Enhanced Care for Older People Learning Session Number 3

EnCOP Lead: Helen Kleiser

Date: 19th January 2022

Housekeeping

- Please ensure microphones are muted and during presentation cameras are turned off.
- If you have any questions throughout the session then please use the chat facility. We will attempt to address questions, if we can't then we will follow up after the event.
- If you have any technical difficulties, please put a note in the chat
- The event will be recorded and shared.
- The webinar recording and presentation will be circulated and uploaded on to the website following the event.
- If you need to take a break at any time throughout the session please feel free to do so.

Session Aim & Linked Competencies

Aim: To develop or enhance understanding of the mental health needs of older people; with a focus on delirium, dementia and depression

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Linked EnCOP Domains:

A: Values, Attitudes & Ethics
B1: Interprofessional an inter-organisational working and communication
B2: Teaching, learning and supporting competence development
D1: Communication with older people, family and friends
D3 Management of dementia
D4 Management of mental health

‘Understanding Confusion’ Delirium, Dementia and Depression in Older People

Judy Mattison

Lead Matron for Dementia and Delirium

Northumbria NHS Foundation Trust

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Is it normal to be confused?

When is confusion normal?

The 3 D's……..

What does dementia look like?

What does delirium look like?

What does depression look like?

Withdrawn
Agitation
Anger
Memory loss
Fear
'Wandering'
Hallucinations
Paranoid
Calm

Sleepy
Distressed
Confused
Disorientated
Driven
Anxious
Erratic
Forgetful
Non –Compliant

'Aggressive'
Swearing
Challenging
Difficult
Sad
Irritable
Frustrated
Quiet
Delusional

So what is Delirium?

- ‘DELIRIUM IS A CHANGE IN A PERSONS MENTAL STATE OR CONSCIOUSNESS, WHICH IS OFTEN SHOWN AS CONFUSION, DIFFICULTIES WITH UNDERSTANDING AND MEMORY, PERSONALITY CHANGES’ NICE 2020

Any person can get delirium, but it is more common when a person is older, has cognitive or sensory impairment or is very ill or frail

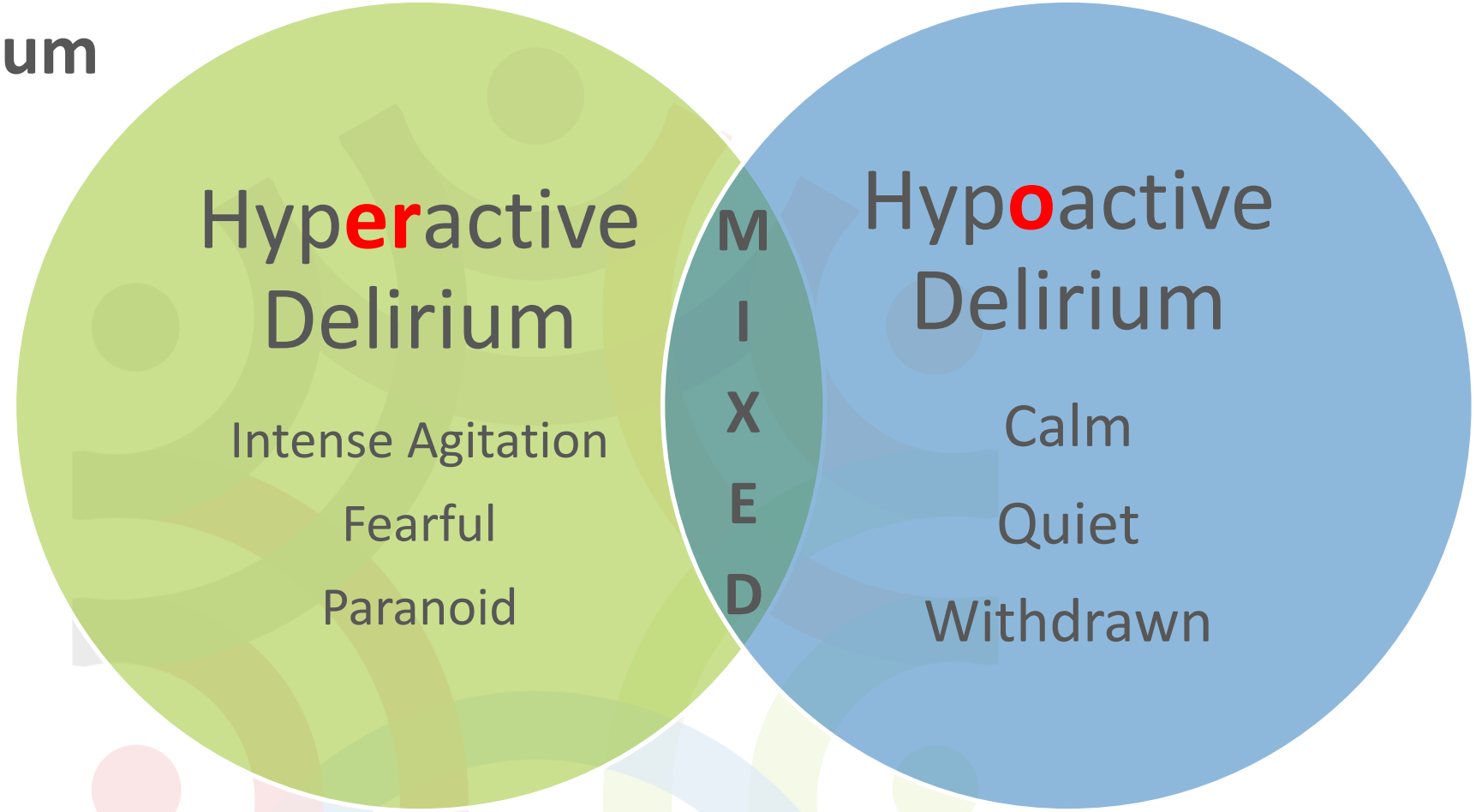
Frailty Syndromes

- Impaired cognition (new or increased confusion ie: delirium)
- Instability (new or recurrent falls)
- Immobility (sudden deterioration in mobility)
- Incontinence (new or worsening)
- Increased susceptibility to medication side effects

How common is delirium?

Population	Prevalence
Adult hospital inpatients (over 65)	Up to 30%
Older Adults in the community (over 85)	Over 14%
Hip fracture patients	Up to 62%
ICU patients	Up to 80%
Care Home resident's	Over 14%
Palliative Care patients	Up to 88%
Inpatients with dementia	Up to 89%
Long term care patients	Up to 70%
Adults in the community	1- 2 %

Types of Delirium



- **Gold Standard and NICE guidelines - all adults over 65 should have 4AT completed within 12 hours of admission to hospital.**
- **For every 48 hours Delirium is left untreated mortality increases by up to 11%**

British Geriatric Society, 2020

4AT ‘Rapid Clinical Assessment test for delirium & cognitive impairment’

- An assessment tool that tests Arousal, Attention, Abbreviated MT, and Acute change.
- Takes less than 2 minutes to complete.
- No special training is required.
- Easy and simple - suitable for use by all practitioners with a basic knowledge of delirium.

- All patients can be assessed, including those unable to speak (eg. with severe drowsiness), so no patients are ‘Unable to Assess.’
- Has built-in brief cognitive tests.

4AT Tool (circle score in each section on right and total score)		Circle
Alertness: This incudes patients who are markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated /hyperactive. Observe the patient if asleep, attempt to wake. Ask patient to state name and address to assist rating.	Normal (fully alert, but not agitated, throughout assessment)	0
	Mild sleepiness for <10 secs after waking then normal	0
	Clearly abnormal	4
AMT4 (Age, D.O.B, place(hospital), current year)	No mistakes	0
	1 mistake	1
	>2 mistakes/untestable	2
Attention: Ask the patient : "please tell me the months of the year in backwards order, starting at December."	Achieves 7 months or more correctly	0
	Starts but scores <7 months/refuses to start	1
	Untestable (cannot start because unwell, drowsy, inattentive)	2
Acute change or fluctuating course: Evidence of significant change or fluctuation in alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and is still evident in last 24 hours.	No	0
	Yes	4
Total		

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4 or above possible delirium +/- cog impairment

1-3: possible cognitive impairment

0: delirium or severe cognitive impairment unlikely

Implementation of the 4AT delirium detection tool in clinical practice: data from 69,462 acute medical admissions in two hospitals

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BACKGROUND

Detection of delirium in routine clinical practice is a major priority. There are multiple delirium assessment tools in clinical practice with few studies providing information in full clinical populations on (a) rates of completion of tools and (b) proportions of scores positive for delirium. Knowledge of real-world performance of tools is crucial.

The 4 A's Test (4AT; www.the4AT.com) is a globally-used clinical tool for delirium detection. It takes less than 2 minutes and requires no special training. The 4AT has been validated in 15 studies involving 3702 patients (meta-analysis to December 2019: sensitivity 0.88, specificity 0.88, Tieges *et al.* Age and Ageing; in press).

The 4AT is scored from 0-12.

ALERTNESS	0 - 4
AMT4	0 - 2
ATTENTION	0 - 2
ACUTE CHANGE	0 - 4
no cognitive impairment or delirium »	**0**
probable cognitive impairment »	**1 - 3**
probable delirium »	**4 - 12**

OBJECTIVES

In this study we examined completion and detection rates of the 4AT in two university hospitals using consecutive medical admissions data.

METHODS

TrakCare® electronic health record database was used to identify consecutive patients admitted to acute medical wards of the Western General Hospital and the Royal Infirmary of Edinburgh, Edinburgh, Scotland, between 1 Apr 2016 and 1 May 2019.

The 4AT is mandated for patients aged ≥65 in the medical admissions process in the two included hospitals. Admission 4AT data in patients ≥50 years old are considered here. We assessed completion rates, 4AT scores, and length of stay.

RESULTS

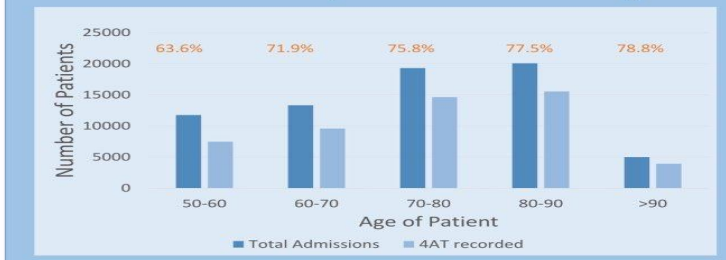
69,462 consecutive patients

51,238 completed 4AT

4AT score

0	1 - 3	4 - 12
33,028 (64%)	**9,499** (19%)	**8,711** (17%)

Rates of 4AT completion increased with age



Length of stay increased with 4AT score

CONCLUSIONS

- Implementation of the 4AT is feasible, with **more than three quarters** of older patients undergoing a 4AT.
- The overall rate of 4AT scores **positive for delirium was 17%**. This figure is broadly in line with existing study estimates of the prevalence of delirium on admission to acute medical units.
- **Length of stay** in hospital **increased** with 4AT score.

Length of stay in hospital increases with 4AT score

(The University of Edinburgh – Collected data from 69,462 acute medical admissions across two hospitals- tweeted October 2020.)

‘Think Delirium’

Am I worried enough to want a review?		YES	NO
	Are they becoming restless or agitated?		
	Are they flushed, sweating hot or cold, or clammy?		
	Are they more or less mobile than usual, or unsteady?		
	Is there new, or worrying, pain?		
	Are there changes in skin colour or condition?		
	Are they short of breath or breathing harder than usual?		

Am I worried enough to want a review?		YES	NO
	Are they more confused or drowsy?		
	Do they have cold hands or feet?		
	Are they feeling sick, or being sick?		
	Are they off their food or drinking less fluid?		
	Any changes in urine colour or smell?		
	Any changes in bowel habits?		

Soft Signs

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Awareness

Think DELIRIUM?

Use 'A PINCH ME'

- Assessment & collateral 
- Pain 
- Infection 
- Nutrition 
- Constipation & continence 
- Hydration 
- Medication 
- Environment 

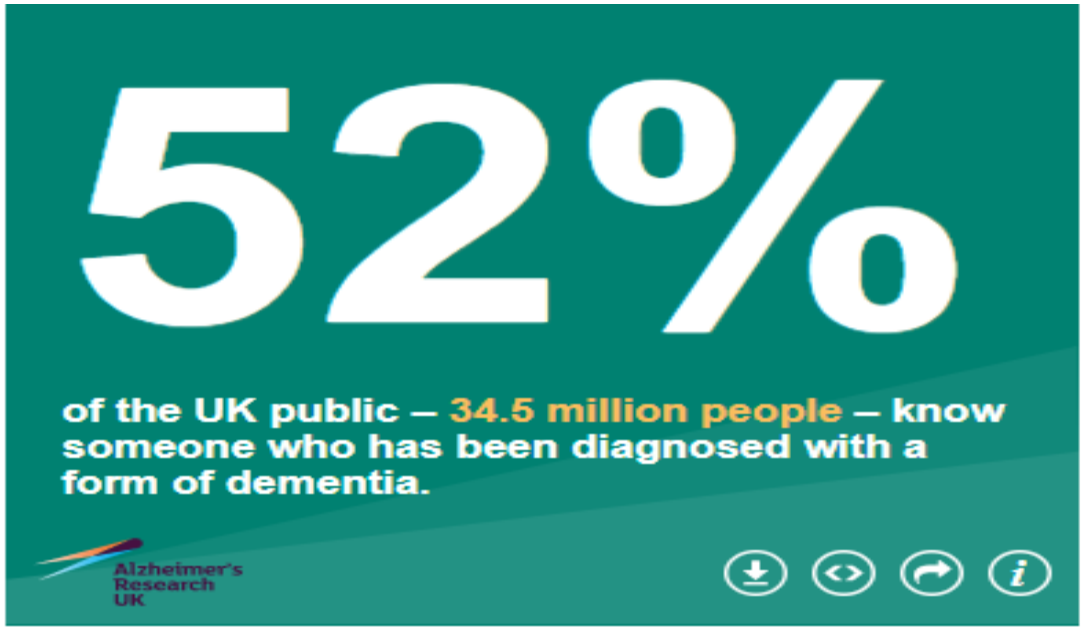
What is dementia?

Dementia is an umbrella term…

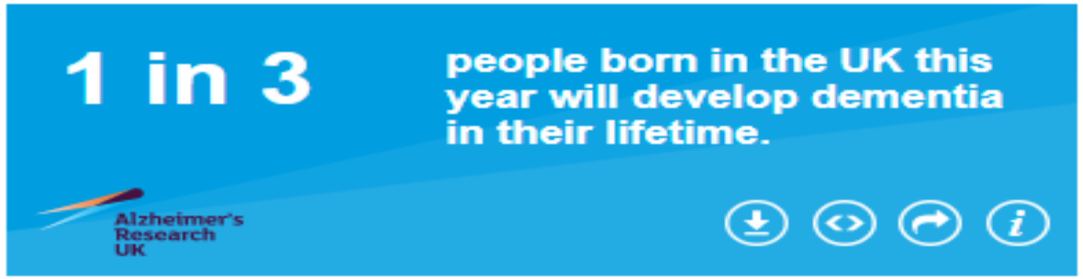
"Dementia is the term used to describe a range of usually progressive conditions that affect the brain."

- How common is dementia?
- How many different types of dementia?
- Most common types?

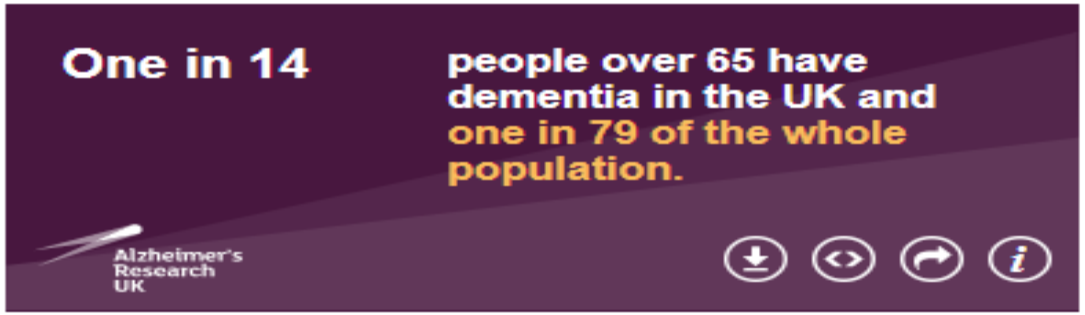
Source: Prince, M et al. (2014) Dementia UK: Update Second Edition report produced by King's College London and the London School of Economics for the Alzheimer's Society



Source: Dementia Attitudes Monitor (2019) and ONS 2018 population estimates



Source: Lewis, F: Estimation of future cases of dementia from those born in 2015 (July 2015); Consultation report for Alzheimer's Research UK



Source: Prince, M et al (2014) Dementia UK: Update Second Edition report produced by King's College London and the London School of Economics for the Alzheimer's Society

Most Common Types of Dementia

Alzheimer's Disease

Alzheimer's disease is the most common cause of dementia. Affecting around **66 %** - 2/3 of UK population. Causes problems with

memory, language,

and reasoning

Vascular Dementia

Up to **20%** of dementia cases have a vascular cause. Causes impaired judgement, Difficulty with motor skills and balance. Heart disease and Stokes increases its likelihood.

Mixed Dementia

Frontotemporal Dementia (FTD)

Accounts for less than **5%** of dementias, It often occurs between the ages of 45 and 65, but can also start as early as age 20 or as late as the 80s. Can cause changes in personality, mood and changes language problems

Dementia with Lewy Body (DLB)

15% of people with dementia have DLB. Caused by Lewy body proteins may develop symptoms of Parkinson's disease, may also include hallucinations and disordered sleep

Alzheimer's Research UK

Dementia……

Diagnosis

- Minimum of 6 month History
- Collateral – from patient, family, GP, carers
- Imaging of the Brain
- Assessment by specialist
- Cognitive and Functional
- OT, Psychiatrist, Psychologist, Nurse, Memory Clinic

Treatment

- Progressive Condition –no cure
- Lifestyle Changes
- Polypharmacy
- Use of Cognitive Enhancers
- Education and Awareness
- Living Well with Dementia
- Health heart, healthy mind
- Services – Alzheimer's Society, Dementia UK

Depression……"the common cold of mental health"

Depression is one of the leading causes of disability worldwide and a major contributor to suicide and coronary heart disease

ONS, 2020

Depression causes a low mood that lasts a long time and affects your daily life.

- It can range from mild to severe. Mild depression can make you feel low and as though everything is harder to do. Severe depression can lead to feeling hopeless and, in some cases, suicidal.

- There is no single cause of depression, It can often be a combination of factors.
- Sometimes depression can happen without any obvious reason
- Biological changes in the brain can trigger a relapse in depression
- Some personality types are more susceptible
- A family history indicates a higher risk

Persistent sadness or low mood	Loss of interest in life	Harder to make decisions	Poor concentration and memory	Feeling restless or agitated
Loss of appetite or weight	Difficulty sleeping	Worrying more	Loss of confidence	Feeling guilty
Avoiding people	Thoughts of suicide	Feeling a burden	Feeling exhausted	Not enjoying things

Some stats…..

Pre Pandemic

The Office for National Statistics found that nearly one in 10 (9.7%) of British adults suffered some sort of depression between July 2019 and March 2020.

24% of women and 13% of men in England are diagnosed with depression in their lifetime

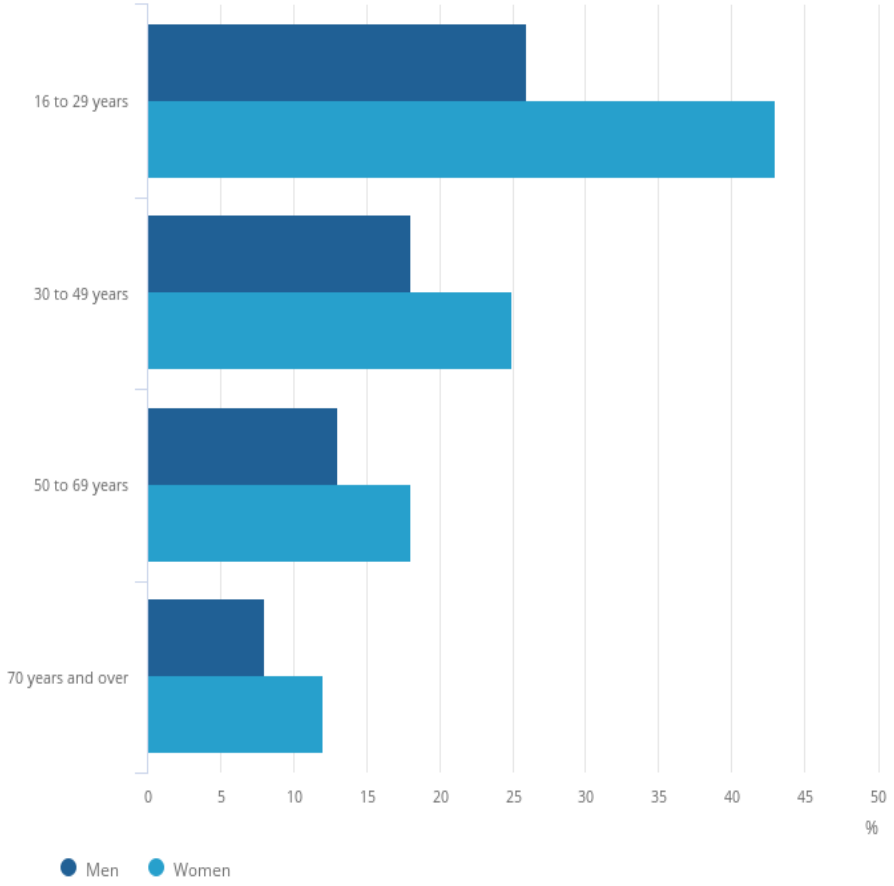
Depression often co-occurs with other mental and physical health issues

1:4 Older adults suffer from **depression**

Over 65's have the **highest rate** of suicide of any other age groups.
Over 65's have the lowest rate of ATTEMPTS and the **highest rate** of **COMPLETED SUICIDE**

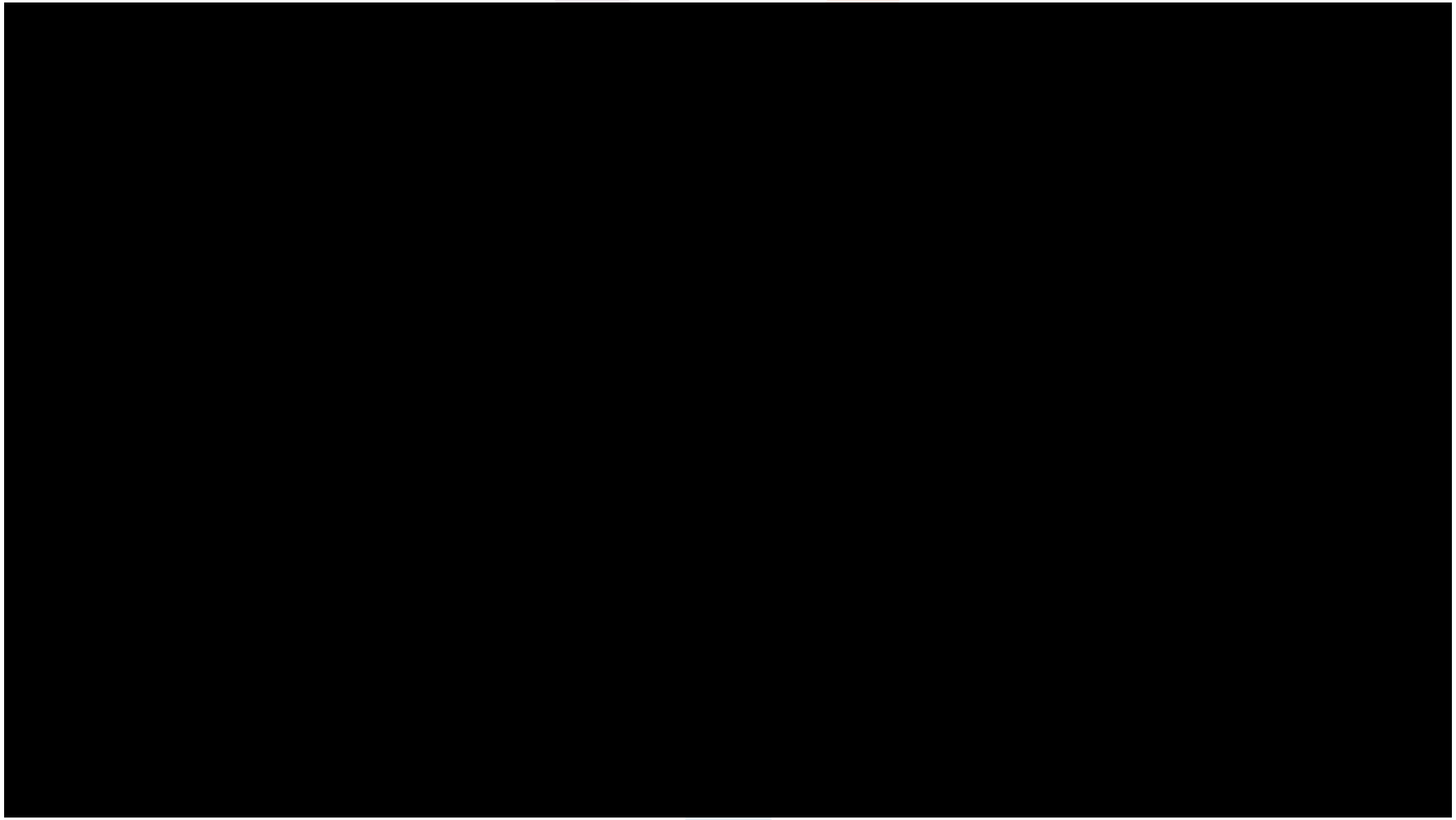
Figure 4: Younger women were most likely to experience some form of depression

Percentage of adults with some form of depression by age and sex, Great Britain, 27 January to 7 March 2021



Source: Office for National Statistics – Opinions and Lifestyle Survey

Depression in Older People



	Delirium	Dementia	Depression
Definition	an acute fluctuating onset of confusion, disturbance in attention, disorganised thinking and/or decline in level of consciousness.	Dementia is a gradual and progressive decline in mental processing ability, affecting memory, communication, language, judgement and abstract thinking.	A change of mood that lasts at least two weeks with feelings of sadness and loss of interest and pleasure in usual activities.
Onset	Sudden onset over hours or days.	Gradual onset over months to years.	Variable: Weeks to months. May coincide with life changes.
Course	Reversible with early treatment but can cause serious disability or death. Often fluctuates over 24 hour Period, can be worse at night and on awakening.	Progressive: May be slowed with treatment but not reversed.	Usually reversible with Treatment. Often worse in the morning.
Memory	Impaired - recent and immediate memory	Impaired - recent and remote memory	Generally intact or may be minimally impaired. Can be selective. In severe cases can present as a pseudo-dementia.
Thinking	Fluctuates between rational and disorganised/ distorted thinking. Fluctuating alertness and Cognition.	Difficulty with abstract thinking Poor decision making. May have word finding Difficulty.	May be indecisive, reduced concentration, low self esteem, Feelings of hopelessness.
Perception	Distorted: Illusions, delusions and / or hallucinations. Difficulty distinguishing between reality and misperceptions.	Signs may include delusions of theft/ persecution. Hallucinations depending on type of dementia e.g. LBD	Themes of guilt and self Loathing. May experience delusions and/or hallucinations in severe depression
Sleep	Disturbed but no set pattern. May have nocturnal confusion, day/night reversal.	Disturbed - Early morning wakening or hypersomnia.	Normal to fragmented, may have nocturnal wandering and confusion.
Mood	Variable – irritable, aggressive, fearful.	Variable – irritable, apathetic, Labile, Depressed mood often present in early dementia	Depressed, flat, sad, withdrawn, Changes in appetite, diminished interest in usual activities.
Diagnosis	Diagnosis based on rapid onset of fluctuating symptoms.	Usually diagnosed approximately 2-3 years after onset of symptoms Must rule out other cause of cognitive decline e.g. depression or delirium	May deny being depressed but exhibit anxiety, Others may notice symptoms first, Increased complaints of physical illness, social withdrawal is common.

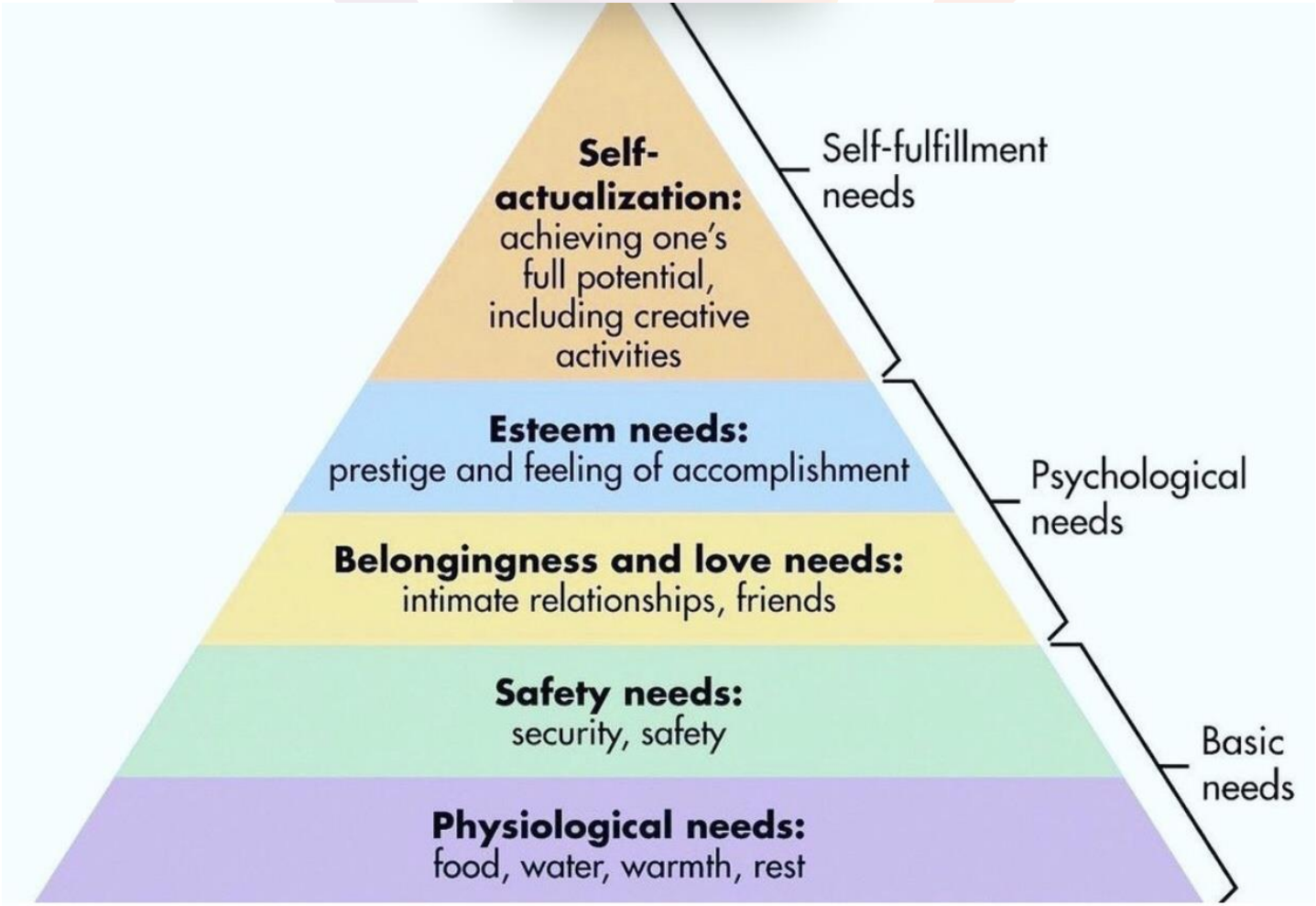
See the person, not the disease…..

“It is much more important to know what sort of a person has a disease than what sort of a disease a person has.”

(Dr William Osler)

Personhood and the Flower of Emotional Need
TOM KITWOOD – 1997

Maslow's Hierarchy of Needs



The language we use……Control and Command

WAIT

DON'T

SIT DOWN

IN A MINUTE

STOP

NO

YOU CAN'T

How might someone with dementia, delirium or depression present?

1. Look sad, angry or agitated and can't say why.
2. Asking to leave or go home regularly.
3. They become withdrawn or aren't responding to you.
4. Who are you? What are you doing here?
5. Asking for mum, dad, their children.

FIGHT; FLIGHT; FRIGHT

'The safer we feel the more receptive we are and the more effective the brain becomes' - Torres

Strategies we can use

- **Differentiate between dementia, delirium and depression –** avoid making assumptions
- **Gain Collateral** – harness information from families/ carers such as Personal Profiles - This Is Me
- **Identify it, diagnose it, document it**
- **Be with People – in that moment – let them lead**
- Build relationships based on recognition, trust, inclusion, empathy, compassion and respect.
- **Listen** – validate feelings
- Confrontational v Supportive body language
- Approach from the front at an angle – not from above, walk slow
- Create **Meaningful activity and engagement**
- **Encourage** people to be outside, active and use their senses
- Create an **environment** that allows for **social interaction**, **inclusion**, and **connection**.
- **Focus** on capabilities, not risk
- **Focus** on strengths rather than deficits.
- **Be mindful of communication** – Avoid correction, controlling or condescending language
- **MEDICATION** – think about the side effects and impact of antipsychotic, sedation etc.

Every Interaction has “therapeutic potential”

Thanks

involve consider assess respond evaluate

Ideas for Learning Consolidation & Competency Conclusion

Consolidating Learning:

Reflection on the session & considering application to practice & what this means 'your people'

- Think about this session in relation to your own role
- How much of this was revision?
- What have you learned today ?
- How will this help you in your role ?
- Think about your EnCOP self–assessment; consider which performance indicators this session may relate to and how this can be used as part of your own development / competency achievement.

Competency Domain
A: Values, Attitudes & Ethics
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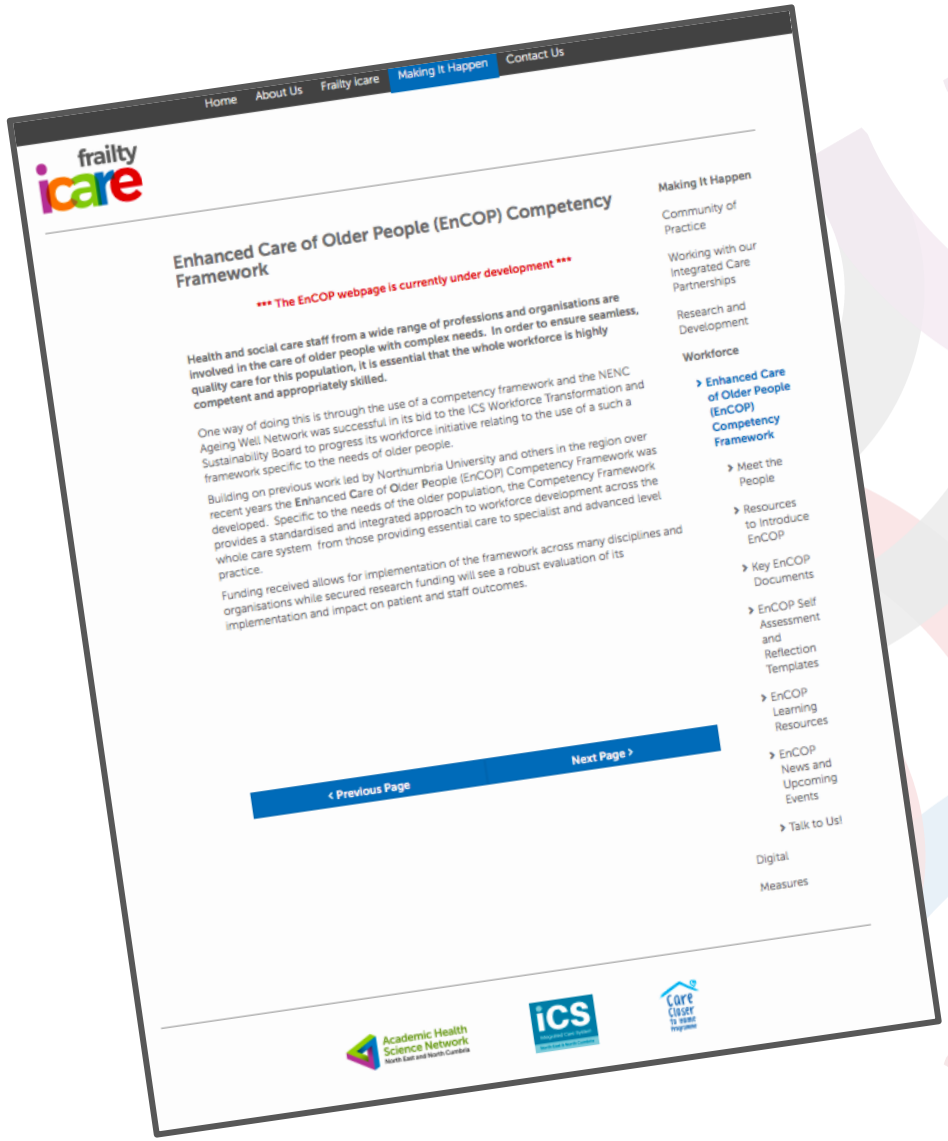

More information can be found within the Frailty icare website

www.frailtyicare.org

Our EnCOP pages are located in the workforce section

EnCOP Library of Learning & Development Resources can be found at:

http://frailtyicare.org.uk/making-it-happen/workforce/enhanced-care-of-older-people-with-complex-needs-encop-competency-framework/encop-learning-resources/learning-resources/

Feedback about today's session and any future sessions you may like to see included in our webinar series….

All feedback welcomed; You may want to consider the following –

- Was it easy to book onto the session?
- Did you find the session went well in this online format ?
- Was the content of the session relevant to your area of practice / job role?
- Did you enjoy the session?

Thinking about future webinar's, which topics linked to older person's care would you be most interested in? Please put any suggestions in the chat.

Please comment in the chat today or feel free to email us: ghnt.encop@nhs.net