Caring for Cognitive Impairment Campaign

Webinar No 4: Be alert to Delirium (repeat)

14 February 2017

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Overview

- Aim of today's webinar

  To highlight the importance of identifying and treating delirium and what we can do to prevent it in hospital.

- Background

- Delirium Clinical Care Standard

- Be alert to Delirium

  Presenter:
  A/Professor Gideon Caplan, Geriatrician
  President, Australasian Delirium Association

- Question time. Type them as we go into the Questions pane of the control panel.

- Summary and resources

CARING FOR COGNITIVE IMPAIRMENT

Cognitive Impairment

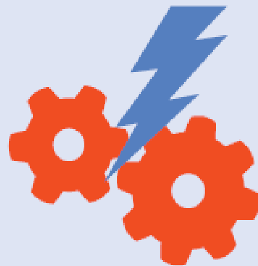
is an important safety and quality issue for all Australian hospitals

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

Cognitive Impairment Program

Main areas:

1. *A better way to care*

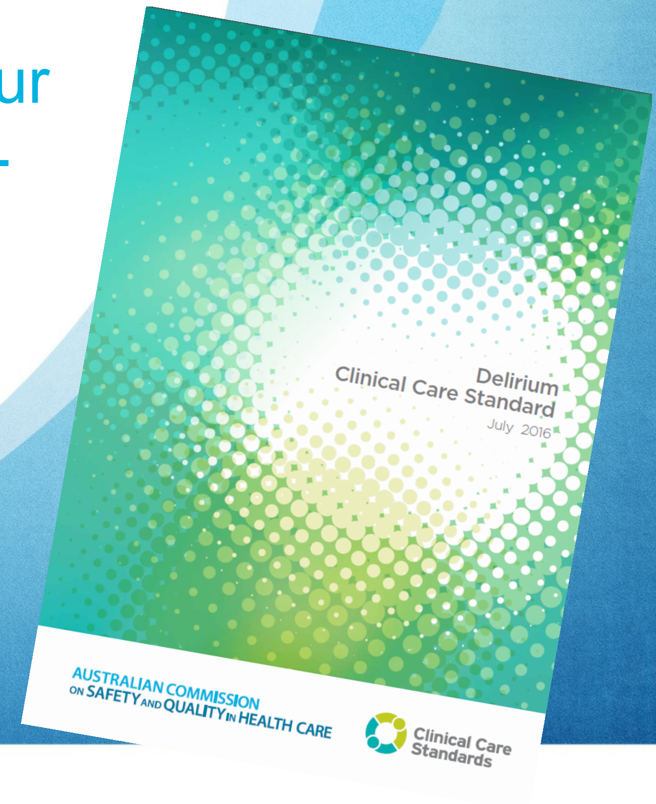
2. Delirium clinical care standard

3. National Safety and Quality Health Service Standards

4. Caring for Cognitive Impairment campaign

Delirium Clinical Care Standard

https://www.safetyandquality.gov.au/our-work/clinical-care-standards/delirium-clinical-care-standard/



Goals

- to improve the prevention of delirium in patients at risk
- to improve the early diagnosis and treatment of patients with delirium, so as to reduce the severity and duration of delirium.

Delirium Clinical Care Standard

1. Early screening
2. Assessing for delirium
3. Interventions to prevent delirium
4. Identifying and treating underlying causes
5. Preventing falls and pressure injuries
6. Minimising use of antipsychotic medicines
7. Transition from hospital care

1. Early screening

A patient presenting to hospital with one or more key risk factors for delirium receives cognitive screening using a validated test.

In addition, the patient and their carer are asked about any recent changes (within hours or days) in the patient's behaviour or thinking.

2. Assessing for delirium

A patient with cognitive impairment on presentation to hospital, or who has an acute change in behaviour or cognitive function during a hospital stay, is promptly assessed for delirium by a clinician trained and competent in delirium diagnosis and in the use of a validated diagnostic tool.

The patient and their carer are asked about any recent changes in the patient's behaviour or thinking. The patient's diagnosis is discussed with them and is documented.

3. Interventions to prevent delirium

A patient at risk of delirium is offered a set of interventions to prevent delirium and regular monitoring for changes in behaviour, cognition and physical condition.

4. Identifying and treating underlying causes

A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment.

5. Preventing falls and pressure injuries

A patient with delirium receives care based on their risk of falls and pressure injuries.

6.Minimising use of antipsychotic medicines

Treatment with an antipsychotic medicine is only considered if a patient with delirium is distressed and the cause of their distress cannot be addressed and non-drug strategies have failed to ease their symptoms.

7. Transition from hospital care

Before a patient with current or resolved delirium leaves hospital, the patient and their carer are involved in the development of an individualised care plan and are provided with information about delirium.

The plan is developed collaboratively with the patient's general practitioner and describes the ongoing care that the patient will require after they leave hospital. It includes a summary of any changes in medicines, strategies to help reduce the risk of delirium and prevent complications from it, and any other ongoing treatments.

This plan is provided to the patient and their carer before discharge, and to their general practitioner and other ongoing clinical providers within 48 hours of discharge.

Professor Gideon Caplan

Be alert to Delirium

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

Delirium 101

A/Prof Gideon Caplan
Director, Geriatric Medicine
Prince of Wales Hospital
President, Australasian Delirium Association

Content

- What it is?
- Why is it important to be alert to delirium and long term consequences,
- When? It’s risks + how to diagnose,
- How we can prevent it?
- Whose business is it?

What is delirium?

- Most common side effect affecting older people in hospital
- Acute confusion (acute brain injury/ acute exacerbation of dementia)
- Often mistaken for dementia
- Frightening for patient and their carers
- Underlying pathophysiology poorly understood

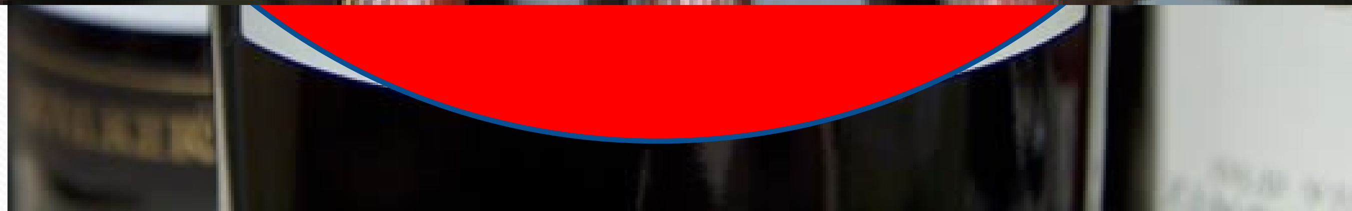
Symptoms and signs

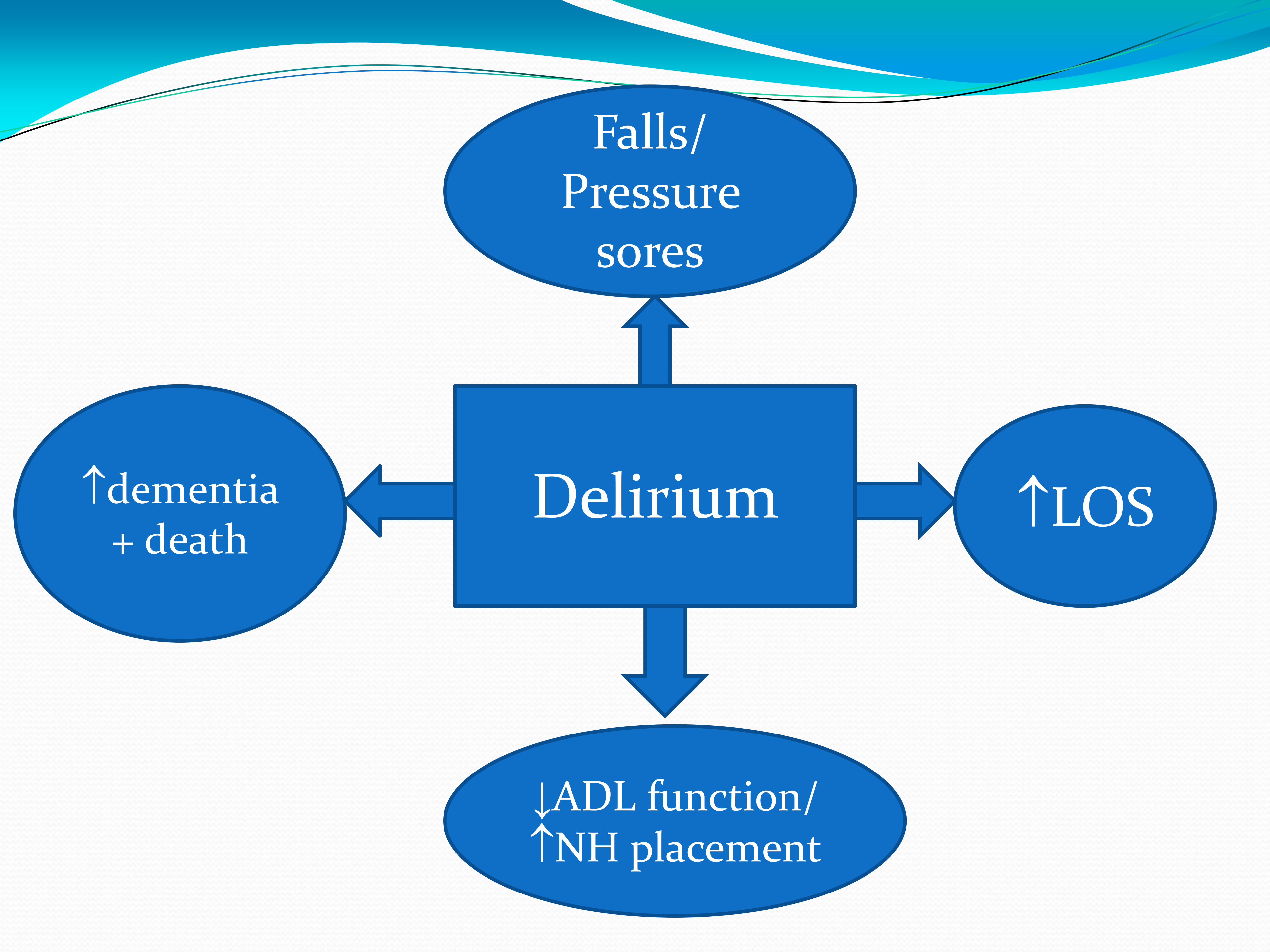
Caplan G. *Australian Prescriber* 2011; 34(1): 16-18.

- Syndrome of acutely altered
  - Alertness (level of consciousness)
  - Attention
  - Cognitive function
  - Perception
- Hyperactive/hypoactive/mixed
- Underlying medical/surgical issue

Why is delirium important?

- Delirium is the “lynchpin”

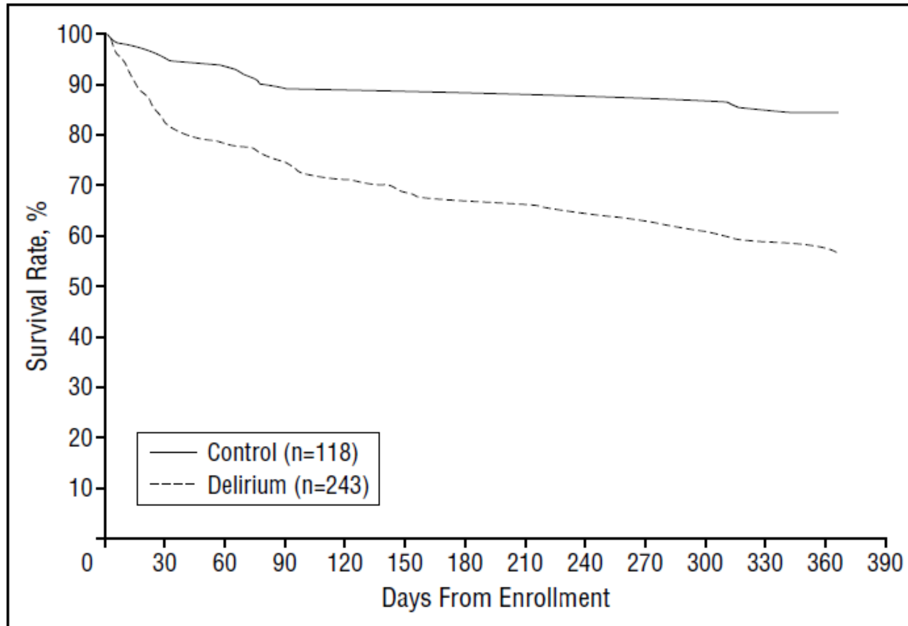



Falls/ Pressure sores
↑dementia + death
Delirium
↑LOS
↓ADL function/ ↑NH placement

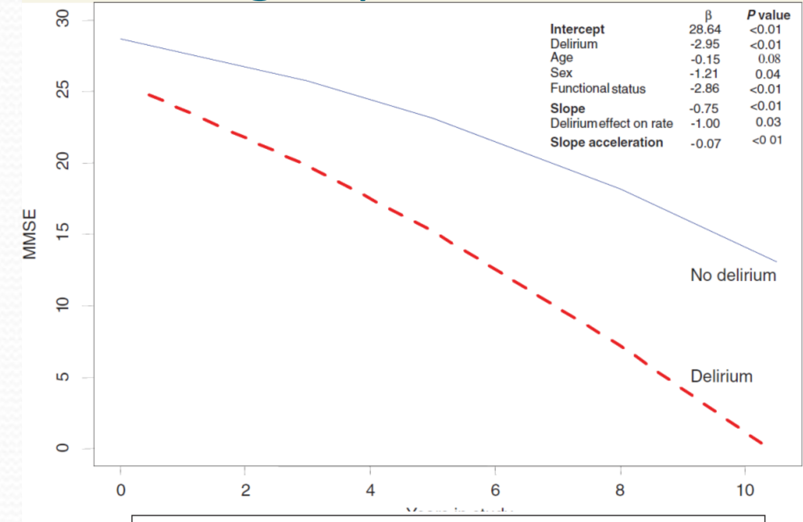
Outcomes

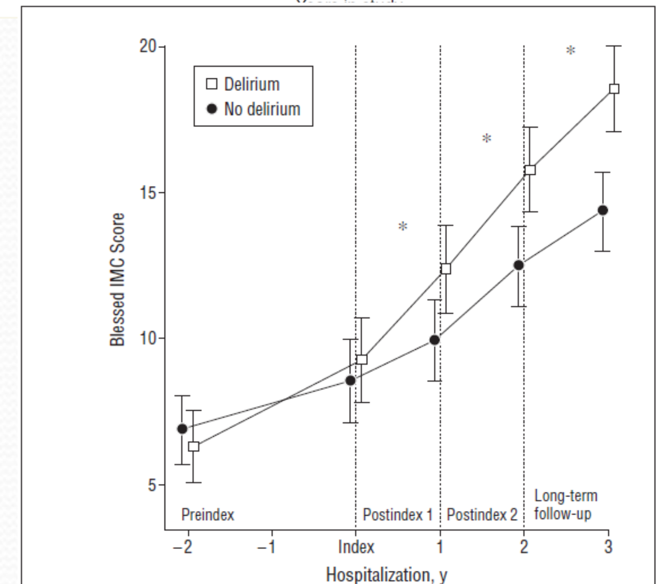
McCusker J. Arch Int Med 2002; 162:457-63.
Davis DHJ. Brain 2012; 135: 2809-16.
Gross AL. Arch Int Med 2012 172: 1324.

Mortality



Cog impair + dementia





Nursing home placement

Author	Journal	Patients	NH placement Delirium v not
O'Keefe S Ireland	JAGS 1997; 45: 174-8	Acute Geriatrics	36% v 13% $p<0.001$
Givens JL USA	JAGS 2009; 57: 1347-1353	Gen Med	46.2% v 26.1%
Vazquez FJ Argentina	Medicina (Buenos Aires) 2010; 70: 8-14	Int Medicine >70	27.5% v 7.9%
Uthamalingam USA	Am J Cardiol 2011; 108: 402-8	CCF	42.5% v 20.4%
Turco R Italy	J Geriatric Psychiatry + Neurology 2013; 26(2): 63-8	CVA	44.8% v 13.6% $p<0.005$
Miu DKY Hong Kong	Geriatrics & Gerontology International 2013; 13: 123-9	CVA	43% v 9.6%, $p<0.001$
Raats JW Netherlands	International J Surgery 2015; 18: 216-9	Colorectal surgery	13% v 1%, $p=0.002$
Basic D. Australia	Clinical Interventions In Aging. 2015; 10: 1637-43	Geriatric Med	13.01% v 9.04%

Home care after delirium

Author	Journal	Patients	Home care use post D/C Delirium v not
Rakhonen T	Intl Psychogeriatrics 2001; 13: 37-49	Ac Geriatrics	35% v 18%
Bellelli G	Arch Int Med 2008; 168: 1717-8	Ac Geriatrics	26.2% v 13.6% $p < 0.002$

So, delirium is bad!
That’s pretty straightforward…

When? Delirium risk factors

Delirium risk factors

Inouye SK. *JAMA* 1996; 275: 852–57.

- Predisposing factors (Vulnerability of patient)
  - Dementia/cognitive impairment/other brain disease (eg CVA)
  - Previous delirium
  - Frailty/ functional impairment
  - Older age
  - Multiple medical conditions, dehydration
  - Polypharmacy
  - Sensory deprivation: poor vision or hearing
  - ETOH abuse

Delirium risk factors

- Precipitating factors (insults)
  - Drugs, esp psychoactive meds
  - Physical restraints
  - Bladder catheter
  - Biochemical Δs, AKI, hypo or hyper-Na, BSL, K, pH
  - Infection
  - Surgery/anaesthetic esp CABG
  - Trauma, esp #NOF
  - Emergency admission
  - Coma

How to diagnose?

- Delirium much more common in hospital
- Screening: On and during admission
- Ask the carer: (SQID) Is this person different from usual?
  Screening tools: AT4, RADAR
- Diagnostic tool: CAM

4AT

www.the4AT.com

Bellelli G. Age and Ageing 2014; 43: 496

Assessment test for delirium & cognitive impairm

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December."
To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores <7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

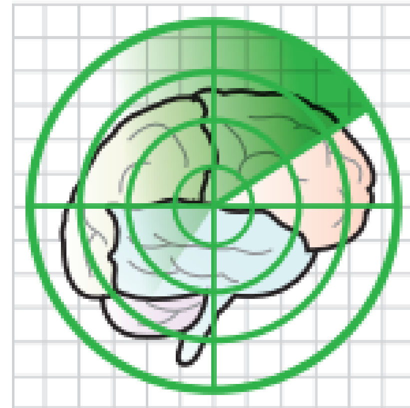
Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	**0**
Yes	**4**

R.A.D.A.R.

Recognizing Acute Delirium As part of your Routine
© Philippe Voyer

www.fsi.ulaval.ca/radar



Voyer P. BMC Nursing 2015; 14:19

The 7 second screener to be done on drug rounds

1. Was the patient drowsy?
2. Did the patient have trouble following your instructions
3. Were the patient's movements slowed down?

Confusion Assessment Method

Inouye SK. Ann Int Med 1990;113:941-8.

1. Acute change in mental status from the patient's baseline?
2. A. Difficulty focusing attention?, eg, easily distractible, or having difficulty keeping what was being said?
   B. Did this behaviour fluctuate during the interview?
3. Was thinking disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
4. Altered level of consciousness?

Prevention of delirium

Inouye SK. *N Engl J Med* 1999; 340: 669–76.
Marcantonio ER. *J Am Ger Soc 2001; 49: 516-22.*
Caplan GA. *Aging Health* 2008; 4(1): 69-74.

- Decrease risk factors: prevent dehydration, reorientation, ensure vision/hearing optimised, minimise restraints + psychoactive drugs, sleep protocols (eg HELP)
- Multifactorial interventions to address medical/surgical issues: Geriatrician + MDT
- Hospital in the Home
- Meta-analysis shows that antipsychotics are not effective to prevent delirium

Whose business is it?

Caplan GA. Med J Australia 2016; 205(10): S12-15.

- Delirium can happen to anyone at any age from paediatrics up
- Therefore it is everyone's business
- BUT… it needs
  - Prevention
  - Systematic screening program
  - Diagnosis
  - Multidisciplinary treatment

What do we do at POW?

- When we started our ASET in 2002 we incorporated the AMTS (10 item) and CAM into the ASET assessment
- CHOPS program – rolled out education about CAM to a variety of wards

Australasian Delirium Association

www.delirium.org.au

Masterclass

Monday 23rd Oct 2017
Sydney

ANY QUESTIONS?

Summary

- Delirium is common in hospital
- Patients with delirium are at a greater risk of harm
- Delirium can have long-term consequences
- Delirium is preventable
- Delirium is an important safety and quality issue for all Australian hospitals

Resources

- ACSQHC – Delirium Clinical Care Standard
- ACSQHC – On My Mind:Delirium
- ACSQHC - *A better way to care*
- ACSQHC – Delirium infographic

Resources

- Delirium Awareness Video
- Patient Delirium Experience
- Australasian Delirium Association
- QUT - Learn about Delirium
- (US) Health Research & Educational Trust - Preventing Iatrogenic Delirium Change Package: 2016
- Hospital Elder Life Program (HELP) for Prevention of Delirium

Thank you

CARING FOR COGNITIVE IMPAIRMENT

Join the campaign and make a difference

cognitivecare.gov.au #BetterWayToCare

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