Enhancing Care for Older People Webinar Series. Session number:

Date: Wednesday 25th February 2026 1.30 – 3pm

Title: Recognising and managing treatable eye disease in people living with dementia

Presenters: David Knight
Advanced Clinical Research Optometrist
Newcastle upon Tyne Hospitals NHS Trust

EnCOP Strategic Lead: LYNNE SHAW

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Enhanced Care for Older People

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- The event will be recorded and shared.
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- If you need to take a break at any time throughout the session please feel free to do so.

Session aims and linked EnCOP Competencies

- **Aim:** To raise understanding of common treatable eye diseases and how we can recognise these in dementia

- **Linked EnCOP Domains:**

Domain A : Values, Attitudes, Safe and Ethical Practice
Domain B: Partnership Working and Communication with Older People, Families, and Others
Domain C: Inter-professional and Inter-organisational working, communication, and collaboration
Domain D2: Ageing Well – Assessing, Planning, Implementing and Evaluating Care and Support with Older People
Domain D3: Ageing well: Promoting and supporting holistic physical health and wellbeing with older people
Domain D4: Ageing well: Promoting and supporting holistic psychological health and wellbeing with older people
Domain D5: Ageing Well - Promoting and Supporting Independence, Autonomy, and Community Connectivity for Older People
Domain D6: Ageing Well: Promoting and Supporting Medicine Optimisation with Older People

Dual Diagnosis

Recognising and managing treatable eye disease in people living with dementia

David Knight
Advanced Clinical Research Optometrist
Newcastle upon Tyne Hospitals NHS Trust

Declarations/Disclosures

Author of book chapter: “Visual Dysfunction in Dementia and Cognitive Decline” in A New Approach to Dementia (Taylor & Francis, 2025).

Member of International Medical Advisory Panel for Astrazeneca

Honoraria received from Astrazeneca and Samsara

Lecture outline

Vision and cognition inter-relatedness (see previous lecture)

Refractive dysfunction

Common ocular diseases

- Cataract
- Dry Eye
- Age-Related Macular Degeneration (AMD)
- Glaucoma
- Diabetic Retinopathy

Managing multiple eye conditions

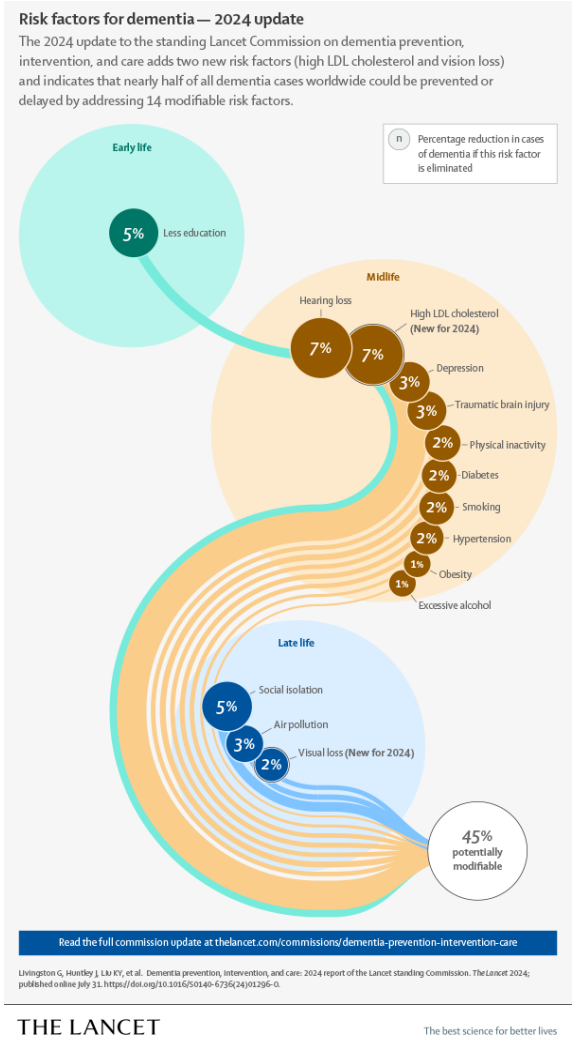
Vision and Cognition

Vision loss as dementia risk factor:

- 44% ↑ risk of dementia with visual impairment (Mukadam et al., 2020)
- Cataract surgery reduces risk by 29% (Lee et al., 2023)
- Potential mechanisms: Reduced cognitive stimulation, social isolation, shared pathology

Vision loss mimics/compounds cognitive decline:

- Functional impairment: falls, ADL difficulty, confusion
- Misidentification: Visual deficits mistaken for worsening dementia (e.g. CBS)
- Compounding effect: Ocular and cognitive visual dysfunction = severe disability
- Depression and behavioural disturbance



Ocular dysfunction or Refractive Error?

Refractive Error

- The eye's inability to focus light.
- Correctable with task-specific glasses.

Ocular dysfunction

- Diseases that damage the eye structures.
- Requires medical or surgical management.

Why the distinction?

- They usually co-exist – always check for updated glasses before attributing visual symptoms to disease.
- Refractive error: Immediate, low-cost interventions
- Ocular disease: May require surgical/medical intervention, capacity assessment

Prevalence in Dementia Populations

PrOVIDe study (2016, n=708)

Key findings:

- 32.5% had vision worse than driving standards (≤6/12)
- 16% unable to newspaper even with glasses
- 22% no eye test within 2 years
- **52%** had correctable visual impairment

Main causes:

- 42% Uncorrected refractive error (treatable)
- 25% Cataract (treatable)
- 15% Age-Related Macular Degeneration (subset treatable)

>50% of vision loss in dementia is CORRECTABLE

Refractive Error

Main types:

Myopia	Hyperopia	Astigmatism (Irregular corneal/lens shape)	Presbyopia (Age-related near focus loss)
•~30% O60	•~50% O60	•~40% O60	•100% O45

Refractive error progresses with age. Glasses from 5 years ago may now be significantly wrong.

Refractive Error Solutions

- Single vision – two pairs may be challenging (confusion, loss)
- Bifocal – ↑falls risk (~1.5x single vision in outdoor environments) Lord et al., 2022; Haran et al., 2010
- "Varifocals" - ↑↑falls risk (~2.3x vs single vision for outdoor activities, 40%↑ outdoor falls Lord et al, 2022
- Contact lenses – Infection risk, insertion/removal difficulty, poor compliance
- Cataract surgery – ↓33% falls risk (Brannan et al., 2003)

Refractive Error Management

Should all PLwD stop wearing varifocals?

- No! But requires individualised risk-benefit assessment:

Consider switch to single vision if:

- High falls risk
- Outdoor mobility is main concern
- Good adaptation potential (early dementia)

Consider keeping varifocals if:

- Low falls risk
- Mostly sedentary/indoor activity
- Strong habituation (worn for decades)
- Advanced dementia (retraining unlikely to succeed)

Refractive Error – considerations for management

- Miscommunication: "I can see just fine"
- Glasses may be lost, damaged, or "borrowed"
- Non-compliance: wrong glasses or wrong task

Which glasses?

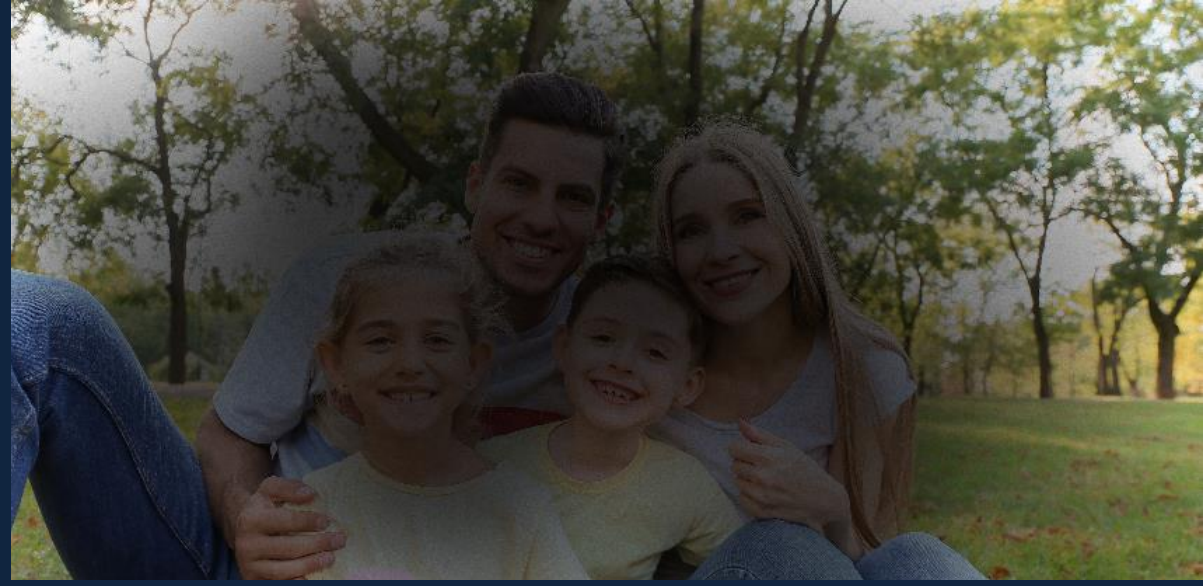
Identification challenges:

- Multiple pairs without clear labelling
- Borrowed/swapped with other residents
- Outdated prescriptions kept "just in case"

Solutions:

- Label inside arm: NAME, PURPOSE, DATE
- Photos: Person wearing correct glasses for each task
- Document whether needs task-dependent glasses
- Contact optician for latest prescription/dispensing records
- Red Flags:
- Person squinting/struggling despite wearing glasses
- Lost interest in hobbies
- Glasses don't "feel right" on face
- Recent eye test but still complaining

Common Eye Conditions - Cataract



Clouding of the crystalline lens

Pathophysiology:
Protein aggregation (crystallins) and oxidative damage
Nuclear, cortical, or posterior subcapsular types
Progressive loss of transparency
Prevalence: (Congdon et al., 2004)
Age 65-74: ~35-40%
Age 75+: ~50-70%
Near universal by age 80+

Risk factors:
Age (strongest), diabetes, smoking, UV exposure, steroids
Potentially accelerated in dementia (shared oxidative stress pathways)

Cataract surgery in dementia: The evidence

Benefits:

- Improved visual function
- ↓33% Falls risk (Brannan et al., 2003)
- ↓29% Dementia progression risk (Lee et al., 2022)
- Improved mood and quality of life (Wang et al., 2024)
- ↓Behavioural disturbance (Tamura et al., 2004)
- Maintained longer in the community (Yoshida et al., 2023)

Surgical safety in dementia:

- Complication rates similar to general population (Pershing et al., 2021)
- Can be performed under topical/local anaesthetic
- ~15-minute procedure
- Same-day discharge

Cataract impact on ADLs

Functional difficulties

- Reading (books, clocks, cooking labels)
- Face recognition (compounded by dementia)
- Navigation (falls risk)
- Activities (affects cognition)
- Self-care (meds management)

Referral pathway

- Optometrist -> Cataract surgery referral via GP

Cataract Surgery – Decision-making framework

Clinical indications (same as general population)

- Visual acuity <6/12 affecting function
- Significant glare disability
- Impaired ADLs due to vision (reading, TV, mobility)
- Falls attributed to poor vision

Decision process:

- Capacity assessment → Best interests decision → MDT discussion

Cataract Surgery – Decision-making framework

Favourable factors:	Challenging factors:	Contraindications:
Mild-moderate dementia (MMSE > 15)	Advanced dementia (MMSE < 10)	Active delirium
Still mobile and engaged in activities	Bed/chair-bound (functional benefit limited)	Unable to tolerate examination even with sedation
Good family/carer support for post-op care	Agitation preventing examination/cooperation	Palliative phase
Behavourial disturbance potentially vision-related	No support for post-op administration	
Medical fitness for local anaesthetic	Life expectancy < 6 months	

Mental Capacity Assessment for Cataract Surgery

- Can the person understand, retain, weigh up, and communicate:
  - What cataract surgery involves
  - Why it's being recommended
  - What happens if they don't have surgery
  - The risks and benefits
  - Alternatives

Pre-operative assessment in dementia

Pre-Op for PLwD. Standard checks plus:

Cognitive/functional:

- Baseline cognitive screen (MMSE/MoCA)
- Behavioural assessment (agitation, cooperation)
- ADL assessment (what will improve?)
- Falls history

Medical:

- Polypharmacy review (anticholinergics, sedatives)
- Delirium risk assessment (4AT score)
- Nutritional status
- Pressure areas if bed-bound

Social:

- Identify primary carer
- Post-op drop admin plan
- Transport needs
- Does environment support improved vision? (e.g. hazards, lighting)

Capacity:

- Formal MCA documented
- Best interests decision if needed
- Family discussion documented

Post-op delirium prevention:

- Familiar person present day of surgery
- Maintain orientation (calendar, clock)
- Avoid sedatives
- Early mobilization
- Pain control

Standard Post-Cataract Surgery Drop Regimen

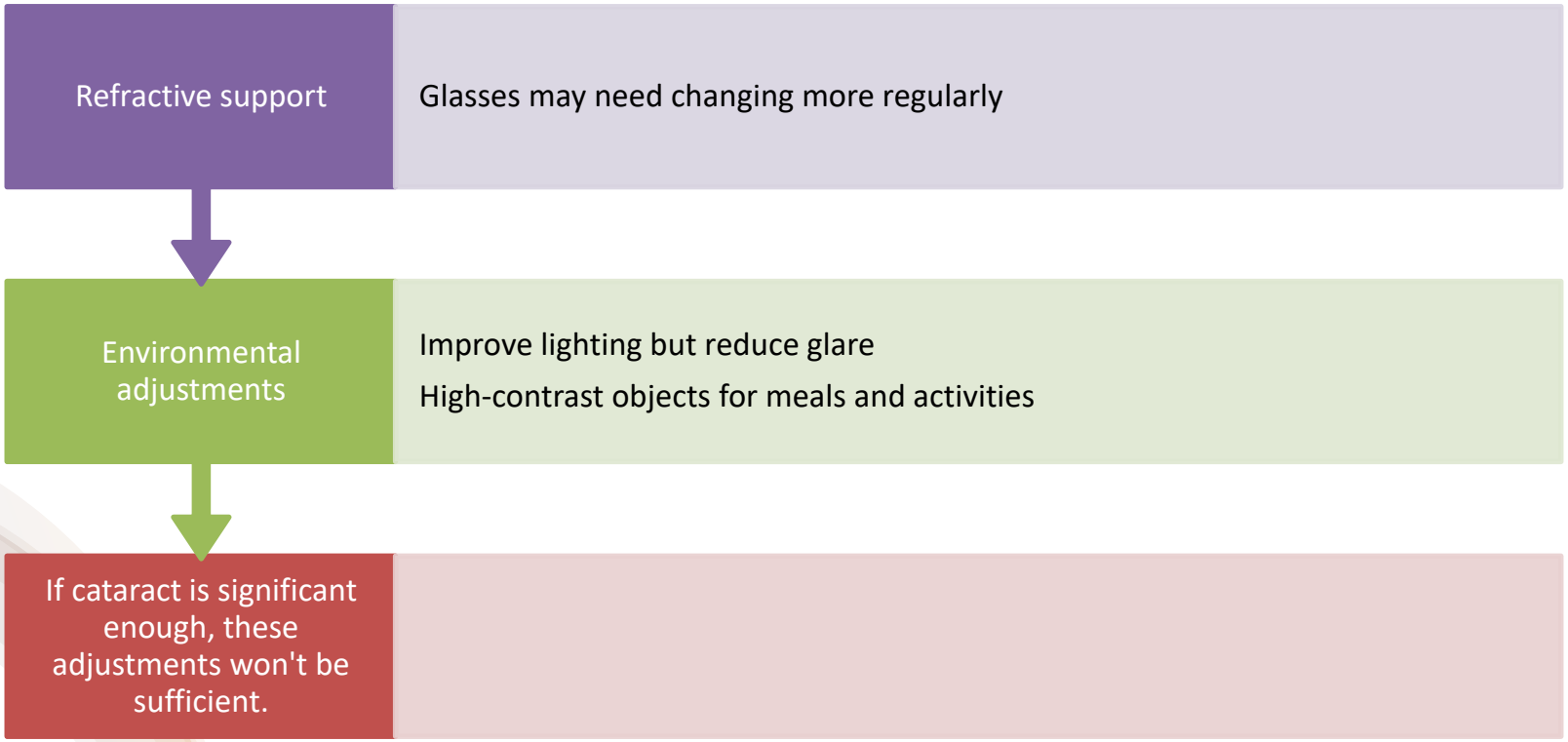
Typical protocol (varies):

- Avoid touching eye for 2-4 weeks
- Wear plastic shield for 7 nights
- Combined antibiotic and steroid eye drop applied four times per day for 4 weeks (some providers offer dropless surgery)

Dementia-specific challenges:

- Poor compliance (forgets, refuses, lacks coordination)
- Contamination risk
- Wrong eye/wrong drops
- Family/carer burden

If cataract surgery is not possible



Posterior capsular opacification (PCO)

"Secondary cataract" - clouding of lens capsule after surgery

Prevalence:

- 20-40% within 5 years of surgery (Schaumberg et al., 1998)
- Higher in diabetics

Symptoms

- Blurred vision over weeks/months
- Glare/halos
- Faded colours

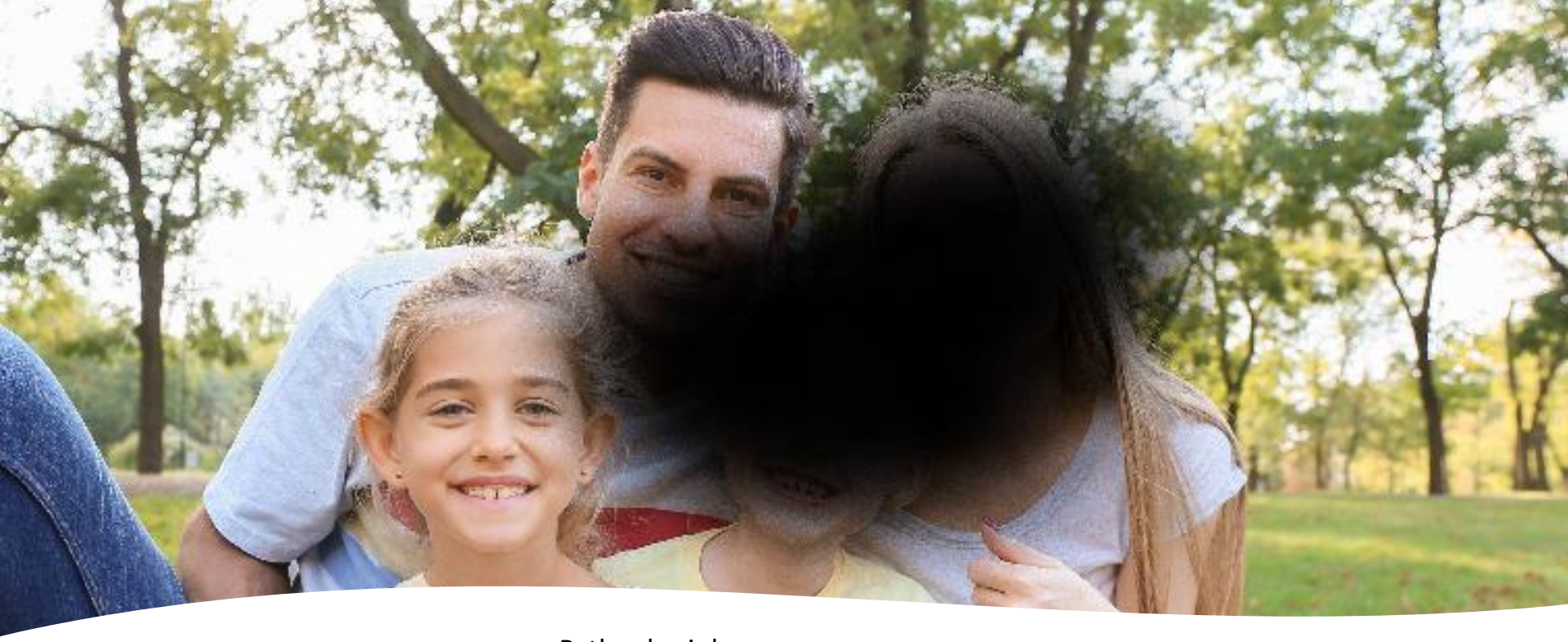
Posterior capsular opacification (PCO)

Treatment

- YAG laser capsulotomy
- 5-minute outpatient procedure
- No drops, no anaesthetic
- Immediate vision improvement

Dementia considerations

- Treatment requires brief cooperation/carer support (head position)
- Well tolerated in moderate dementia



Age-related Macular Degeneration (AMD)

Pathophysiology

- Degeneration of retinal pigment epithelium (RPE) and photoreceptors
- Affects central macula → central vision loss (peripheral vision preserved)
- Two types:
  - Dry AMD: 90%, Drusen deposits (lipid/protein waste), gradual progression, almost universal in O75 age group. No medical treatment.
  - Wet AMD: 10%, Abnormal blood vessel growth causing rapid haemorrhage → rapid vision loss over days/weeks. Treatable if caught early

AMD Risk factors

Risk factors:

- Age (strongest) (Tian & Zhang, 2025)
- Smoking (3-4x risk) (Tian & Zhang, 2025)
- Genetics (CFH, ARMS2) (Vavvas et al., 2018)
- Diet (Tian & Zhang, 2025)
- ?Dementia (inconclusive, possible association with ADD) (Rong et al., 2019)

AMD Symptoms

Symptoms

- Central vision loss, peripheral preserved
- Metamorphopsia (distortion) RED FLAG

Functional Impact

- Difficulty: reading, recognising faces, TV, detailed tasks
- Can walk independently

Behavioral clues

- Holding material very close then giving up
- Not recognising family (not related to dementia)
- Anxiety about central activities, comfort with navigation

AMD Management

Dry AMD

- Smoking cessation (↓progression 50%)
- Diet ("rainbow plate", AREDS supplements)
- AREDS2 supplement (↓progression 25%)
- Low vision rehabilitation
  - Magnifiers
  - Large print/audiobooks
  - Sight loss registration
  - Eye Clinic Liaison Officer (ECLO) support

AMD Management

- Wet AMD (URGENT treatment required)
  - Window of opportunity: 2 weeks
  - Anti-VEGF intravitreal injections
  - 4-16 weekly intervals
  - Stabilises in 90%, improves in 30-40%

AMD Management in Dementia

Dry AMD

- Universal/Very common, but severity varies
- Environmental optimisation:
  - ↑Lighting (2-3x normal for reading)
  - ↑Contrast (high-contrast tableware, markings)
  - ↑Size (sit closer,.large print books, playing cards, dominoes)
  - Consider AREDS2 supplements if able to swallow pills
  - Annual monitoring – risk of conversion to wet

AMD Management in Dementia

- Wet AMD
  - Rapid onset -> sudden behavioural changes
  - Increased confusion (may mimic cognitive decline)
  - Anxiety/agitation (distorted vision)
  - Withdrawal from activities
  - Increased falls risk (distortion impairs depth perception)
  - Treatment challenges
    - Monthly hospital-based injections require cooperation
    - Risk-benefit – treat or accept vision loss?
    - Capacity/best interests decision required

Wet AMD Treatment Decision-making

Ethically complex

Factors favouring treatment:

- Mild-moderate dementia
- Mobile/engaged in activities
- Family/carer support for hospital visits
- Distressed about vision loss
- Medical Fitness
- Life expectancy >1 year

Wet AMD Treatment Decision-making

If not treating, focus shifts to low vision support and comfort

- Approach from side (peripheral vision intact)
- Optimise environment (lighting, contrast, positioning)
- Use other available senses
  - Verbal announcement/TV descriptions/audiobooks
  - Use touch for reassurance
  - Describe surroundings

Diabetic Retinopathy (DR)

Pathophysiology

- Chronic hyperglycaemia -> microvascular damage to retinal capilleries through oxidative stress, pericyte loss, inflammation
- Results in capillary leakage, microaneurysms, ischaemia, triggering VEGF-mediated neovascularisation
- Advanced DR: Proliferative retinopathy threatens blindness from haemorrhage, fibrosis, and tractional retinal detachment.

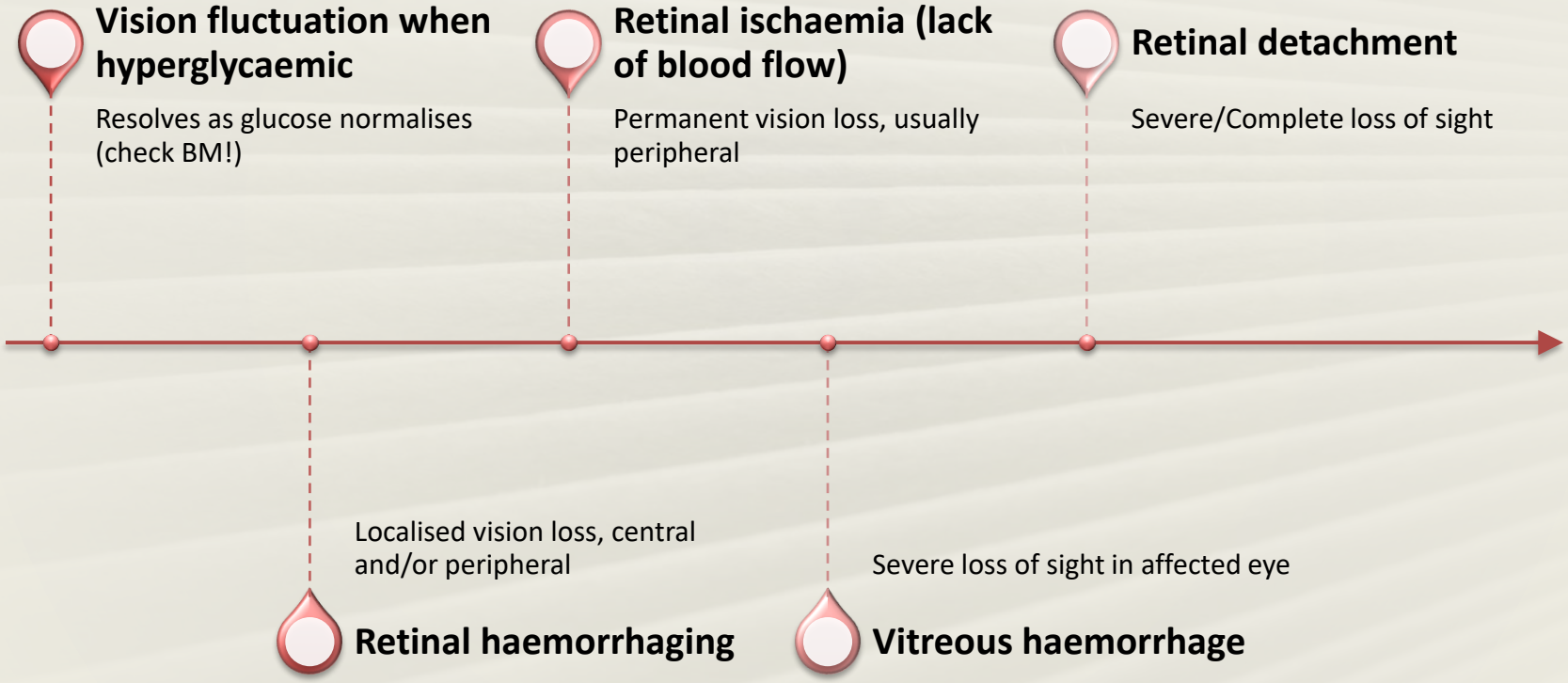
Regular screening (DESP) important

Diabetic retinal screening challenges

- Annual DESP screening requires:
  - Transport burden
  - Stinging eye drops (mydriatics)
  - Long wait (30 minutes+)
  - Sitting still for photos (2-5 minutes)
  - Bright flash
  - Blurred vision/light sensitive for 2-3 hours

Screening reduces blindness by 50% (Scanlon, 2021)

Diabetic retinopathy symptoms



Diabetic retinopathy management

Medication/diet (especially bvFTD)

Risk factors (smoking++)

Treatment options:

- Anti-VEGF intravitreal injections (same as wetAMD)
- Laser photocoagulation (one-time treatment, uncomfortable, requires consent/cooperation)

Risk-benefit: Worth treating to prevent blindness/painful eye

Diabetic Retinopathy – Carer Guidance

Screening compliance is crucial to prevent blindness

Non-urgent symptoms (eye test):

- Gradual blurred vision over weeks/months
- Difficulty reading

Urgent symptoms (attend EED)

- Shower of floaters, flashing lights
- Curtain/shadow in vision
- Sudden vision loss

Dry Eye Disease (DED)

Pathophysiology

- Multifactorial disorder involving tear film instability, hyperosmolarity, inflammatory cascade, meibomian gland dysfunction, neurosensory abnormalities
  - Reduced tear production
  - Increased tear evaporation

Prevalence

- 30-60% in O70 (Craig et al., 2017)
- 53-60% in dementia population (Bansal & Grover,2024)
- Often underdiagnosed

DED – Risk factors

- Age
- Polypharmacy (anticholinergics,antidepressants, antihistamines)
- Diabetes
- Reduced blink rate (common in dementia)
- Mouth breathing
- Poor hydration

DED - Symptoms

- Grittyness, Burning, Watery eyes
- Fluctuating vision
- Symptoms worse in the morning upon waking

May present as:

- Behavioural: Rubbing eyes, agitation
- Avoidance: Keeping eyes closed, turning away from light
- Functional: Refusing activities requiring vision

DED - Management

LUBRICATING EYE DROPS/GELS/OINTMENT

EYELID HYGIENE/WARM COMPRESSES/MASSAGE

ENVIRONMENTAL CONTROL (HUMIDIFIERS, AVOIDING DRAFTS)

REVIEW MEDICATIONS IF APPROPRIATE

DED – Self-management challenges

Eyedrop administration

- Cognitive: Forgets to instill, wrong frequency
- Motor: Reduced grip strength, hand-eye coordination
- Behavioural: Refuses "Don't need them", suspicion

Consequences if untreated:

- Conjunctivitis (common)
- Corneal abrasion -> ulcer -> blindness
- Severe pain -> behavioural disturbance
- Avoidance of activities -> cognitive decline

DED – Practical drop administration

Dementia-friendly techniques:

Best approach - from the side

- Sit/stand beside person, NOT in front
- Left side for left eye, right side for right eye
- Gently pull down lower lid
- Instil one drop into lower fornix (you cannot overdose)

Alternative – from behind:

- Sit behind and tilt head back slightly
- Rest hand on forehead
- Instil drop whilst person looks down

Wait 5 minutes between different drops – avoids washout

Glaucoma – "The thief of sight"

Pathophysiology

- Progressive optic nerve damage
- Usually from elevated intraocular pressure (IOP)
- Treatable but Irreversible

Prevalence

- 10% of O75 (Tham et al., 2014)
- Often undiagnosed as no symptoms in early stages

Glaucoma risk factors

- Age
- Family history
- Ethnicity (Afro-Caribbeans, Asians)
- Myopia (pre-cataract surgery)
- Diabetes

Glaucoma - Symptoms and Detection

Chronic Primary Open Angle Glaucoma

- Asymptomatic until advanced
- Gradual (years) peripheral vision loss – "Tunnel vision"
- Central vision preserved initially
- Glare
- Bumping into door frames, objects on floor
- Difficulty in crowds
- Eye test essential to prevent symptoms worsening

Acute Angle Closure Glaucoma (Emergency)

- Severe eye pain + headache
- Blurred vision, red eye
- Nausea/vomiting

Glaucoma - Management

IOP-lowering eye drops (lifelong, daily)

Surgical interventions

- Laser trabeculoplasty (non-invasive laser)
- Trabeculectomy
- Advanced surgical options

Eyedrop compliance challenges are similar to dry eyes, but the consequence = irreversible vision loss

Very important to ensure correct administration

Glaucoma – Carer Management

- Peripheral vision loss is commonly missed by the general population
- Routine eye tests vital for detection
- Ophthalmology reviews vital to monitor progression and adjust management plan
- People with glaucoma usually have good central vision but may struggle to locate objects and navigate.
- Their perception of brightness may be altered, and they may struggle more particularly in dim light or direct sunlight.
- Daily drop administration is non-negotiable
- Use techniques from dry eye section
- Keep spare bottles to avoid running out

When multiple conditions exist

This is the norm!

- Refractive error + Cataract + Dry eye = very common
- AMD + Glaucoma = Common
- All of the above + cognitive visual dsyfunction = complex!

Where to start?

Managing multiple visual conditions

Poor vision can be a treatable sensory deficit masquerading as cognitive decline.

- Address reversible/simple first:
  - Update/label glasses (Immediate vision improvement)
  - Treat dry eye (immediate comfort)
  - Environmental modifications (lighting, contrast, proximity, declutter)

Managing multiple visual conditions

High-impact surgical interventions:

- Cataract surgery
- YAG laser capsulotomy for PCO

Maintenance/prevention:

- Routine eye tests
- Glaucoma drops
- AMD monitoring
- Diabetic screening

Multidisciplinary pathways

Fragmented care remains a problem:

- Optometrist finds cataract -> GP -> Ophthalmology (3 month wait)
- Meanwhile: Falls -> A+E -> Orthopedics (Unaware of vision issue)
- Care home staff unaware of vision issues

Summary

- Vision loss is common, undertreated, and has significant impact
- Simple interventions have significant impact
- Capacity and consent remain critical
- Evaluate treatment burden vs benefit
- MDT coordination prevents care fragmentation

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Thank you

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EnCOP

Enhanced Care for Older People

Consolidating Learning:

Reflection on the session & considering application to practice & what this means 'your people'

- Think about this session in relation to your own role
- How much of this was revision?
- What have you learned today ?
- How will this help you in your role ?
- Think about your EnCOP self–assessment; consider which performance indicators this session may relate to and how this can be used as part of your own development / competency achievement.

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Reminder of linked EnCOP domains

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EnCOP WEBINAR CALENDAR

Year – 2025 Month	Session Title	Presenter(s)
Thursday 19th March 2026	Delirium and Dementia: Bridging Gaps in Recognition and Care	Professor Mani Santhana Krishnan, Tees Esk and Wear Valley Mental Health NHSFT, Anna Wilson, Lead Dementia Nurse, South Tees NHSFT, Dr Ahmad Khundakar, Teesside University
Thursday 23rd April 2026	NHC FT Decaf Project	Claire Collins , EnCOP Clinical Educator , Northumbria Healthcare FT
May TBC	Falls	
Wednesday 24th June 2026	Bowel and Bladder – Continence Title TBC	Jo Smith , Occupational Therapist , Bowel and Bladder Team , South Tees NHS Foundation Trust
Tuesday 21st July 2026	Narrative Medicine for the Wider Workforce	Dr James Fisher , Consultant Geriatrician , Northumbria Healthcare Foundation Trust

OCCUPATIONAL THERAPY CONFERENCE

FRIDAY 27 MARCH 2026
08.30 – 12.00

STRIVE Academic Centre
The James Cook University Hospital,
Marton Road, Middlesbrough, TS4 3BW

Join us for a **FREE half-day event** showcasing the creative and innovative work delivered by our **Integrated Occupational Therapy Service**. Discover how early, proactive support helps people live well and reduces pressure across the system

LEARNING OUTCOMES

- Gain a deeper understanding of clinical specialities across the partnership
- Learn from real-world experiences in service development
- Explore how occupational therapists act as **changemakers**, leading innovation and improving access for us all
- Understand the life-changing impact of Occupational Therapy
- Hear from experts across a wide range of clinical specialities

TARGET AUDIENCE

- Occupational Therapists and OT Support Staff
- Allied Health Professionals
- Service Managers and Leaders
- Students and Educators in Health and Social Care
- Commissioners and Partnership Stakeholders
- Health and social care staff

Stalls and **exhibits** featuring the latest clinical developments, ongoing projects, equipment and assistive devices will be **available for viewing** throughout the day

events.southtees.nhs.uk

TO BOOK VISIT

Right Support, Right Time: Unlocking the Power of Occupational Therapy

NHS
University Hospitals Tees

Better mealtimes for people living with dementia

Sustainability and cultural diversity

- We have developed a care homes training course about good practice in mealtime care. We have recently received funding from NIHR for a new project, which will make sure the training leads to lasting improvements, and is meaningful for staff and residents from diverse cultural backgrounds.
- We would like people to give us advice on how to do this new project well. People with relevant experience and insight into the topic.
- This could include people living with dementia, carers of people living with dementia, care home residents, care home staff, and other health and care professionals
- Your involvement means the project is more likely to lead to real benefits for people living with dementia. And helps to ensure that taking part in the project is a positive experience. We would also love your help with looking at the project findings, and making sure they get turned into something practical and helpful for the care homes community.
- We expect there to be about 4 meetings in total, and they will take place every few months. There will be different options for meeting up, to suit people's preferences. E.g. in-person, online, in a group, or one-to-one. We can reimburse reasonable travel expenses and provide gift vouchers in acknowledgement of people's time.

To find out more please contact **James Faraday** on james.faraday@nhs.net or 07513702894

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Feedback about today's session and any future sessions you may like to see included in our webinar series….

All feedback welcomed; You may want to consider the following –

Was it easy to book onto the session?
Did you find the session went well in this online format ?
Was the content of the session relevant to your area of practice / job role?
Did you enjoy the session?

Thinking about future webinar's, which topics linked to older person's care would you be most interested in? Please put any suggestions in the chat.

Please comment in the chat today or feel free to email us: ghnt.encop@nhs.net

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More information can be found within the Frailty icare website

www.frailtyicare.org

Our EnCOP pages are located in the workforce section

EnCOP Library of Learning & Development Resources can be found at:

EnCOP Assessment Toolkit Domains « I-Care (frailtyicare.org.uk)

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