment for dementia; meta-analysis of randomized placebo-controlled trials. Journal of the American Medical Association 294, 1934– 1943.

Sutor, B., Rumman T.A. & Smith, G.E. (2001). Assessment and management of behavior disturbances in nursing home patients. Mayo Clinic Proceedings; May 2001; 76, 5, 540-550.

Wilkinson, D. (2011). Realistic outcomes in the treatment of Alzheimer's disease (AD) – what can physicians expect? Presentation in joint symposium organized by The Hong Kong Geriatrics Society, The Hong Kong Neurological Society and The Hong Kong Psychogeriatric Association dated 7/7/2011, Hong Kong.

PSYCHOSOCIAL INTERVENTION AS TREATMENT OPTION

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Psychosocial Interventions

Psychosocial interventions have long been used as a treatment option for older people and in particular those with mental illness, including dementia. Dolls for example, are commonly used in nursing home care as a means of comfort and reducing agitation. However, the use of dolls as a therapeutic intervention has received limited attention in the research literature. Furthermore, in the last five years there has been an increased interest in the Montessori method as a treatment option for people with dementia. The following two papers explore the Montessori method and dolls. [WM]

Montessori Method and Nutrition

Nurse researchers from Taiwan investigated the efficacy of a Montessori intervention on eating ability and nutritional status of people with dementia living in nursing home care. Montessori methods focus on creating an environment where all of the items that are required for the activity are provided as a means to support the memory loss in dementia. The method also emphasizes the practice of skills that fit the ability of the resident. Residents living in one of two dementia special care units (SCUs), diagnosed with dementia, scoring >2 on the Edinburgh Feeding Evaluation in Dementia (EdFED), and with a MMSE between 10-23 were selected to participate. An experimental crossover design was used whereby the two SCUs were randomly allocated into sequence groups to compare the duration of the effects of the Montessori intervention and routine activities. The Montessori intervention was provided in 30-min sessions once a day, three days per week, for 8 weeks. There was a 2-week washout period between each intervention. The Montessori intervention involved the procedural movements of hand-eye coordination, scooping, pouring and squeezing and included sensory stimulation through music. The food used during the intervention was served as snacks, which were in addition to the regular meal routine and they were the favourite foods of participants. Participants were assessed at two time periods on the Edinburgh Feeding Evaluation in Dementia (EdFED), Eating Behaviour Scale, Mini-Nutritional Assessment, and their weight and height were measured as well as length of meal duration. Twenty-nine residents with a mean age of 82.90 (SD 5.96 years) participated. Over half of the participants were men (58.6%). To investigate differences between the Montessori intervention and routine activities, mean differences between the intervention periods were compared. Key findings indicate a significant reduction in the EdFED for the Montessori intervention between pre and post-test (-1.57 + 3.41) but not the routine activities (0.71+ 2.43). EdFED scores and nursing intervention scores at post-test were less than the pre-test scores for the Montessori intervention ($p < 0.05$). Scores on indicators of feeding difficulty and nursing intervention at post-test in the Montessori intervention were both significantly less than routine activities ($p < 0.05$).

The Montessori intervention increased participants' self-feeding and to accommodate this longer eating times are recommended. Although the Montessori intervention resulted in improved eating ability no significant difference was found in BMI and the Mini Nutritional Assessment. The researchers recommend that a longer intervention period may be needed to see significant BMI changes.

Reference

Lin, Huang, Watson, Wu & Lee. Using a Montessori method to increase eating ability for institutionalised residents with dementia: a crossover design. J Clin Nrs, 20, 3092-3101.

Doll Therapy

Nursing staff explored the effect of a doll on preceding negative behaviors (PNBs) (agitation, aggression, excessive pacing, or wandering) and haloperidol use among geropsychiatric inpatients. An exploratory design was used whereby over a 3-month period, each patient admitted to the 21-bed geropsychiatric unit was offered a doll that was considered to be ethno-centric to the patient. Data were collected via a retrospective chart review and a review of recorded staff observations of negative behaviors. Data from 115 patients (72 female, 43 male) were analysed. The top three primary diagnoses of participants included dementia (39%), depression (30%) and schizophrenia/psychotic (23%). The mean age of the sample was 69 years (SD=14.6 years). PNBs were significantly related to the prn use of haloperidol ($r = .56$; $p < .01$). Patients who had one or greater PNBs and who had a doll (n=22) were given a lower average number of prn haloperidol compared with patients (n=3) who did not have a doll (0.77 doses compared with 2.12). Although the findings are limited by the small sample size and the retrospective design there were no reported side effects related to the dolls and the dolls appeared to increase patient-patient and patient-staff interactions. The use of dolls needs further investigation.

Reference

Green, Matos, Murillo, Neushotz, Popeo, Aloysi, Samuel, Craig, Porter, Fitzpatrick. Use of dolls as a therapeutic intervention: Relationship to previous negative behaviours and pro re nata (prn) Haldol use among geropsychiatric inpatients. Arch Psych Nrs, 25:388-9.

ENGAGING CLIENTS WITH DEMENTIA IN ACTIVITIES USING MONTESSORI PRINCIPLES IN LOCAL CARE AND ATTENTION HOME

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A non-pharmacological intervention for dementia

There has been an accelerating increase in the number of clients with dementia in care and attention homes for the elderly in the past 10 years. For instance, the percentage of clients with dementia in the care and attention home where I am working was doubled from 2001 to 2011. Innovative and effective non-pharmacological interventions for these clients with cognitive dysfunction are essential to improve their quality of life in institutional environment.

As an occupational therapist, my aims of service for these clients are four-fold:
(1) to facilitate their usage of the remaining functions; (2) to enhance independence; (3) to reduce undesirable behaviors and; (4) to cultivate meaningful life with pleasure and dignity. I found that Montessori Method for Dementia™ can help achieve these aims.

Montessori Method for Dementia™ (MMD) was introduced to Hong Kong therapists in 2010 by Gail Elliot. She is a gerontologist and a dementia specialist in Canada. MMD is based on a set of clearly articulated principles, primarily the original philosophy and theories developed by Dr. Maria Montessori (1870-1952), who was a famous clinician and educator. The Montessori principles were first adapted by Dr. Cameron Camp, an Australian gerontologist in the 1980s. Gail Elliot developed the MMD from the work of Dr. Camp, Dr. Michelle Bourgeois, and other researchers. The methods can be adopted as a philosophy of care. I was impressed by one of the theories about behavioral and psychological symptoms of dementia (BPSD). It states that what people have labeled as problem behaviors of demented clients are responsive behaviors. The clients respond to unmet needs with their limited functions. If the reason for the behavior is discovered, appropriate interventions could be used to address the needs.

MMD can be applied on individuals or groups. The focus of the methods is on “doing”. Engagement in living is the emphasis. The goal is to provide clients with the opportunities to enjoy an enriched life by remaining purposefully and meaningfully engaged in daily roles, routines and activities of daily living. Using one sentence to summarize MMD would be: Activities, roles and routines are created and presented based on the needs, strengths, skills, abilities and interests of individuals with dementia, and delivered in an environment that supports the cognitive loss associated with dementia.

Examples of major principles of MMD:
> Thorough assessment of clients’ past history, interests and abilities are significant before creating and implementing activities effectively.
> Freedom of choice should be given, at least clients can say yes or no to the invitation to activities.
> Environment has to be modified to meet the needs of the clients.
> Materials used are familiar and aesthetically pleasing to clients.
> Activities are always demonstrated. Use less verbal instruction but make clear demonstration of steps.
> Focussing on spared abilities including the procedural memory, and supporting the impaired functions such as the declarative memory.

Major principles are further elaborated into specific guidelines for creating and implementing activities. The philosophy and mission of MMD echo with my service aims. The techniques are familiar to me as an occupational therapist. The principles are practical and easy to understand by frontline assistants with training. Moreover, the underlying principles of MMD are well supported by overseas researchers. The methods were thus tried in my department.

Actually anybody can use the methods when the approach is properly learned. All the principles have to be followed in order to have positive effects. The methods can be applied in different settings including long term care homes, day care centers or even at clients' homes. Gail Elliot was invited to hold 2-day courses for training practitioners of MMD in Hong Kong in the past 2 years. A train-the-trainers course is going on from late 2011. It is hoped that local trainers are available to train more local professionals of the health care sector in the coming year.

Experience sharing

My experience can be divided into 3 stages:
1. Starting from zero – I applied Montessori Method for Dementia™ by incorporating the activities into the existing Occupational Therapy Program for individual clients who had BPSD.

2. Creating activity workshop – I defined a period and found a place for a group of clients to be engaged in the created activities. Then more activity workshops for more clients were developed. One year later, there were 4 workshops entertaining more than 50 clients. Frontline staffs were responsible to run the workshops under my supervision and guidance. Basically, individual client was invited to participate in an activity appropriate to his ability, interest and need. Regular activity groups (such as reading, singing, craft groups) using principles of MMD were held in the workshop too. Clients in group activities are selected with some common features, depending on the nature of the group. For example, all clients are literate in the reading group.

3. Creating roles and routines – I started to design daily schedule for individual clients so that they could be engaged in meaningful activities other than program time. Making beds, copying poem books for the reading group, cleaning the handrails in the corridor are roles created. Some roles can be arranged into daily routine. I invited the social workers to join the new intervention.

No scientific research had been done on my clients yet. But changes were observed during the development of the service: Clients were willing to participate in the offered activities where the principles and techniques of MMD were applied. BPSD of most clients diminished when they were engaged in the activities. Non-engagement behaviors such as sleeping in day time were reduced. Participants were responsive and active in the activity workshops. Spared functions such as reading, writing and knitting were enhanced. Conversation and social interaction were increased. Negative affects were reduced; smiles and laughter were frequent in group activities. Involved staff got a clearer picture of 'the person' behind the client's dementia. This surely helped the management of BPSD.

Discussion

Though some of the theories and principles of Montessori Method for dementia™ are evidence based, the approach as a whole still needs scientific studies to proof its effectiveness both overseas and locally for Chinese elderly. In my opinion, Montessori Method for dementia™ is not just a set of principles for introducing activities to clients. It is a client-centered life design model. Thus all staff in the service providing organization and relatives living with clients in the community should be involved when daily schedule designed for the clients have to be well implemented. How the multi-disciplinary team members co-ordinate together to work for consistent programs and supportive environment would be a challenging but worthwhile issue for future development.

References

Gail Elliot(2011).Montessori Methods for Dementia™ Focusing on the Person & the Prepared Environment
McMaster University, Hamilton, Canada
(The 2nd edition with Hong Kong Perspective is available for sale from Hong Kong Occupational Therapy Association)

Cameron J Camp(1999) .Montessori based activities for Dementia
Myers research institute, Menorah Park Center for senior living

Jennifer A. Brush and Cameron Camp (1998). A therapy technique for improving memory: Spaced Retrieval
Myers research institute, Menorah Park Center for senior living

Michelle S Bourgeois (1992).Conversing with memory impaired individuals using memory aids
Northern speech services State University of Ohio

Websites:

Margaret Jeanne Trela (2009) Using Memory Books
https://kb.osu.edu/dspace/bitstream/handle/1811/44566/Trela_Margaret_Thesis. pdf
Ontario Behavioural Support System Project Team (2010). Behaviours have Meaning. Retrieved from : www.bssproject.ca.

COUNCIL NEWS

The new office bearers of the HKPGA Council 2011-2013 are:

Prof. Helen FK CHIU *President*	Ms. Anita YM WONG *Vice-President*
Ms. Elsie WONG *Honorary Treasurer*	Dr. Joshua TSOH *Honorary Secretary*

Please refer to the HKPGA website *www.hkpga.org* for the list of Council members.

Dr. Jess Leung L.M. (Department of Psychiatry, United Christian Hospital) will attend the 27th Japanese Psychogeriatric Society Annual Meeting in Saitama (Japan) from 21-22 June 2012 on behalf of HKPGA. She will present her expert experience on "screening for cognitive disorders in acute geriatric admissions".

EVENTS CALENDAR

Date	*Activity*	*Venue and contact*
15 Jun, 2012 Afternoon	HKPGA Mid-year Meeting	Kowloon Hospital info@hkpga.org
7 to 11 Sep 2012	IPA International Meeting	Cairns, Australia www.ipa2012cairns.com
26 to 28 Oct 2012	15th Asia-Pacific Regional Meeting of ADI	Beijing, PR China adi2012aprc@gmail.com

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