WELCOME

‘Dementia, delirium and Frailty: exploring best practice’
Who are you?

Why are you here?

What are you hoping to learn?
Aims of today;

• Increase your understanding of delirium and your ability to recognise it
• Increase your understanding of frailty and your ability to recognise it
• Increase your understanding and insight into the inter-relationship between dementia, delirium and frailty
• Explore best practice in assessment, treatment and support options for people with multi complex conditions including dementia, delirium and frailty
• Meet colleagues from a range of health and care settings, share experiences, ideas and good practices
Presentation Plan

• Introduction and Context
• Why it is a priority
• What are the Issues
• Government and Policy response
Number of people with dementia in Scotland

- 90,000 People with dementia in Scotland
- 86,000 over 65 years with greatest number over 80 years old
- 61% of people with dementia -3 or more co morbidities (Diabetes, COPD, Musculoskeletal, Cardiovascular Disease)
Why is this a Priority?

- People with dementia – increased risk of delirium and frailty
- Increased risk of unplanned hospital admissions
- Significant issue – poor outcomes and reduced quality of life
- Increased morbidity and mortality
- Complexity of needs – Specialist Care
- High Healthcare costs
What are the Issues?

• 10% of people admitted to hospital as an emergency stay more than two weeks
• 55% of all hospital bed days
• 80% are aged over 65 years.
• Average age 80
• 40% of older people in hospital have dementia
• Unplanned admission 18% of people with dementia
Why?

• Age
• Co morbid conditions - Parkinson’s disease and diabetes etc - increases risk of developing some types of dementia
• Multiple health problems – not managed – dehydration, malnutrition, constipation and infection.
• Visual impairment, sleep disturbance, oral health issues and frailty – if untreated – Pain, distress and worsening symptoms.
Why?

- As dementia progresses, increase in comorbid condition
- Change or infection – trigger acute episode results in hospital admission
- Focus on single conditions
- Silo pathway of care – ‘acute’, ‘primary’ or ‘social’
- Person-centred care vs Medical Model
What happens in Hospital?

- Adverse events- prolonged stay, pressure ulcers, falls, delirium.
- Limited recovery of functional decline
- Decision making process
- Increase admission to care homes
- Increased mortality 6 months – despite successful reductions in incidence of delirium
Government and Policy Response

- National Priority
- National Dementia Strategy, E.G. 10 Care Actions
- Wider policy agendas – Reshaping care of older people, Palliative and End of Life Care
- OPAC Inspections
- Focus on Delirium
- Focus on Frailty
- Approaches to prevention of hospital admission
Thank You for Listening

Any Questions?

Patricia Howie
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‘Dementia, delirium and Frailty: exploring best practice’
Fundamentals of Delirium

What exactly is delirium- quick quiz

• Slow, gradual onset (YES/NO)
• Does not need to be addressed/treated urgently (YES/NO)
• Always the result of infection (YES/NO)
• Having dementia means delirium is likely to affect you more profoundly (YES/NO)
• Delirium will clear up quickly, as soon as it is addressed/treated (YES/NO)

What are your experiences of delirium?
**Delirium: a definition**

‘An aetio logically nonspecific organic cerebral syndrome characterized by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion, and the sleep-wake schedule. The duration is variable and the degree of severity ranges from mild to very severe’.

*(International Classification of Diseases:10)*
Scenario one-

Mrs Johnson is 86, and has moderately advanced Alzheimer’s dementia. She has a degree of expressive dysphasia associated with this, and finds it difficult to describe issues such as discomfort to others. She lives in a sheltered house, with three social care visits a day to assist her with ADLs. Over the course of two days, she becomes more confused and develops agitation. Her behaviour changes; she begins disrobing in front of others and is aggressive towards her care workers. She is seen by a GP, who pronounces her chest clear. He takes bloods, which come back without significant abnormalities. Lab tested urine is also normal. The GP says ‘it’s her dementia’.

Do you think the changes are the result of progressing dementia? Discuss.
Scenario two-

Mr Jamieson has mild cognitive impairment. He lives at home with his wife. He is self-caring and lives an active life. His cognitive ability can fluctuate to a slight degree. He is admitted to hospital for planned surgery to replace his knee. The operation goes well, and he appears to be his usual self the day after the procedure. However, the following day, he is much more confused and has significant language difficulties. He now struggles to carry out almost any ADL. The surgical team CT scan his head, fearing a cerebrovascular event. Nothing is found other than mild small vessel disease. He is found to be free of infection, his pain is well controlled and he is moving his bowels. He does not improve over the next month. He is discharged to a care home, as he is no longer able to function in his own home. The consultant surgeon feels he may have vascular dementia. He is referred for a dementia assessment post-discharge, and has not improved significantly by the time this assessment takes place, approx. 10 weeks after his operation.

Do you think Mr Jamieson has developed vascular dementia?

Discuss
Thanks! Any questions?

Dr Steve Mullay,
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SIGN 157
Risk reduction and management of delirium

A national clinical guideline
March 2019

**Overview of Session**

- Background to guideline; what is it, and why is it needed?
- Implementation of the guideline
  (an example of local implementation/best practice; NHS Shetland)
**SIGN 157; what is it, and why is it needed?**

**What’s in it?**

The guideline provides recommendations based on current evidence for best practice in the detection, assessment, treatment and follow-up of adults with delirium, as well as reducing the risk of delirium.

**Why do we need it?**

Delirium is a serious clinical phenomenon, especially for people with dementia/pre-existing cognitive impairment. Unfortunately, there are deficiencies in the care of people with delirium in Scotland. It is under-diagnosed, and the treatment of patients with established delirium is variable. Preventative measures can reduce the incidence of delirium, yet few clinical settings have formal delirium risk reduction programmes in place.
SIGN 157—what does it cover?

- Detecting delirium (4AT)
- Non-pharmacological risk reduction
- Pharmacological risk reduction
- Non-pharmacological treatment
- Pharmacological treatment
- Implementing the guideline
- The evidence base
- Development of the guideline
Assessment test for delirium & cognitive impairment

[1] ALERTNESS
This includes patients who may be markedly drowsy (e.g., difficult to arouse 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 (e.g., 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)

NHS Education for Scotland

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 0-2 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), e.g., your own knowledge of the patient, other staff who know the patient (e.g., 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 seen or heard anything unusual?”

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Implementing the guideline

Key considerations-

• Broad adoption/use.
• Consistency in application.
• Proficiency in use.
• Local processes/pathways to ensure the above.
Implementing SIGN 157; NHS Shetland

- Background; the story before SIGN 157....
- Promoting its use locally.
- Ensuring proficiency in its application (education, demonstrating, shadowing etc.)
- Putting processes/pathways in place (4AT, TIME bundle etc).
SIGN 157; where can I find it?

- Full guideline: https://www.sign.ac.uk/assets/sign157.pdf
- Quick reference guide: https://www.sign.ac.uk/assets/sign157_qrg.pdf
Thanks! Any questions?

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Frailty

Nicola Wood
Alzheimer Scotland Dementia Nurse Consultant
Learning outcomes

• Understand what is frailty?
• Risks
• Screening
• Assessment/care planning
• Prevention
‘Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves’
‘Frailty is not an illness, but a syndrome that combines the effects of natural ageing with the outcomes of multiple long-term conditions, a loss of fitness and reserves’
‘Frailty describes how our bodies gradually lose their in-built reserves, leaving us vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment’
Frailty

- Varies in severity for individuals
- Not static – can be made better or worse
- Not an inevitable part of ageing
- Can be in conjunction with other co-morbidities or be a stand alone long term condition
- The cause of disability in some and the consequence of disability in others

Living with one or more long term conditions (although there may be overlap)

Not age related
Co-morbidity/disability overlap

Fried et al 2011
Stats

- 10% of people over 65
- 25 – 50% of people over 85%
- More studies emerging regarding people under 65
Outcomes

• Inability to withstand sudden changes in physical condition
• Increased likelihood of hospital admission (with associated outcomes)
• Risk of loss of independence/confidence
• Preventable move to supported accommodation
• Death
Who can identify?

- Home care providers
- GPs
- AHPs
- Nurses
- Ambulance crew
- Community care teams
- Pharmacists
- Proactive assessment rather than reactive
Risk factors

- Poor mobility / risk of falls
- Poor diet
- Drug interactions
- Loneliness
- Incontinence
- Mental health concerns
- Functional impairment

People with dementia at higher risk of all of the above
Dementia risk factors

- Physical weakness, gait changes poor balance
- Incontinence /urgency
- Communication difficulties
- ↑Risk of delirium
- Retention of new information
- Impaired judgment/lack of insight
- Medication side effects
- Perception difficulties
- Stress and Distress
- Type of dementia
## Psychotropics & sedation

<table>
<thead>
<tr>
<th>Category</th>
<th>Drugs</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sedatives: Benzodiazepines</strong></td>
<td>Temazepam, Nitrazepam, Diazepam, Chlordiazepoxide, Lorazepam, Clonazepam</td>
<td>Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.</td>
</tr>
<tr>
<td><strong>Sedatives: “Zs”</strong></td>
<td>Zopiclone, Zolpidem</td>
<td>Drowsiness, slow reactions, impaired balance.</td>
</tr>
<tr>
<td><strong>Sedating antidepressants</strong></td>
<td>Amitriptyline, Dosulepin, Lofepramine, Mirtazapine, Trazodone</td>
<td>All have some alpha blocking activity and can cause postural hypotension. All are antihistamines and cause drowsiness, impaired balance and slow reaction times.</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td>Haloperidol, Risperidone, Quetiapine, Olanzapine</td>
<td>All have some alpha blocking activity and can cause postural hypotension. Sedation, slow reflexes, loss of balance. Haloperidol best choice short term.</td>
</tr>
</tbody>
</table>
Anticholinergic Drugs

Associated with increased risk of cognitive impairment

• This can majorly impact on patients with dementia whose cognition is already impaired
  – Cognitive enhancers working in the opposite way

Anticholinergic effects

• Constipation
• Falls
• Sedation
• Confusion
• Photophobia
• Delirium
# Anticholinergics

<table>
<thead>
<tr>
<th>Type of drug</th>
<th>Use</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimuscarinics</td>
<td>Urinary frequency</td>
<td>Solifenacin, oxybutynin</td>
</tr>
<tr>
<td>Antiemetics</td>
<td>Nausea</td>
<td>Cyclizine, metoclopramide, prochlorperazine</td>
</tr>
<tr>
<td>Antihistamines (first generation)</td>
<td>Allergy, itch</td>
<td>Chlorphenamine, hydroxyzine</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Low mood</td>
<td>Amitryptiline</td>
</tr>
<tr>
<td>Analgesics</td>
<td>Pain</td>
<td>Tramadol and pethidine in particular</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Aggression/ psychosis</td>
<td>Prochlorperazine</td>
</tr>
</tbody>
</table>
Discuss in groups what happens in local area?
Forth Valley frailty at front door team

• 7 day service (January 2019)
• 3 x full time nurses (1 x band 7, 2 x band 6)
• Supported by Consultant geriatricians
• Daily input from AHP’s, Mental Health Services and Social Work
• Ageless service (February 2019)
Frailty team aims

• Screen all admissions to FVRH for frailty
• Undertake CFA assessment on those identified as living with frailty
• Ideally supported discharge home when safe
• Consider alternative pathways
• If admitted, transfer to A&H area for specialist care and treatment
• Personalised care plan/goal setting
FV Screening - exclusion

- Chest pain or Suspected Acute Coronary Syndrome
- TIA or Stroke
- GI Bleed (Haematemesis or Maleana)
- PR Bleed
- COPD exacerbation
- Suffered from trauma or hip fracture
- Acute Abdominal Pain or other Surgical Condition
- Urinary Retention or other Urological Problem
- Referral from Cancer Treatment Helpline
FV Screening - inclusion

- Fragility fracture – vertebral, humerus, wrist/radius, pelvis
- Functional impairment (new) - Do they need new help to care for themselves on a daily basis?
- Resident in a care home
- Altered mental state – Do they have delirium/new or worsening confusion?
- Immobility/instability. Do they have new decline in mobility or have fallen?
- Living at home with support more than 1 x daily (either professional or family support)
Clinical Frailty Scale*

1. Very Fit — People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well — People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. Managing Well — People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable — While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5. Mildly Frail — These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail — People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail — Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail — Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill — Approaching the end of life. This category applies to people with a life expectancy < 6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

The 4m walking speed test detects frailty

Taking more than 5 seconds to walk 4m predicts future:

- Disability
- Long-term care
- Falls
- Mortality

Van Kan et al JNHA 2009; 13:881
Systematic Review of 21 cohorts
Comprehensive Geriatric Assessment (CGA)

- Holistic, interdisciplinary assessment
- Focuses on medical, social, psychological environmental and functional abilities
- Frailty Screening index in communities under trial (HIS)
Aims of CGA

• Improved care experience
• Reduction in need for hospital care
• Shorter admissions if required
• More likely to be cared for at home
• Person centred care planning
what's included
Comprehensive Frailty Assessment (CFA) in Forth Valley

- Consent/capacity assessment
- ACP, RESPECT, DNACPR
Home and social circumstances

- Place of residence
- Who lives with
- Type of setting ie stairs
- Support (formal/informal)
- Aids/adaptions in place or required
Pre illness abilities

- ADL's
- Household tasks
- Mobility/transfer/falls
- Continence
- Dietary intake/requirements
Mental Health history

- Previous contact with MH services
- Current mental health concerns
- Medication
- Need for specialist review
Expectations

• Patient history/expectations
• Collateral history from family
• MDT review/discussion/plan in collaboration with patient
Areas for development in FV

• Exclusion criteria – what happens to people with frailty who are excluded?
• What about people with CFA started who don’t go to an A&H area?
• Dedicated frailty unit
• Whole system approach
Preventable Components for “Frailty”

- Alcohol excess
- Cognitive impairment
- Falls
- Functional impairment
- Hearing problems
- Mood problems
- Nutritional compromise
- Physical inactivity
- Polypharmacy
- Smoking
- Social isolation and loneliness
- Vision problems

(Systematic review of 78 studies)

Additional topics:
- Look after you feet
- Make your home safe
- Vaccinations
- Keep warm
- Get ready for winter
- Continence
- ..........others.........??
Barriers?

- Language – living with frailty
- Communication tools
- Awareness levels – systems
- Health promotion
- Time
- Clear roles
- Expectations
- Resources
Mrs Andrews

https://www.youtube.com/watch?v=Fj_9HG_TWEM
What can YOU Do?
Questions
http://www.knowledge.scot.nhs.uk/dementia.aspx

TWITTER
@DouglasNES
# Reflection and Action Planning Tool

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<tr>
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<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>What are your top 3 (or more) learning points from today's session?</strong></td>
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<tr>
<td><strong>2</strong></td>
<td><strong>What can you take from today into your current role?</strong></td>
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<tr>
<td><strong>3</strong></td>
<td><strong>What will you do differently as a result of today's session?</strong></td>
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</tr>
</tbody>
</table>
Evaluation

1. What has been the best thing about today?

2. What has been your key learning today?

3. What could have been better about today?

(Thanks for taking the time to give us your feedback – much appreciated)
Thank you

Safe Journey Home

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