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Dementia and Delirium & Falls.

outstanding care
listening and leading
working together

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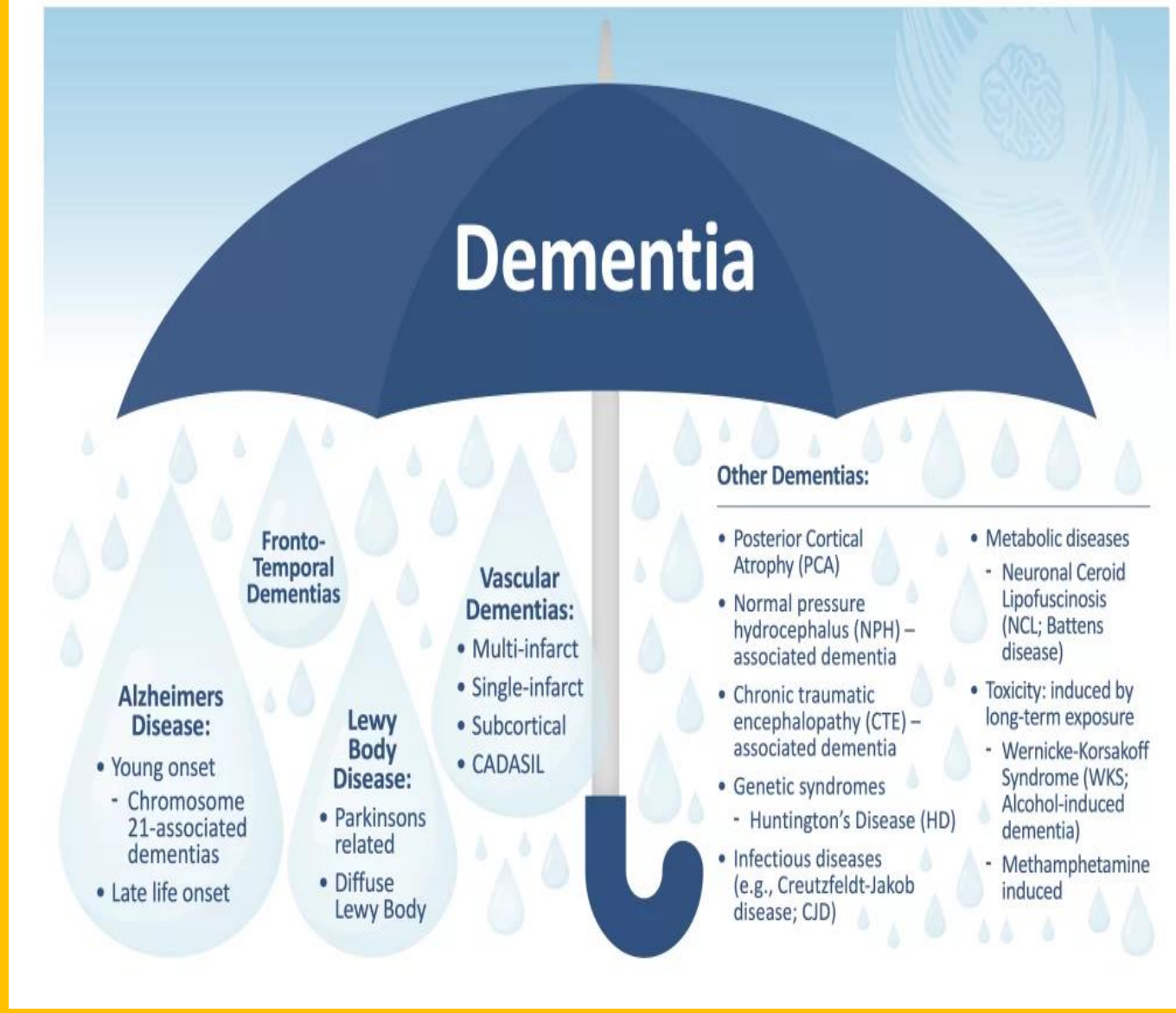
Dementia Team YDH/MPH

What is Dementia ?

- ***Dementia is an umbrella term for a range of progressive conditions that affect the brain.***



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3 stages

Three stages of dementia:

Mild, Moderate and Severe, this describes how much the symptoms affect a person

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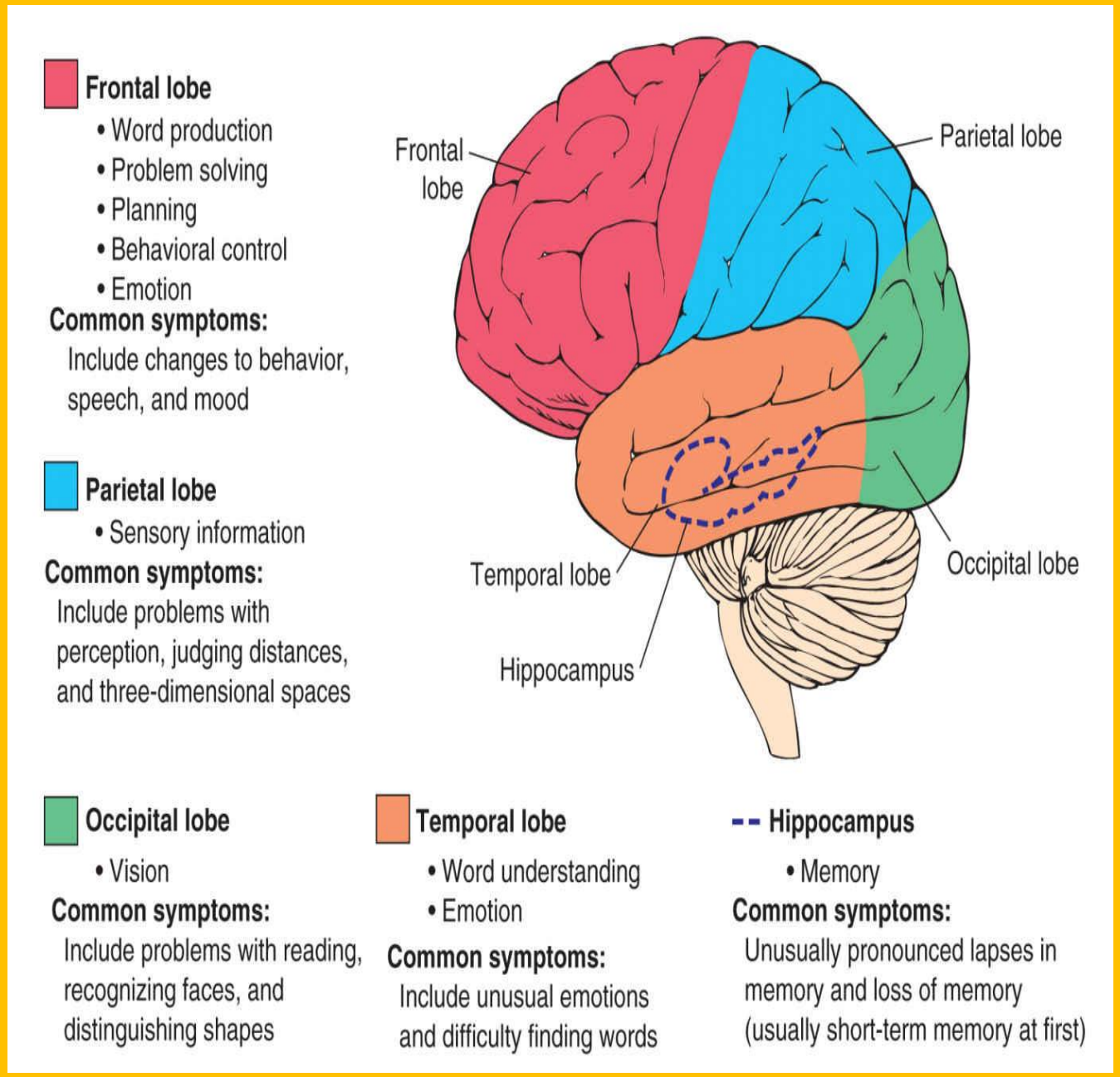
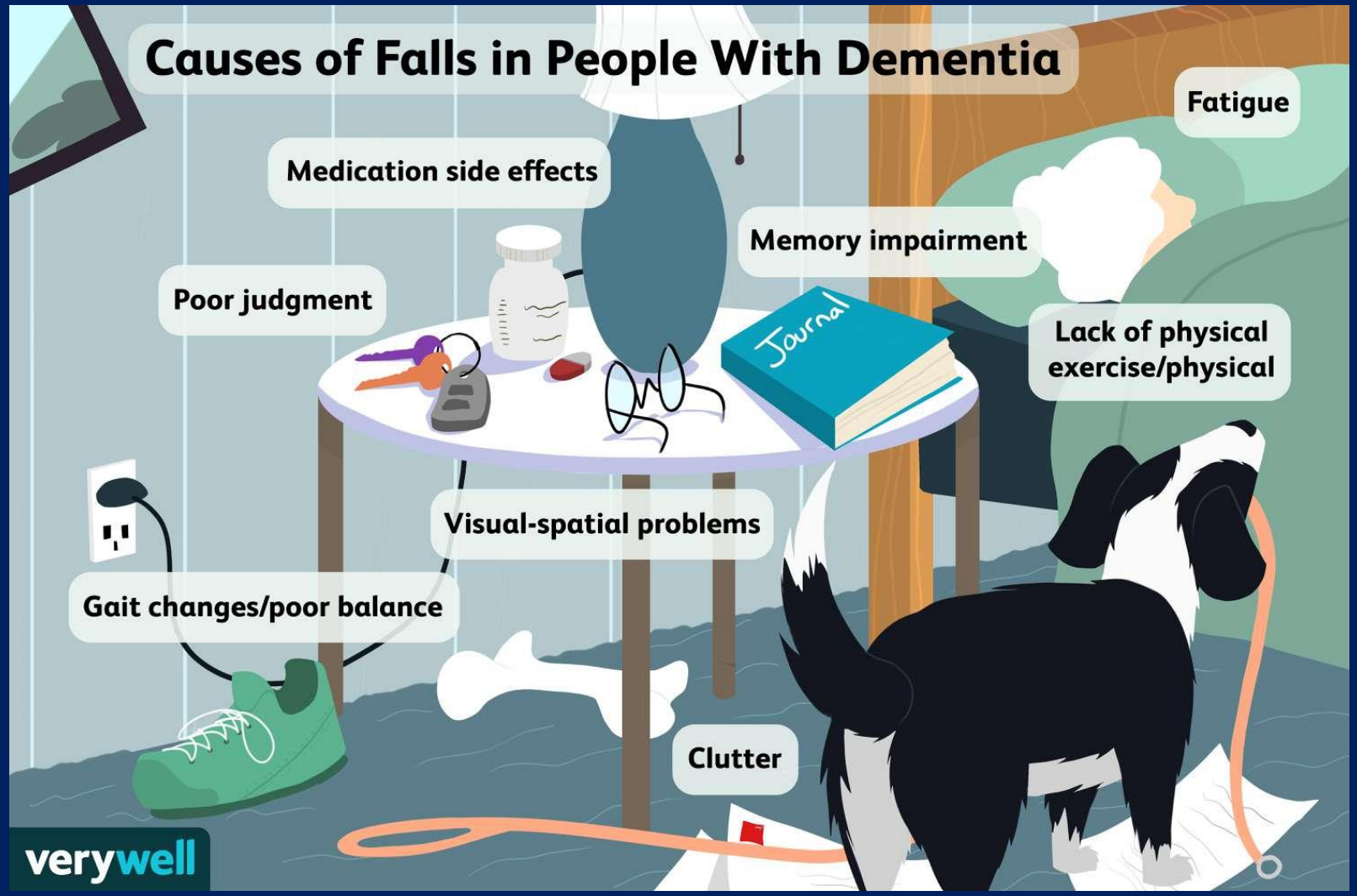
Common Symptoms

- Memory loss.
- Difficulty in thinking things through and planning.
- Problems with language.
- Being confused about the time or place.
- Visual perceptual and Sensory Information Difficulties
- Mood changes or difficulties controlling emotions.



Dementia and Falls:
Falls ARE NOT an inevitable part of living with dementia.

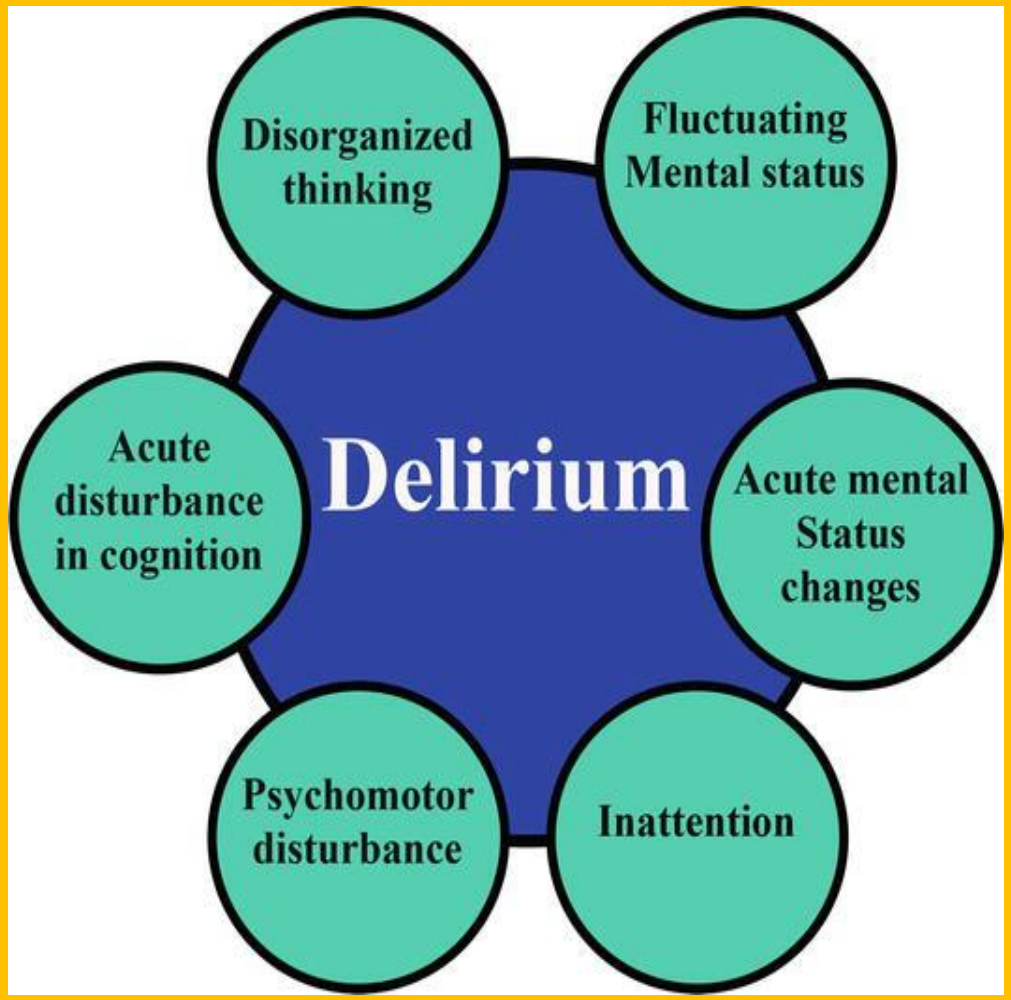
- Physical
- Cognition
- Vision
- Alertness
- Well-Being
- Unmet Needs



Delirium can cause Falls

Latin- ‘Delirare’

to be off track or to go wrong



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What is delirium?

- Delirium is a worsening or change in a person's mental state that happens suddenly, over a few hours or days.
- Acute confusional state characterized by disturbed consciousness, cognitive function or perception
- 'Acute Brain Failure'

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Delirium and Falls: Poor associated outcomes

- Trauma can induce delirium
- Negative Impact on Mortality & Morbidity
- Increased length of stay
- Higher risk of admission to nursing home
- Increased cost to healthcare provider

Delirium: Who is at risk?

- Typically affects older people(over 65) with multiple medical problems
- Less common in younger people
- Pre-existing cognitive impairment/Dementia
- Substance misuse
- Medications
- Pain
- Sensory impairment
- Malnourished
- Dehydrated
- Significant medial illness
- Electrolyte imbalance
- Hip fracture
- Surgical interventions

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Types of Delirium:

Hyperactive	Hypoactive
- Agitated or aggressive - Incoherent speech - Disorganised thoughts - Delusions - Hallucinations - Disorientation	- Withdrawn - Less reactive - Drowsy/sluggish - Unusually sleepy - Reduced motor activity - Have difficulty staying focused

Mixed- Fluctuating

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Presentation of Delirium

Change in cognitive function:

- Worsened concentration
- Slow responses
- Confusion
- Altered perception
- Hallucinations
- Agitation

Physical function:

- Reduced mobility,
- Reduced movement,
- Restlessness
- Hyperactive mobility
- Changes in appetite
- Sleep disturbance

Social behaviour:

- Difficulty engaging with or following requests
- Withdrawal
- Alterations in communication, mood and/or attitude.

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Delirium:

Often missed, why?

Assumed it is dementia.

Put down to ‘old age’.

Attributed to depression.

May be assessed in ‘lucid’ periods.

Why is diagnosis so important?

Sometimes the only sign of life-threatening illness

Associated poor outcomes

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The Screening:

? formal diagnosis of dementia in PMH

Delirium question – is the patient more confused lately? SQUID

Do 4AT

Dementia Question- Memory problems in last 6 months – Consider referral to MAS

If Delirium? Find and treat cause

PINCH ME

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Single Question in Delirium (SQiD) / 4AT

- **SQuID = “Is this person more confused than normal?”**
- **4 AT: 4 A’s Rapid initial Assessment (more than 4 suggests delirium but is not diagnostic)**

4AT Assessment Tool

1. AMT4 Score

0 mistakes = 0
1 mistake = 1
2 mistakes/untestable = 2

2. Alert?

Normal, not agitated = 0
Drowsy < 10 seconds then normal when woken = 0
Clearly abnormal = 4

3. Attention – “please list months of the year backwards”

≥7/12 correct = 0
<7/12 or refuses = 1
untestable = 2

4. Acute change or fluctuating course? E.g. any fluctuations or change in cognition or other mental health in last 2 weeks (hallucinations, paranoia) and still present in last 24h.

No = 0
Yes = 4

Total 4AT Score = /12 **DOCUMENT IN NOTES!**

AT Score:

4 or above: possible delirium +/- cognitive impairment;

1-3 possible cognitive impairment;

0: delirium or severe cognitive impairment unlikely (but delirium still possible)

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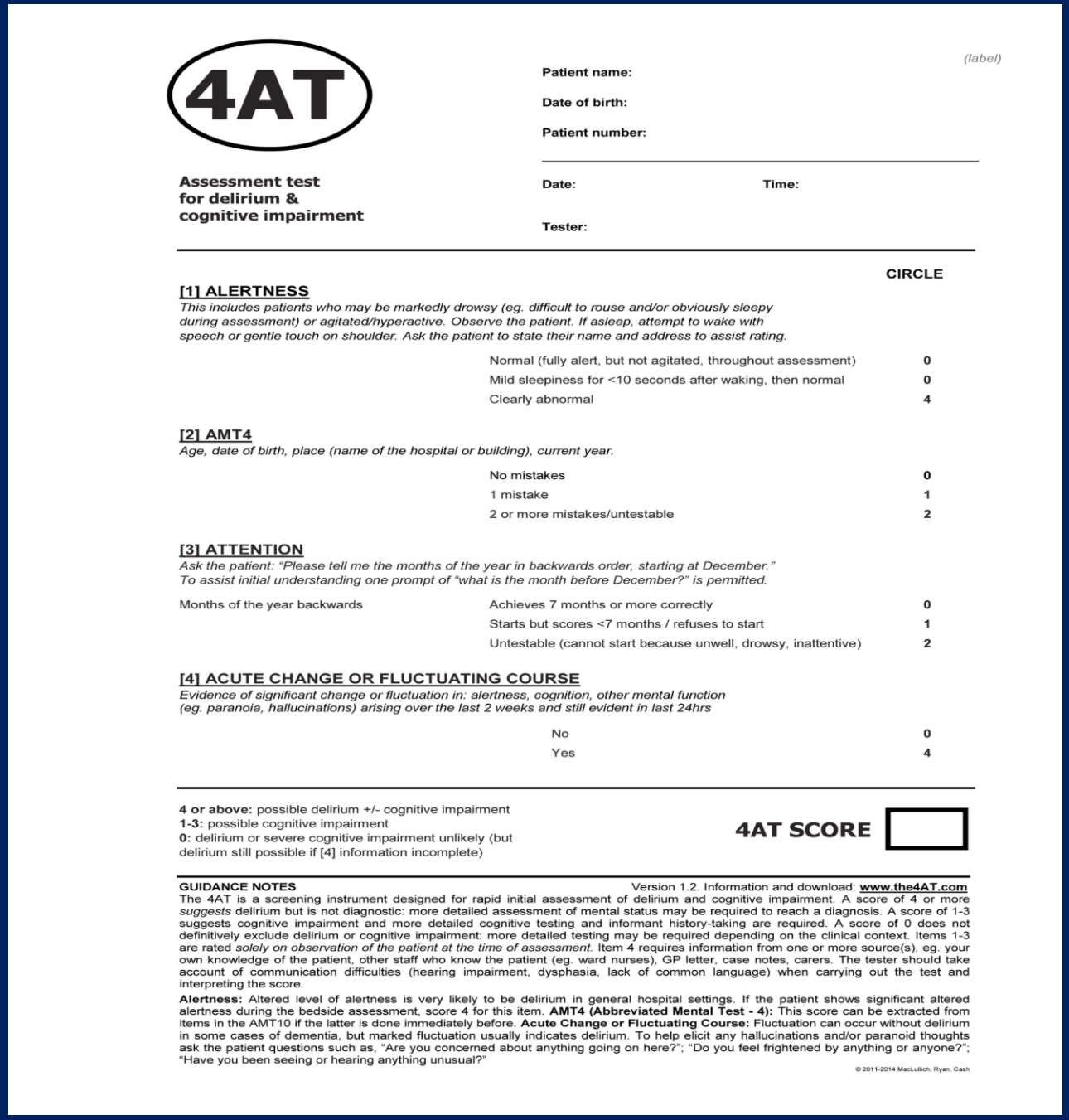
Complete a 4AT

- All health care professionals can complete
- Confusion Screen
- Diagnose Delirium
- Record in Notes
- Document on Discharge Summary



4AT

(label)

Patient name:

Date of birth:

Patient number:

Assessment test for delirium & cognitive impairment

Date: Time:

Tester:

CIRCLE

[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

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE

GUIDANCE NOTES Version 1.2. Information and download: **www.the4AT.com**

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated *solely on observation of the patient at the time of assessment.* Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

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Think PINCH ME
(Reversible Causes)

P
I
N
C
H

M
E

- Pain
- Infection
- Nutrition
- Constipation/Catheter
- Hydration/Hypoxia/Hearing
- Medication/Mobility
- Environment

Meaningful activity

Communication

Other Interventions

What matters to me.

Imagine…

Falls Prevention Summary

- **Think Dementia – Physiological Needs/5 Senses**
- **Think Delirium- PINCH ME**
- **Review Medications**
- **Keep Moving- Maintain Muscle Mass, Avoid De-conditioning, Meaningful Activity**
- **Avoid using bed rails in those who are confused**
- **Therapy Review- Bed Height, Mobility Aids /Do not wait for a therapy ax until mobilising if possible**
- **Use Appropriate Equipment with Training**

WHAT MATTERS TO ME

What Matters to Me

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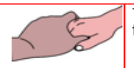
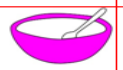
Staff will aim to comply with the following needs:

Date ...../...../.....

Tick if Patient / Relatives have objections ☐ to displaying this or forwarding it to future carers

Name / small sticker Forename MRN No **Do NOT put address**	In discussion with you, and/or your relative / carers, (Please list names of who helped) **The following items have been identified as important to you:**	
Things which make communication easier: 		Things I like doing / talking about: 
Things that help calm me: 	Things to avoid that upset me: 	Help with eating / drinking at home 
Food - Choices at home: 	Drink - Choices at home: 	Help with dressing / personal care at home: SOAP
Home routine: Wake / Sleep 	Home routine: Meal Times 	Home Routine: Toileting 
Other points I would like you to know e.g. who matters to me, what matters to me, my faith / beliefs and if I would like someone to visit.		

To be filed in section D (Nursing and PAMS) of medical records

Approved by MRAG Approval no. 281118/354/01

What Matters to Me

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What matters to me is an Individual Care Plan that can be used by anyone, but was designed for patients living with Dementia or affected by Delirium.

The 'This is Me' document should also be completed for those living with Dementia

Work out how best to personalise a patient's care	
Things that make communication easier: 	Hearing aid, glasses, time to think between question, thumb up/down for yes/no etc
Things I like doing / talking about: 	Think job, family, pets, when younger etc
Things that calm me: 	Time alone, talking, music
Things to avoid that upset me: 	e.g. pain, denied a choice in things, staff standing too close, being hungry
Help with eating and drinking at home: 	Carer feeds me, can hold finger foods
Food - choices at home: 	List a favourite, or things to avoid, e.g. only porridge for breakfast
Drink - choices at home: 	Prefer hot drinks, 2 sugars in tea before bed etc
Help with dressing / personal care at home: SOAP	Handed flannel wash face and top by self, help with rest
Home Routine: Wake / Sleep 	Up at 11am, bed at 9
Home Routine: Meal times 	No breakfast, supper at 7
Home Routine: Toileting 	Regularly at 10am OR when needed. Raised toilet seat used

ON DISCHARGE – Photocopy (Black and White): one copy to go with patient

One copy placed in their medical records

To be filed in section D (Nursing and PAMS) of medical records

Approved by MRAG Approval no. 281118/354/01

Person Centred Approach = Happy patient = Reduced risk of Falls

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Thank you for listening!

Remember…
We can't change the outcome of dementia

But we can change the journey!