Caring for Cognitive Impairment Campaign

Webinar No 4: Responding to Distress

3 May 2017

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Overview

- Aim of today's webinar
- Context
- Presenters:
  - Glenys Petrie
  - Catherine Bateman
  - Leon Flicker
- Panel and question time. Type them as we go into the Questions pane of the control panel
- Summary and resources

Cognitive impairment

- Difficulties with communication, attention, memory, thinking and problem solving.
- May be recent and temporary or permanent.
- Cognitive impairment has many causes – dementia, delirium acquired brain injury, a stroke, intellectual disability or drug use.
- Dementia and delirium are common in older people in hospital.
- Delirium is an acute change in mental status. It can be a treatable medical emergency.
- Any form of cognitive impairment needs to recognised, understood and action taken.

Responding to distress

- What do we mean by distress?
- There are many terms
- There are multiple causes
- You can help prevent and reduce distress
- There are strategies and programs that can help and further learning opportunities

CARING FOR COGNITIVE IMPAIRMENT

Cognitive Impairment

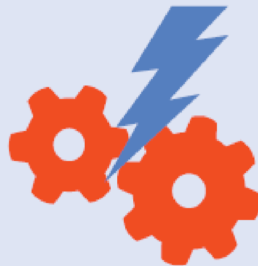
is an important safety and quality issue for all Australian hospitals

Patients with cognitive impairment such as dementia and/or delirium have more falls, pressure injuries and functional decline

Dementia and delirium are poorly recognised

30-40% of delirium cases can be prevented

Learn how to recognise cognitive impairment



Prevent delirium

Act to keep people with cognitive impairment safe

We can all make a difference

NSQHS Standards (second edition)

Clinical governance for health service organisations standard

Partnering with consumers standard

Healthcare-associated infection prevention standard

Medication safety standard

Comprehensive care standard

Communicating for safety standard

Blood and blood product standard

Recognising and responding to acute deterioration standard

NSQHS Standards (second edition)

- Current consultation on resources
- Launch of NSQHS Standards (second edition) and resources planned for November 2017
- Assessment to the NSQHS Standards (second edition) to commence from 1 January 2019

Within Comprehensive Care Standard –Cognitive impairment items

.. A **system** for caring for patients with cognitive impairment to:

a. incorporate best-practice strategies , including the **Delirium Clinical Care Standard**

b. manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation

Clinicians use the system …to:

a. recognise, prevent, treat and manage cognitive impairment

b. collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care

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Glenys Petrie

Consumer perspective

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Cath Bateman

CNC Program Coordinator

Southern NSW Local Health District

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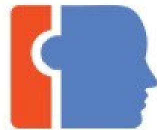
Responding to Distress Webinar



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Cath Bateman

CNC Program Coordinator
Southern NSW Local Health District

3rd May 2017

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Some common triggers or contributors to distress

- Pain
- Fear
  - unfamiliar people and environment
  - hallucinations/delusions
- Physical restraint/catheters/IV lines
- Rushed/abrupt/disrespectful communication approaches
- Visual and hearing impairment
- Multiple room changes
- Sleep deprivation and boredom

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Prevention and management strategies

- Comprehensively assess and address physical causes
- Medication review
- Pain management: non verbal pain assessment
- Involve, inform and support the carers – essential for:
  - gaining an understanding of the person
  - Helping calm the person
  - Understanding potential triggers for distress

- **Calm** respectful communication – be aware of tone and body language/use interpreters
- Avoid multiple room changes

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Prevention and management strategies

- Promote optimal sleep and rest
- Support orientation – large clock calendars/signage
- Ensure wearing of vision and hearing aids
- Mental stimulation and meaningful activities
- Promote safe mobilisation – identify and flag falls risk
- Prevention of constipation
- Adequate hydration and nutrition
- **Team Communication**

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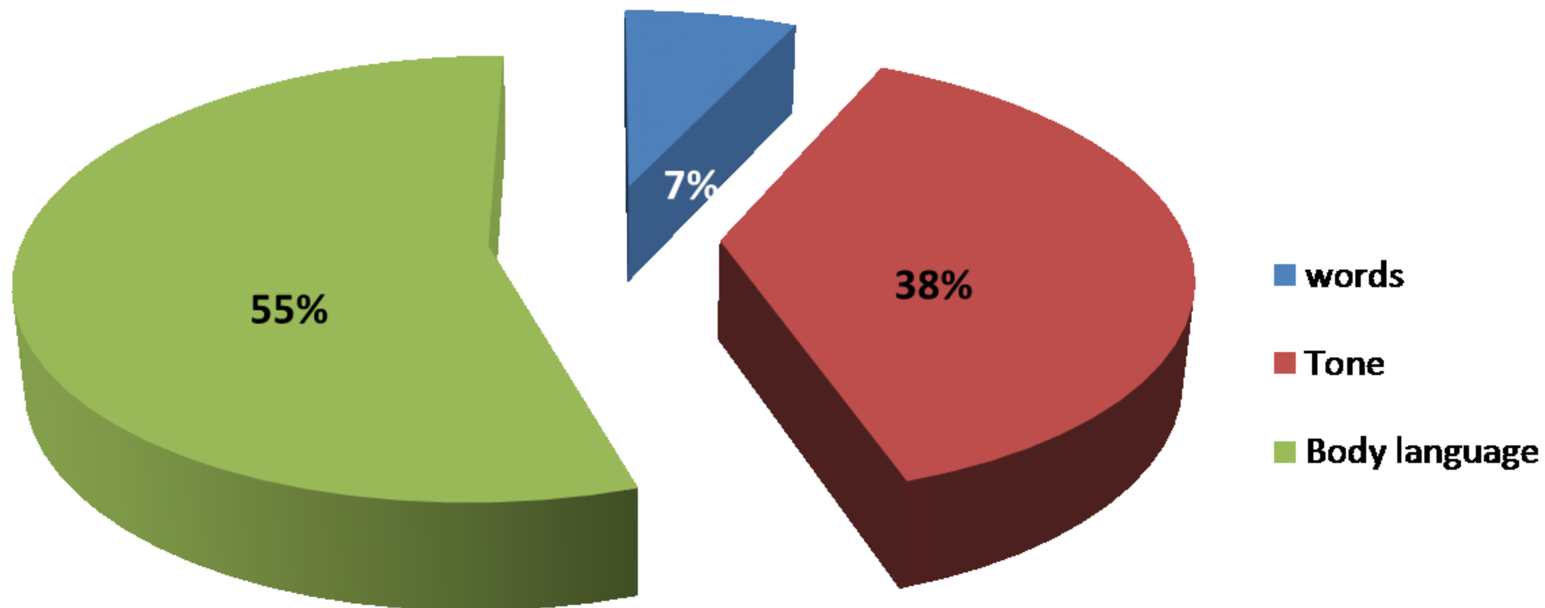
Communication – is more than words



- People with cognitive impairment can both respond and react to tone and body language
- They experience feelings, reactions and emotions no differently to any of us
- How we communicate can both escalate or deescalate distress

When a person is really distressed

- Calmness, reassurance and explanation – don't argue
- Limit people in the room – give them space/don't restrain
- Try to understand what they may be experiencing - fear
- Support the family to stay and provide them with education
- Familiar belongings or comfort objects
- Personally preferred music/radio/programs
- Accessible distraction resources
- One to one specialling - training important/security can escalate
- Antipsychotics last approach
  – start low go slow

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Distraction activities

- Can be very useful if the person is agitated
- Some examples are:
  - Handbags filled with different textured materials
  - Fiddle boxes with locks and latches
  - Fiddle rugs, cushions and aprons
  - Small clothes basket full of washing to fold
- Don't forget the calming benefits and therapeutic effects of personally preferred music

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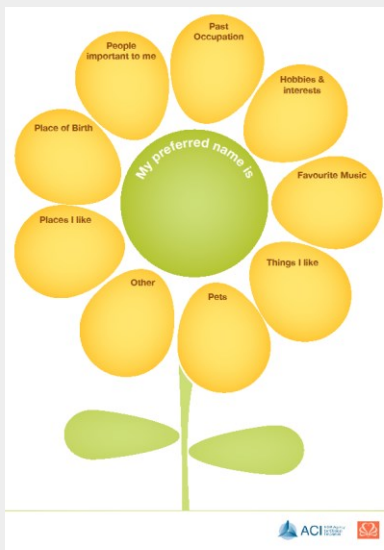
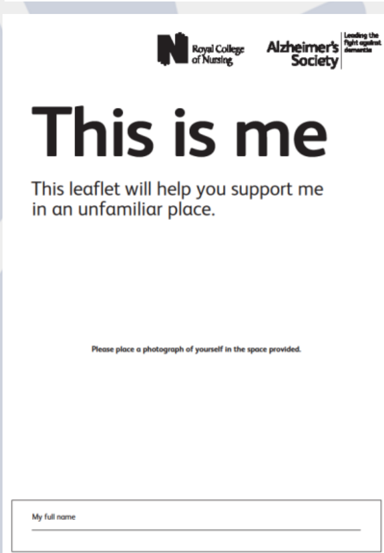
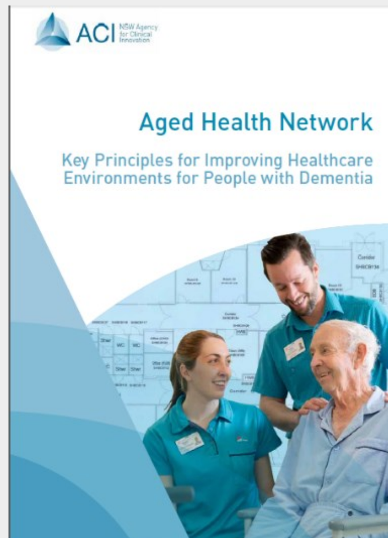
Some resources and programs that can assist to prevent or minimise distress



Dementia Care in Hospitals Program





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Leon Flicker

Professor of Geriatrics

Director of Western Australian Centre for Health and Ageing

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Dementia - ICD 10

- Syndrome due to disease of the brain
- Usually chronic and progressive - at least 6 months for a confident diagnosis
- Involves a decline in multiple higher cortical functions including memory.
- Should attempt to avoid false positive diagnoses, especially depression.
- Decline in intellectual functioning affecting personal activities.
- No clouding of consciousness (delirium)

Domains of Assessment

- Cognition
- Functioning
  - Activities of daily living
  - Instrumental Activities of Daily Living
- Informant information
  - Related to cognitive decline
  - Abnormal behaviour
- Carer Assessment
  - (Medical) Type of dementia & medical co-morbidities

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Delirium ICD 10/DSM 5

- Clouded state of consciousness
- Problems in sustaining attention
- Sensory misperceptions
- Disturbed thinking
- Hyper and hypo activity with disturbance in sleep wake cycle
- Onset is rapid
- Condition fluctuates

Delirium in Australian Hospitals: A Prospective Study

Current Gerontology and Geriatrics Research
Volume 2013, Article ID 284780, 8 pages

C. Travers,[1] G. J. Byrne,[2] N. A. Pachana,[3] K. Klein,[4] and L. Gray[5]

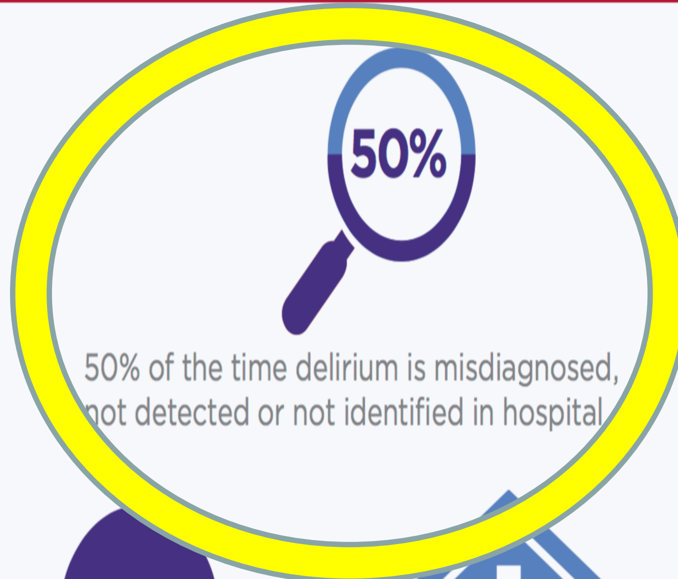
Method: A prospective observational study (n = 493) of patients aged ≥70 years admitted to four Australian hospitals (SE Queensland). Mean age 80 years. Diagnoses of dementia and delirium were established through case reviews by independent physicians.

Results: 102 (20.7%) were considered likely to have dementia. Overall, 9.7% of patients had delirium at admission and a further 7.6% developed delirium during the hospital stay. Dementia was the most important predictor of delirium at admission (OR = 3.18, 95% CI: 1.65–6.14) and during the admission (OR = 4.82; 95% CI: 2.19–10.62). Delirium at and during the admission predicted increased in-hospital mortality (ORs: 5.19 and 31.07)

Conclusion: These Australian data confirm that delirium is a common and serious condition among older hospital patients. Hospital clinicians should maintain a high index of suspicion for delirium in older patients.

Patients with delirium are at a greater risk of harm

Delirium is easier to prevent than to treat. 30-40% of cases are preventable

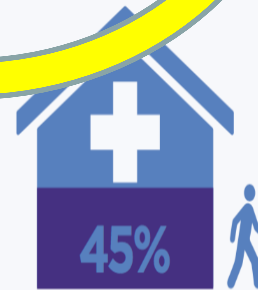


50% of the time delirium is misdiagnosed, not detected or not identified in hospital

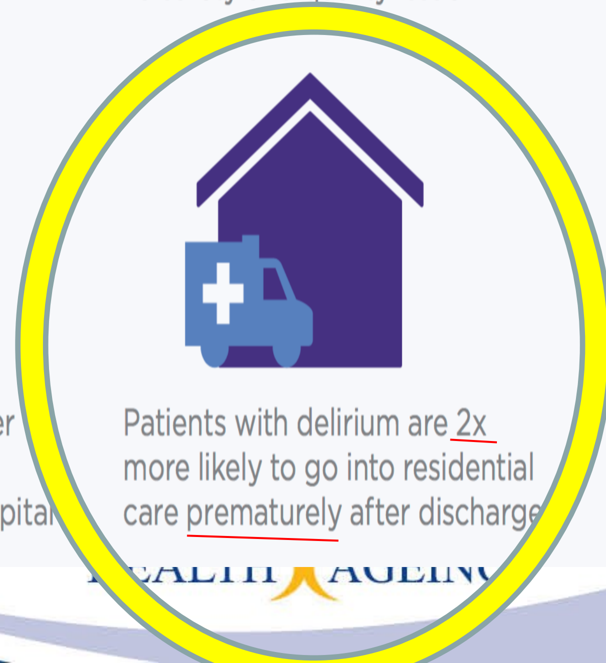
Not recognising delirium is a safety and quality issue

Patients with delirium have more falls, pressure injuries, functional decline and ongoing cognitive difficulties

Patients with delirium are more likely to die



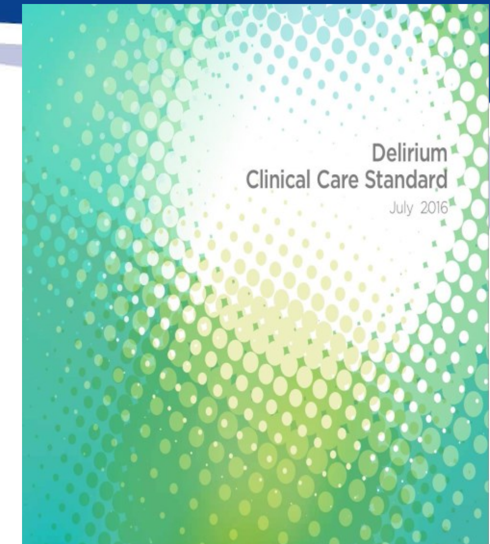
45% of delirium in older patients is unresolved on discharge from hospital



Patients with delirium are 2x more likely to go into residential care prematurely after discharge

Delirium Clinical Care Standard

- Released July 2016



The Delirium Clinical Care Standard

Describes the key steps for preventing delirium and improving the diagnosis and early treatment of patients with delirium.

Early screening

Assessing for delirium

Interventions to prevent delirium

Identifying and treating underlying causes

Preventing falls and pressure injuries

Minimising use of antipsychotic medicines

Transition from hospital care

QUESTIONS FOR THE PANEL

Summary

- Comprehensive assessment
- Effective communication
- Understanding the person
- Carers and family members involvement
- Quality care
- Supportive environment

Summary

- Non-pharmacological first
- Pharmacological treatment
  - Start low, go slow, shortest possible time
  - Document
  - Review
- Mental health services for older people
- Access to guidelines and local policy and procedures

Resources

Commission videos

- Dementia and Delirium in ED – a medical perspective
- Dementia and Delirium – providing a safe and supportive environment

Dementia Training Australia
- *A view from here* online

Clinical Practice Guidelines and Principles of Care for People with Dementia

Thank you

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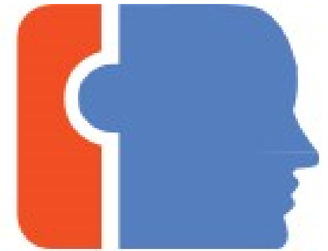

Join the campaign and make a difference

cognitivecare.gov.au #BetterWayToCare

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