TRACS WA
TRAining Centre in Subacute Care

Be CHAMPIONS for Delirium: prevention and management in hospital

Presentation and resources* were provided by:

Katharine Earl

Senior Project Officer, Occupational Therapist

Cognitive Impairment Project

Fiona Stanley Fremantle Hospitals Group

South Metropolitan Health Service

Katharine.Earl@health.wa.gov.au

fsfhg.cognitivecare@health.wa.gov.au

***Please contact Katharine if you would like to re-brand posters**

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South Metropolitan Health Service
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Be CHAMPIONS for delirium: prevention and management in hospital

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Session outline

- Introduction
- Delirium – the basics
- Delirium – so what?
- Evidence
- Know your data
- FSFHG activities

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The basics

- Acute change in mental state characterised by altered attention, disturbance in consciousness, perception and decreased cognitive function
- Degree of symptoms fluctuate in severity
- Three main types of delirium:
  - hyperactive
  - hypoactive
  - mixed

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Risk factors

- Over 65
- Pre-existing cognitive impairment
- Severe medical illness or hip fracture
- History of delirium
- Sensory impairment
- Depression

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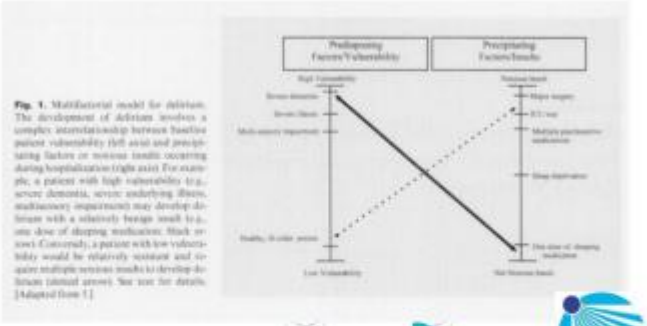
Delirium risk factors



Inouye, S. (1999)

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So what?

- Estimated 10-18% of Aus aged 65+ have delirium on admission to hospital
- Further <10% develop delirium during admission
- Rates vary across setting:
  - >30% following heart or hip surgery
  - >50% in adult ICU regardless of age

Delirium Clinical Care Standards, 2021

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So what?

- Total cost in Aus estimated at $8.8billion
  - $3.5billion financial costs
    - Community and hospital costs
  - $5.3billion health life lost
  - Dementia attributable to delirium - $4.3billion
  - Estimated more than 900 deaths attributed to delirium

Pezzullo et al, 2019

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Evidence base

- Non-pharmacological over pharmacological interventions
- Individualised multi-component over single-component interventions
- Prevention is better than treatment
- Multidisciplinary over single profession

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Prevention and management

- Communicate clearly. Identify yourself and explain what is happening. You may need to repeat yourself
- Use eye contact when culturally appropriate
- Review medicines and reconcile medicines
- Perform mobilisation activities at least 1-2x daily, and mobilise a patient early
- Sit out of bed for meals
- Help patients who usually wear hearing or visual aids
- Maintain optimal hydration and nutrition, and encourage or help the patient as
- Regulate bladder and bowel function
- Regularly reorientate and reassure the patient
- Avoid moving the person within and between wards
- Use activities that help increase cognition – for example, reminiscence
- Use non-pharmacotherapy measures to help promote sleep
- Maintain a quiet environment
- Make a clock and calendar available to the patient
- Provide lighting that is appropriate to the time of day
- Use effective pain management. Assess pain regularly and provide
- Provide oxygen therapy where appropriate

Delirium Clinical Care Standards, 2021

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Safer Care Victoria

Delirium Collaborative

Summary report

In 2010, we partnered with the Institute for Healthcare Improvement to deliver a statewide Collaborative to improve delirium care across Victoria.

Healthcare Improvement Scotland

SIGN

Delirium

NSW

AGENCY FOR CLINICAL INNOVATION

Care of Confused Hospitalised Older Persons (CHOPS)

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A complex intervention to promote prevention of delirium in older adults by targeting caregiver's participation during and after hospital discharge – study protocol of the TRAnsport and DElirium in older people (TRADE) project

CHOP

VOLUNTEER DEMENTIA & DELIRIUM CARE

Tips and strategies from the Older Persons' Mental Health Think Delirium Prevention project

THINKdelirium PREVENTION PROJECT

Canterbury District Health Board

Hospital Elder Life Program

HELP

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Project Management 101

Stage 1: Engage and explore
- Define what needs to change and for whom
- Select and adopt program or practice
- Set up an implementation team
- Assess readiness; consider barriers and enablers

Stage 2: Plan and prepare
- Choose implementation strategies
- Develop an implementation plan
- Decide how to monitor implementation quality
- Build readiness to use program or practice

Stage 4: Sustain and scale
- Sustain the program or practice, embedding as 'business as usual'
- Scale-up the program or practice

Stage 3: Initiate and refine
- Start using the program or practice
- Continuously monitor and improve

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Wow, so what can I do?

- Target ONE aspect
  - Of prevention, mgmt., one discipline, one step
- Promote a process already well known or resource already in existence
- Link to something with a profile
- Ask, chat, Google – don't reinvent the wheel
- Find an ally
- Audit

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Know your situation

Specialty	Med age	WAU Lost	% preventable
Orthopaedics			
Cardiothoracic Surg			
General Surg			
Gerontology			
Cardiology			
General Medicine			
Oncology			
Haematology			

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Achieved and ongoing

- Governance structures
- Policy
- Implement the CII
- Engage the Volunteer service
- Develop the FRAMP-CI
- Audits
- Dementia-friendly changes
- Embedding education
- Links with other services

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Achieved and ongoing

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Aim high! (but every little helps)

- Possible to achieve great things
- Be prepared to do some leg work
- Seize opportunities
- Have a clear plan
- Persistence is key
- You will have setbacks and some barriers will seem like they are impassable
- Build EVIDENCE to support your requests

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Thank you

Please be in touch should you require any further information or any of the resources

katharine.earl@health.wa.gov.au

fsfhg.cognitivecare@health.wa.gov.au

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Discharge Summary Guide
for Cognitive Impairment and Falls

Resolved or resolving delirium / episode of confusion:

- ☐ List delirium as a **Complication**
- ☐ Include details of the delirium/confusion within the **clinical synopsis**
- ☐ Document the patient's delirium care plan (developed in collaboration with care providers and patient), in **Advice to GP** and **Advice to Patient**. *Suggested template:*

Advice to Patient:
Please read through the 'Delirium' information brochure that was provided to you while in hospital.
For you, strategies to help prevent and manage delirium include *appropriate pain management / treating and avoiding constipation / reducing medications / stopping drugs that make delirium worse/ getting the right amount of food and fluid intake / encouraging walking and mobility / having familiar objects from home / having family and carers involved in my care*
Please make an appointment to see your GP within 10 days to review your cognition.

Advice to GP:
Patient developed delirium due to *post op / unknown / other*
Delirium management included *medication change / environmental / other*
Ongoing delirium management is required and includes _____
Please review this patient to ensure resolution of delirium and weaning of medications as appropriate.
Please consider follow-up with a Geriatrician in three months for a cognitive review if required.

Discharged on medication to manage agitation:

- ☐ Specify duration of use in **Current Medications**
- ☐ Include plan to cease within **Advice to GP**

Inpatient fall:

- ☐ List fall as a **Complication**
- ☐ Include details of the fall (injuries/investigations/management) within the **clinical synopsis**
- ☐ Include the care plan within the **Advice to Patient** and **Advice to GP**. *Suggested template:*

Advice to Patient:
You had a fall during your stay in hospital which may increase your risk of further falls. You may be referred for further therapy to manage your falls risk.

Advice to GP:
Your patient experienced a fall while an inpatient. Please monitor falls risk factors and consider referral for multidisciplinary falls review if required.

Known dementia:

- ☐ List dementia as a **Comorbidity**
- ☐ Dementia listed within **Medical History**

Suspected cognitive impairment or dementia:

- ☐ Consider referral to Specialist
- ☐ Request GP to monitor cognition and/or refer on, add to **Advice to GP**

For more information contact the Cognitive Impairment Team on fsfhg.cognitivecare@health.wa.gov.au

Delirium and falls prevention volunteer activities

Research shows that patients who are visited by volunteers and participate in certain activities with them experience better outcomes while in hospital. Patients who may particularly benefit from such interactions are those at risk of delirium and falls, which include those who are older, have a pre-existing cognitive impairment, have had recent surgery or who may have been in hospital for a while.

While all four components should be considered with high risk patients (those meeting the criteria above), they can be incorporated individually with any visit.

1. Talking and reassurance

Reflects the value of simple human connection, communication, patience, and time.
Activities include:

- re-orientation via talking or writing on an orientation chart (re-orientation to their name, age (or DOB), the day, date, year and where they are). This can be included within conversation
- discussing current activities on the ward/hospital setting
- explaining the spatial orientation of the room
- completing the Sunflower Tool with the patient and discussing topics of interest referring to a previously completed Sunflower Tool for guidance on favoured topics
- explaining the use of the call bell, TV, radio etc

2. Therapeutic activities

Designed to prevent cognitive decline, promote active engagement and provide entertainment
Activities to include:

- cognitive stimulation activities such as word search, crosswords, sudoku, colouring
- reading the newspaper, magazine aloud with/for the patient
- reminiscence activities based on patients background – referencing photobooks, books in volunteer office, discussion
- games such as cards
- if the patient is able to walk independently (without the hands on assistance of someone else, may include a walking aid), and nurses say it's OK, you can walk along the corridor with the patient
- music or talking books – a CD player can be left with the patient on short term loan

** *Volunteers should not provide any hands on assistance to the patient when they are standing or walking. If the patient requests assistance with transferring between lying to sitting or sitting to standing, please call the bell and wait for a nurse* **

3. Feeding and hydration

Involves assisting with setting up a meal and providing encouragement to eat and drink
Tasks to include:

- encouraging patients to drink water/hot drink already in their room

- clearing tray table prior to food arriving
- opening cutlery and covers of food when delivered
- gently encouraging patients to eat and drink
- assisting in creating a more normal dining atmosphere, for example, can you have a cup of tea while they are drinking theirs?
- assisting the patient with filling in their paper menu (at Fremantle) or via the PES (at FSH)
- pouring water into glass from jug, opening juice etc

** *Do not provide patients with any food or drink not already in their room. Volunteers should not physically assist with feeding. If unsure, check with nursing staff***

4. Vision and hearing

Tasks include:

- ask if you can collect the patients glasses/hearing aids from a drawer/bag etc
- prompting patients to wear aids if needed and available
- ensuring glasses are clean and within reach of the patient, assist with putting on/taking off if needed
- ensuring hearing aids are working and easy to access
- let nursing staff know if hearing aids are faulty

General tips:

Be aware of any pre-cautions that exist when visiting patients. These may include, but are not limited to, wearing a mask and googles, keeping a safe distance from the patient and practicing hand hygiene. If unsure, please ask.

While with a patient:

- position yourself at their eye level, rather than standing over them
- ask their permission to turn down the TV or radio to reduce distraction
- open the blinds to let in natural light
- remember the nine FSFHG communication tips designed for use with people with a cognitive impairment, but useful to remember in all interactions:
    - introduce yourself and your role
    - make sure you have eye contact at all times
    - remain calm and talk in a matter of fact way
    - involve carers
    - keep sentences short and simple
    - focus on one instruction/topic at a time
    - give time for responses
    - repeat yourself….. don't assume you have been understood
    - do not give too many choices
- keep social distancing rules in mind
- repeat falls prevention strategies:
    - how to use the call ball

- how to turn on the light
- importance of using the call bell and waiting for a nurse when needing to get out of bed

Before leaving a patient:

- ask 'is there anything else I can do for you before I head off'
- ensure the call bell is within reach
- place all necessary items are within reach (glasses, water, newspaper etc)
- assist the Patient with TV or radio on if they request this
- ask patient if they would like a return visit or an activity to complete in the meantime
- if you're worried a patient might get up on their own or needs to go to the toilet, let nursing staff know
- leave completed Sunflower Tool in the Patients room and let nursing staff know about it's completion

As always, if unsure about anything, please ask

Volunteer Kits:

Activity kits have been prepared which include the following:

- paper-based cognitive stimulation activities – word searches, crossword, soduku (various levels of challenge and size), colouring sheets and pens/pencils
- table-top activities such as cards
- magazines
- ipad with pre-loaded apps
- stress-balls and fiddle blankets (single use)
- Sunflower Tools

Volunteers will also have access to a range of resources at both FSH and FH offices including:

- books including photo books
- talking books
- music CDs
- headphones and discmans/CD player

Please send all ideas for new activities or resources through to David or Volunteer Services

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Cognitive Impairment: Prevention and Management

C — Carers, family and friends

- Involve family and carers
- Provide the 'Delirium Information' sheet (on the hub)
- Complete and display the Sunflower Tool
- Display a Cognitive Impairment Identifier if appropriate

H — Hydration

- Encourage fluids and ensure adequate intake
- Offer fluids at every opportunity and provide assistance if required
- Avoid caffeine at night

A — Aids

- Prompt use of hearing aids and glasses
- Consider communication aids such as Interpreters and/or communication boards
- Ensure walking aids are within reach if the patient is able to mobilise independently

M — Medication

- Promote non-pharmaceutical strategies to prevent and manage responsive behaviours
- Consider medication review - avoid polypharmacy

P — Pain

- Regular assessment and management of pain
- Look for non-verbal signs of pain - agitated behaviours may indicate pain
- Consider regular analgesia

I — Infection

- Monitor for signs and symptoms of infection and monitor skin integrity
- Ensure regular oral care
- Avoid use of catheters

O — Output - bladder and bowels

- Monitor bowels and avoid constipation by considering regular aperients encourage regular toileting
- Provide opportunity for incidental activity (eg walking to the toilet and shower)

N — Nutrition

- Monitor nutrition and encourage intake, provide assistance as required
- Ensure dentures in and oral care
- Consider dietician referral

S — Setting / environment

- Personalise environment and reduce clutter
- Lighting appropriate to time of day
- Provide regular orientation. Avoid bed moves

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Precipitating factors for delirium

Monitor daily for all high risk patients

- **D** Dehydration
- **E** Electrolyte imbalance
- **L** Level of pain
- **I** Infection. Sepsis. Inflammation
- **R** Respiratory failure (hypoxia / hypercapnia)
- **I** Impaction of faeces
- **U** Urine retention
- **M** Medication toxicity

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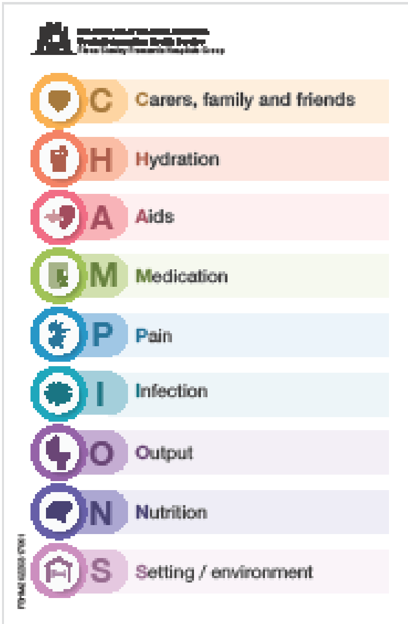
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