THINKdelirium

PREVENTING DELIRIUM AMONG OLDER PEOPLE IN OUR CARE

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

Canterbury District Health Board
Te Poari Hauora o Waitahi

Canterbury District Health Board
Te Poari Hauora ō Waitaha

THINKdelirium
PREVENTION PROJECT

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Available online:

This document is available on the THINKdelirium project site on the CDHB intranet.

Resources marked with a * in the text are also available through links on this site:

cdhbintranet/olderpersonshealthandrehab/THINKdelirium

The document is also available on the CDHB intranet by searching for

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THINK DELIRIUM:
PREVENTING DELIRIUM
AMONG OLDER PEOPLE
IN OUR CARE

INTRODUCTION: TIME TO THINK DELIRIUM PREVENTION

You probably know that delirium is common amongst older people in our care.

You probably know that it's not only unpleasant, it can also have serious consequences.

But did you know that 30-50% of delirium that occurs while people are in our care can be prevented?

We are often used to working in a curative model, the kind of health care that focuses on identifying and managing delirium once it has occurred. In the Think Delirium project we want to encourage people to also think about delirium prevention, and to help people before they suffer delirium and its negative impact on their lives.

IT'S SIMPLE BUT EFFECTIVE

A third or more of all the cases of delirium that start during a hospital stay could be prevented by introducing simple preventative protocols.[1] In 2015 a major review combined the results for 14 high quality studies involving over 4000 patients using simple multi-component interventions to reduce delirium. The interventions reduced the risk of developing delirium by a staggering 53%.[2] The components of these interventions seem so simple that people often assume that they must be being done already. But the key is consistency.[3]

The Think Delirium project was initiated to help overcome the "but aren't we doing that already" hurdle and help staff see ways that they could do more to help prevent delirium.

OUR APPROACH

An Appreciative Inquiry approach offered us a way to find out what is working well for staff, and then to explore how this could inform and inspire improvements in delirium prevention.[4] Using interviews and discussion groups, we encouraged staff to reflect on and share what was working well and then to build on this to identify changes themselves. In this booklet we share some of the tips and possibilities they shared, in the hope that they may inspire you too.

Delirium

Delirium is an acute disturbance of consciousness, attention, and cognition that tends to fluctuate during the course of the day.

Delirium is common in hospital

10% of patients aged 70 and over have delirium on admission to hospital

Up to 80% of patients aged 70 and over in intensive care have delirium

Patients with dementia are 6x more likely to develop delirium

Patients with delirium are at 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

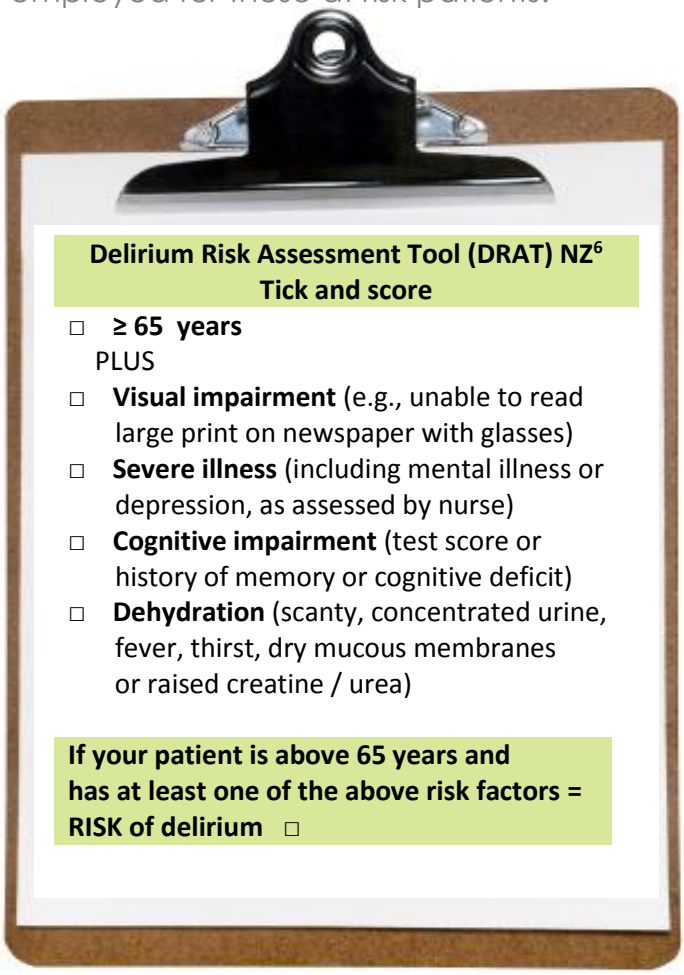
Patients with delirium are 2x more likely to go into residential care prematurely after discharge

We can improve hospital care of patients with delirium

WHO IS AT RISK AT ADMISSION?

Chances are that you encounter older people who are at risk for delirium in your role.

Some of the risk factors for delirium are characteristics the person already has when they are admitted to your care.[7] These characteristics make the person more vulnerable to delirium, so it will take less to 'tip them over' into a delirium. Extra care and specific delirium prevention strategies should be employed for these at risk patients.



Delirium Risk Assessment Tool (DRAT) NZ[6]
Tick and score

- □ **≥ 65 years**

PLUS

- □ **Visual impairment** (e.g., unable to read large print on newspaper with glasses)
- □ **Severe illness** (including mental illness or depression, as assessed by nurse)
- □ **Cognitive impairment** (test score or history of memory or cognitive deficit)
- □ **Dehydration** (scanty, concentrated urine, fever, thirst, dry mucous membranes or raised creatine / urea)

If your patient is above 65 years and has at least one of the above risk factors = RISK of delirium □

PREVENTABLE RISKS

Anything that can be done to reduce a cause or risk factor for delirium could help prevent delirium.

The focus for us to reduce delirium is to target the triggers that can occur during the episode of care. There is now considerable consensus about these preventable risks which has helped guide effective prevention protocols. We use a simple mnemonic to summarise these risk factors: PINCHES ME Kindly

DID YOU KNOW?

Up to 50% of delirium affecting older people in hospital develops after admission (incident delirium). These are the cases that we can often prevent by better care. It has been suggested that incident delirium is an indicator of how well we are looking after older people.[6]

THINK DELIRIUM PREVENTION & MANAGEMENT

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No pain, lots of gain

Suspect it, spot it, stop it

Remember fluid, fibre, and footwork

Don't wait, hydrate

Make the move to prevent delirium

Don't get delirious, sleep is serious

Don't prescribe delirium

Be **HOUSE** proud
Help
Orientate,
Use
Sensory aids,
Engage

Kindly
Be calm, patient and mindful of emotional needs

One third to one half of delirium that occurs while older people are in our care can be prevented by addressing these risk factors

Think
PINCHES ME
kindly

P
PAIN

No pain – lots of gain

Assess for pain.

Look for non-verbal signs of pain, particularly in people with communication difficulties.

Start and review appropriate pain management in any person in whom pain is identified or suspected.[7]

TIPS & POSSIBILITIES

Prevent

- Change people's position in bed.
- Keep people mobilising to help prevent stiffness. Encourage variety – sitting, walking, moving, leg exercises etc.
- Be aware of pace and activity level when helping people - go slow and use aids.
- Provide pain relief medication early and regularly. Think ahead, for example before occupational therapy sessions.

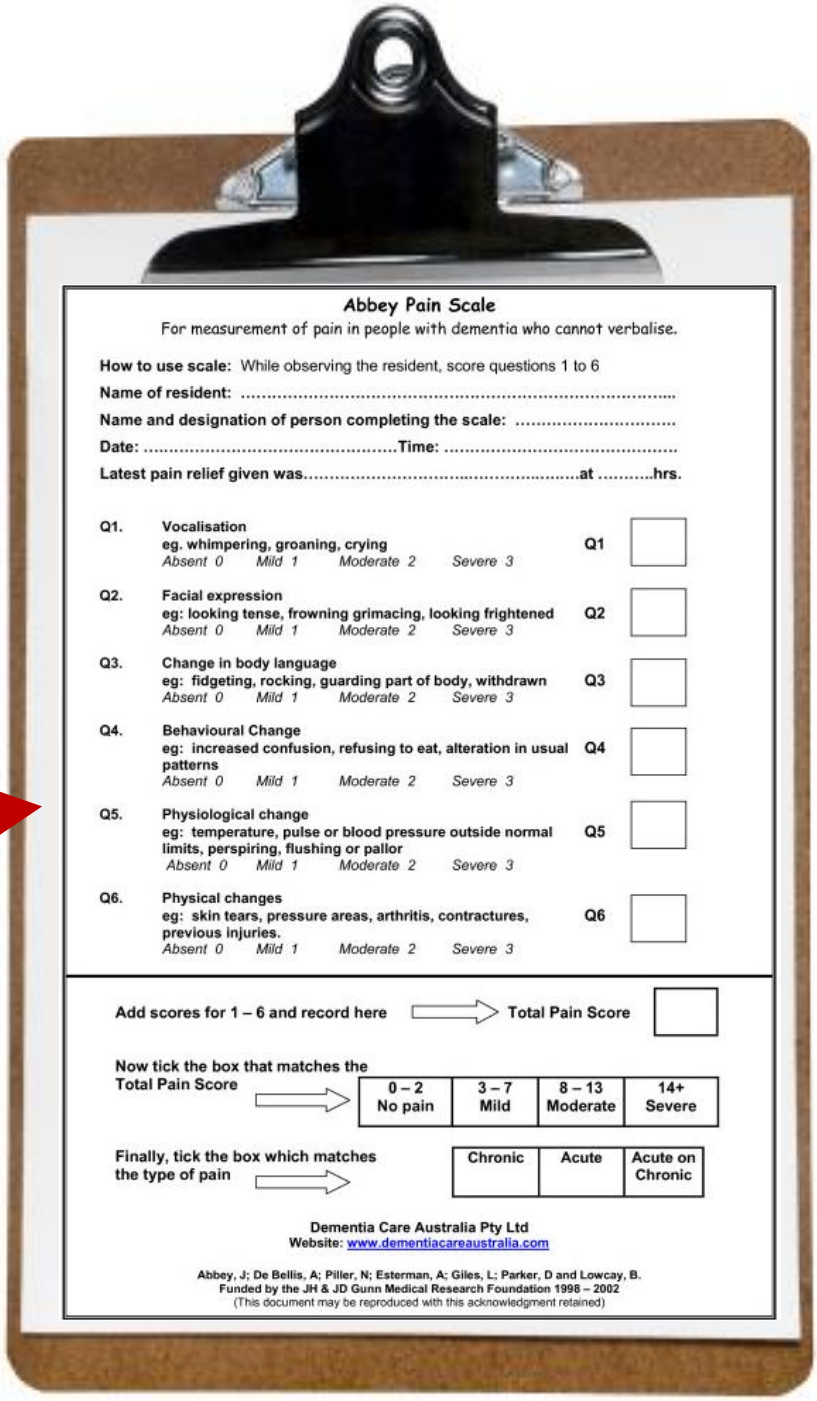
Identify

- Don't wait for people to complain or request pain relief.
- For people who are able to communicate verbally:
  - Always ask.
  - Take your time and 'have a conversation'.
  - Using a variety of words (e.g, sore, nuisance, uncomfortable).
- Assess thoroughly (e.g., investigate falls or injuries, known problems that may cause pain, new pains etc).[8]

"Relieve pain early as a starting point because it has flow-on effects -to mobility, sleep, eating, drinking, constipation" . . . Staff member

- Keep an eye out for nonverbal cues such as facial expression and body language (rubbing leg, holding stomach, rocking, flinching).
- Pain may also be communicated through behaviours such as restlessness and agitation or refusing support with personal care.
- Consider using an assessment scale to help document and communicate between staff.

For people with dementia who can't verbalise, use the Abbey Pain Scale*



Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6

Name of resident: .....

Name and designation of person completing the scale: .....

Date: .....**Time:** .....

Latest pain relief given was.....at .....hrs.

Q1.	**Vocalisation** **eg. whimpering, groaning, crying** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q1	
Q2.	**Facial expression** **eg: looking tense, frowning grimacing, looking frightened** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q2	
Q3.	**Change in body language** **eg: fidgeting, rocking, guarding part of body, withdrawn** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q3	
Q4.	**Behavioural Change** **eg: increased confusion, refusing to eat, alteration in usual patterns** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q4	
Q5.	**Physiological change** **eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q5	
Q6.	**Physical changes** **eg: skin tears, pressure areas, arthritis, contractures, previous injuries.** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q6	

Add scores for 1 – 6 and record here ⇨ **Total Pain Score**

Now tick the box that matches the Total Pain Score ⇨

0 – 2 No pain	3 – 7 Mild	8 – 13 Moderate	14+ Severe

Finally, tick the box which matches the type of pain ⇨

Chronic	Acute	Acute on Chronic

Dementia Care Australia Pty Ltd
Website: www.dementiacareaustralia.com

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002
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- Watch for patterns (e.g. after food, when walking) to help investigate causes and plan how to help.

DID YOU KNOW?

Improved pain management dramatically reduced delirium after surgery for older patients in a randomised controlled trial (from 18% to 2%).[9]

Manage

- Provide pain medication promptly and early
  - Discuss preferences and concerns such as swallowing, addiction, or seeing as using analgesia as a weakness
  - Have a sliding scale of medications
  - Monitor and review
  - Check for side effects.
- Assist people to be as comfortable as possible, e.g., reposition in bed, warm wheat or ice packs.
- Help people to relax, e.g., offering relaxation or breathing techniques, or distraction.
- Provide aids to help with ADLs., e.g., mobility frame, raised toilet seats.
- Remember the wider team resources such as the pharmacist and pain service.

In INFECTION

Suspect it, spot it, stop it.

Look for and treat infection.

Avoid unnecessary catheterisation

Follow infection control guidelines[7]

Manage aspiration risk[10]

TIPS & POSSIBILITIES

Prevent

- Educate the older person and their family about risk factors and prevention.
- Ensure hygiene – basic hand washing, personal cares, protocols for catheters.
- Encourage regular mobilising.
- To help prevent UTIs, minimise the use of catheters, mobilise, and encourage fluids. Suggest quality cranberry juice or capsules (but not if they have kidney stones).
- To help prevent aspiration pneumonia, assess risk (e.g. swallowing problems), tilt bed for meals, and provide regular oral care.[10]

Identify

- Be aware of past history and risks (e.g., diabetes, incontinence, kidney stones etc for UTIs).
- Be proactive and check often for
  - Skin and urine issues. ADLs can be an opportunity for this.
  - Pain or discomfort.
  - Confusion or behaviour changes.
  - Fever or pneumonia.
- Follow-up any signs with tests.
- Check for MSU.

Manage

- Use antibiotics for UTI if test results positive AND the person has symptoms.
- Follow-up if symptoms persist after the course of antibiotics.
- Keep hydrating and mobilizing.

DID YOU KNOW?

Half of infections acquired in hospital by older people are either urinary tract infections or aspiration pneumonias.[10]

Infections are a leading cause of delirium for older people. [11]

Indwelling catheters are a major risk factor for UTI and are implicated in 40–75 per cent of all hospital-acquired UTIs.[12]

NC
NUTRITION & CONSTIPATION

Fluids, fibre & footwork!

Ensure adequate nutritional intake.

If person has dentures, make sure they fit properly.

Encourage fluids, fibre, mobility, and regular toileting.

Provide laxatives if required.[7]

Constipation TIPS & POSSIBILITIES

Identify

- Monitor and act if people haven't had a bowel movement for several days or have hard stools. Use bowel chart C280030*.
- Check for other symptoms (e.g., tummy or back ache, feeling bloated or unwell, off their food).
- Consider constipation as a cause of Irritability or agitation.
- Arrange physical examination if required.

Prevent / Manage

- Encourage fibre in diets, offer kiwi crush.
- Emphasise hydration.
- Promote mobilisation.
- Ensure regular toileting.
- Allow privacy and time to use the toilet or commode.
- Treat with laxatives if needed.
- Prescribe laxatives with constipating medications, especially opiates.
- Monitor and provide other treatments if required.
- Educate patient and family.

Nutrition TIPS & POSSIBILITIES

Identify

- How much is the person eating?
- Is the person losing weight?
- Observe and check with family.
- Consider using the food and fluid balance chart C280046*, and weighing regularly.
- Be aware of coughing during eating as this may indicate swallowing problems.
- Check for mouth sores.

Prevent / manage

- Find out about individual preferences –likes and dislikes, routines, whether finger food is easier.
- Have normal food to offer e.g. have a toaster and kettle, and ensure toast is warm.
- Suggest to family that they bring in favourite foods.
- Identify someone to be responsible for knowing how much the person is eating and to help them eat meals if needed, this could be staff or family. Don't just allow meals to be cleared.
- Providing companionship while someone is eating can encourage eating – suggest family visit at meals, have staff sit and chat at food times, provide breakfast / afternoon tea / lunch clubs, snack tasting afternoons.
- Encourage people to sit up in a chair for meals.
- Don't rush taking plates away, as people may rest.
- Be flexible with dining times, and reheat cold food.
- Fit in with the person, for example 'Walk and graze' with a person who finds it hard to sit still at a table.
- Try to make the food easy to see and eat – serve it in contrasting plates with the lids off.
- Having food constantly available and visible can help trigger eating for people with dementia.
- Consider eating neighbours who may 'put people off their food" (messy eaters, coughing, taking dentures out).
  - Clean people's dentures before eating.
  - Talk through worries about continence to ensure that they do not limit fluids.

"On our ward everyone has a bowel chart and bowel movements are recorded on every shift, which is good because we can quickly gain an understanding of the person's pattern". –Staff member

H

HYDRATION

Don't wait, hydrate!

Encourage the person to drink.

Consider parenteral fluids if necessary.

Seek advice about fluid balance in individuals with comorbidities (e.g., heart failure or renal disease).[7]

TIPS & POSSIBILITIES

Prevent / manage

- Ensure that people can and do drink. Encourage fluids unless contraindicated.
- Provide help if needed and extra prompts for people with cognitive impairment.
- Know people's preferences for what they like to drink. Regularly offer fluid and have a variety of fresh drinks, cold water, and other fluid options (e.g. ice cream, soup) available, and place fluids within easy reach.
- Encourage frequent small sips if a cup is too much. The whole team can be involved.
- Remind people to drink after each trip to the bathroom.
- Make it social. Involve family.
- Educate about the importance of good hydration.
- Explore whether the person is limiting fluids to reduce accidents or trips to the bathroom, and resolve issue.

Identify [8,13]

- Aim for 1.5 litres a day (more for heavier people) unless there are special considerations for fluid balance.
- Assess / monitor how much they are drinking and their urine output.
- Check risk factors such as swallowing difficulty, lack of thirst cues, cognitive impairment, physical limitations, or diuretics.
- Check for dehydration symptoms, e.g., head ache, postural hypotension, irritability or lethargy, weight loss, little or dark urine, poor skin elasticity, or urea / creatine.
- Signal people who require extra support e.g., by putting a red tray under their jug.

Did you know?

As people age the amount of water in the body, renal function, and the perception of being thirsty all change, increasing the risk of dehydration. Educating older people not to trust their thirst but to drink to stay healthy has been shown to increase the amount that they drink.[13]

E

EXERCISE / MOBILITY

Make the move to prevent delirium

Mobilise early and regularly.
Ensure walking aids are accessible.
Encourage range of motion exercises.

Did you know?

Delirium and falls have many of the same risk factors. Multi-component delirium prevention packages also substantially reduce falls, without restricting mobility. A recent review found delirium prevention strategies reduced the odds of having a fall by 60%.[2]

TIPS & POSSIBILITIES

- Assess everyone for early mobilisation. Monitor whether people do mobilise, not just whether they can.
- Take a restorative approach and encourage mobility and independence, including getting up for activities and meals.
- Offer appropriate aids and pain relief.
- Raise awareness with staff, patients, and family about the benefits of mobility. Set expectations – older people and family may expect that patients have to rest in bed. Encourage family visitors to move during visits, not just sit. Clarify who can move independently and who needs to be supervised, and educate family members to help mobilise if needed.

S
SLEEP

Don't get delirious – sleep is serious

Avoid medical and nursing procedures during sleep if possible.

Schedule medications to avoid disturbing sleep.

Reduce noise during sleep periods.[7]

"It's crucial to allow the patient's normal night time routine – what helps get them comfortable: staying up in bed reading a while, or having a warm drink"... Staff member

TIPS & POSSIBILITIES

- Increase sleep hygiene and promote good sleep and a normal sleeping pattern.
- During the day, ensure that it is obviously daytime through lighting and open curtains.
- Provide advice about daytime napping where appropriate. Be flexible about where people nap, e.g., in chair.
- Encourage typical bedtime routines.
- Provide options to help to sooth and relax people at bed time such warm drinks, back rubs, or music through headphones.
- Attend to toileting needs and pain.
- Provide reassurance for the night that the individual is safe and looked after, and that they can use their button if they need assistance and someone will come promptly.
- Be positive: "you look cosy"," have a good night", "rest is as good as sleep."
- Have it darker at night, close the curtains.
- Minimise night time noises, for example quiet trollies, whispering.
- Offer earplugs.
- Separate snorers from other sleepers.

M
MEDICATION

DON'T PRESCRIBE DELIRIUM

Carry out a medication review for people taking multiple drugs, taking into account both the type and number of medications.

TIPS & POSSIBILITIES

- Do a medication reconciliation and review.
- Be aware of all the medications that the person uses as home, including over the counter and herbal medications.
- Ensure medications are being used correctly.
- Ask about recent changes in medications.
- Involve the pharmacist to check for interactions.
- Reduce unnecessary medications, but be careful of withdrawal issues.
- Regularly review new medications to see if they are still needed, and document whether or not they work.
- Consider nonpharmacological options to reduce the use of new psychoactive medications, for example to help people sleep or keep calm.
- Take care with pain medications that can cause delirium.

Did you know?

Medications are one of the most common triggers for delirium amongst older people in hospital, and many drugs can increase the risk of delirium.[14] Adding three new medications while in hospital increases the risk of delirium threefold for older people.[15]

E
ENVIRONMENT

Be HOUSE proud
Help
Orientate,
Use
Sensory aids,
Engage.

Provide lighting, signs, calendars, clocks.

Re-orientate individual to time, place, person, your role.

Resolve reversible sensory impairment.

Ensure working hearing and visual aids are available and used.

Introduce cognitively stimulating activities.

Facilitate regular visits from family and friends.

STAFF LIKE...

Windows

A safe outdoor / garden space

A communal lounge to facilitate interaction between patients

Kitchen space to make a cuppa

A sensory room

Space where family and friends can stay

An area for groups and a quiet area

Shelving for personal items

... USE IF YOU CAN

TIPS & POSSIBILITIES

Help Orientate

- Provide suitable clocks, calendar, and an orientation board with staff names.
- Encourage personal items like photos and pictures.
- Aim for a low stress environment e.g., clutter free, natural light, familiar furniture, homely, calming colours, individual music and TV choice / devices.
- Avoid dark mats as they can look like holes.
- Use big room labels and other visual cues.
- Enable easy access to personal items to help people re-orientate and keep active.
- Try to ensure continuity of nursing and other staff.
- Drop in orientating information into conversations.
- Keep personal routines as normal as possible.
- Minimise room and ward changes. Understand the disorientating impact of changing environment. Ensure good handovers and transfer of care with all staff having consistent goals and knowledge about the person.

Use Sensory aids

Clean glasses and check that hearing aids are working and in use. Offer adaptive equipment (e.g., hearing wand, magnifying lens, large print etc).

Engage

Encourage and enable a range of meaningful activities that appeal to the individual, for example

- music
- games, puzzles
- walking
- occupational, functional, self-care
- social, visits from family and friends, talking about current events and reminiscence
- newspapers, reading
- sensory
- visiting services such as pet therapy.

Did you know?

Activities that are personally interesting and at the right level of challenge engage people's attention. This may help maintain people's cognitive reserve capacity, particularly if they have a dementia, and may help prevent delirium (as well as improve well-being!).[16]

Kindly

Be calm, patient, and mindful of emotional needs

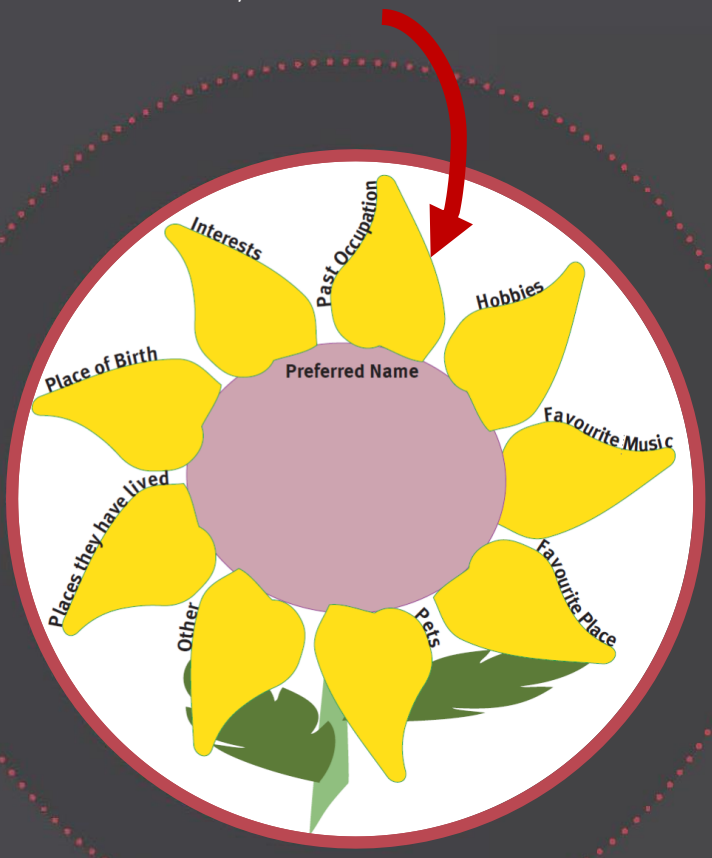
Care should take into account people's needs and preferences, and be culturally appropriate.

People should have the opportunity to make informed decisions.

Good communication is essential.

If the person agrees, families and carers should have the opportunity to be involved and given the information and support they need.

Fill in and display the sunflower chart*. Staff say that this can help start conversations and provide reassurance and a sense of belonging – "They know me", "I'm safe here".



TIPS & POSSIBILITIES

- Think 'what can we do to enhance well-being and meet needs?" rather than just keep people quiet.
- Know your patient. Have conversations. Ask questions.
- Engage with people and provide care in their own way. Let them participate in their own care.
- Be flexible – for example when ADLs occur.
- Try to engage at their pace.
- In some situations it may be possible to gather information before (or at) admission using a telephone questionnaire.

DID YOU KNOW?

An Australian 'Top 5" initiative for people with dementia asked hospital staff to

- Talk to the carer about the patient,
- Obtain information about their behaviour and preferences, and
- Personalise the care to support the patient's sense of self.
- 5 strategies were developed to assist keeping the patient calm, reassured and engaged.

This improved outcomes, length of stay, and satisfaction.[17]

INVOLVE FAMILIES

- Seek information from families and listen to them.
- Respect and utilise families and their experience and knowledge of the person.
- Give families the delirium prevention brochure (*236937). Help families to understand about delirium prevention and how they can help.
- Meet with families soon after admission. Ask about baseline functioning and personal routines, etc.

AIDES/ SITTERS CAN BE A HUGE RESOURCE

They can:

- provide stimulation and company,
- get to know the person and alert the team of changes,
- help re-orientate the person,
- ask about meal preferences, and involve the person in meal decision making,
- help with many of the prevention strategies.

Don't be a 'watcher' or a 'sitter' – be an Engager!

Our Vision

What staff want for a service that thinks delirium prevention.

Committed

- We are proactive about preventing delirium.
- The principles of PINCHES ME kindly are ingrained throughout our service.
- We encourage all professions to be responsible for prevention and assessment in a team approach.
- We have education for all on why assessing risk factors for delirium is so important.
- We have reminders and support resources.

Consistent

- We assess and address these risk factors consistently, comprehensively, and holistically.
- We discuss and assess pain with each client.
- Medication reconciliation is done on admission for all high risk patients.
- We have documentation resources available to accurately monitor delirium risk factors and cognitive status.
- We are confident in our assessment skills in a safe and supported environment.

Great care environment

- We provide individualized and person-centred care.
- We are a facility that understands patients' needs.
- We are actively engaged in making an environment that is calm, comfortable, and safe for our patients.
- We maximise independence and enable activities that are meaningful and individualised.
- We encourage whanau, family and friends to have a positive impact on patient's cognitive care.

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Resources marked with a * in the text are available on the CDHB intranet, including on the THINKdelirium project site cdhbintranet/olderpersonshealthandrehab/THINKdelirium

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Infection *agingcare.com, readersdigest.co.uk, gstatic.com, wisegeek.org, bardmedical.com*

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Hydration: *nursingtimes.net*

Exercise: *pixforweb.com, Duke Regional Hospital, allhawaiinews.com*

Sleep: *3age.com, medscape.com*

Medication: *thedementiaqueen.com, hsnewsbeat.washington.edu, paradigmcorp.com*

Environment: *threeriverswindowcompany.com, decadants.xyz, hellolidy.com, thayray.com, blog.emergingscholars.org, inhousedesignservices.com, encrypted-tbn1.gstatic.com, leememorial.org, whakatohea.co.nz, secondfamilyhc.com*

Kindly: *microsoft;* carenovatemag.com, fote.org.uk, heather young

Our Vision: *qualifiedseniorcare.com,clipartpanda.com*

Canterbury
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