NHS Education for Scotland

# WELCOME

**‘Dementia, delirium and Frailty:**

**exploring best practice’**


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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 9of 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, Cardio vascular 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 co morbid 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 V 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?

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NHS Education for Scotland

# ‘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 aetiologically 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?

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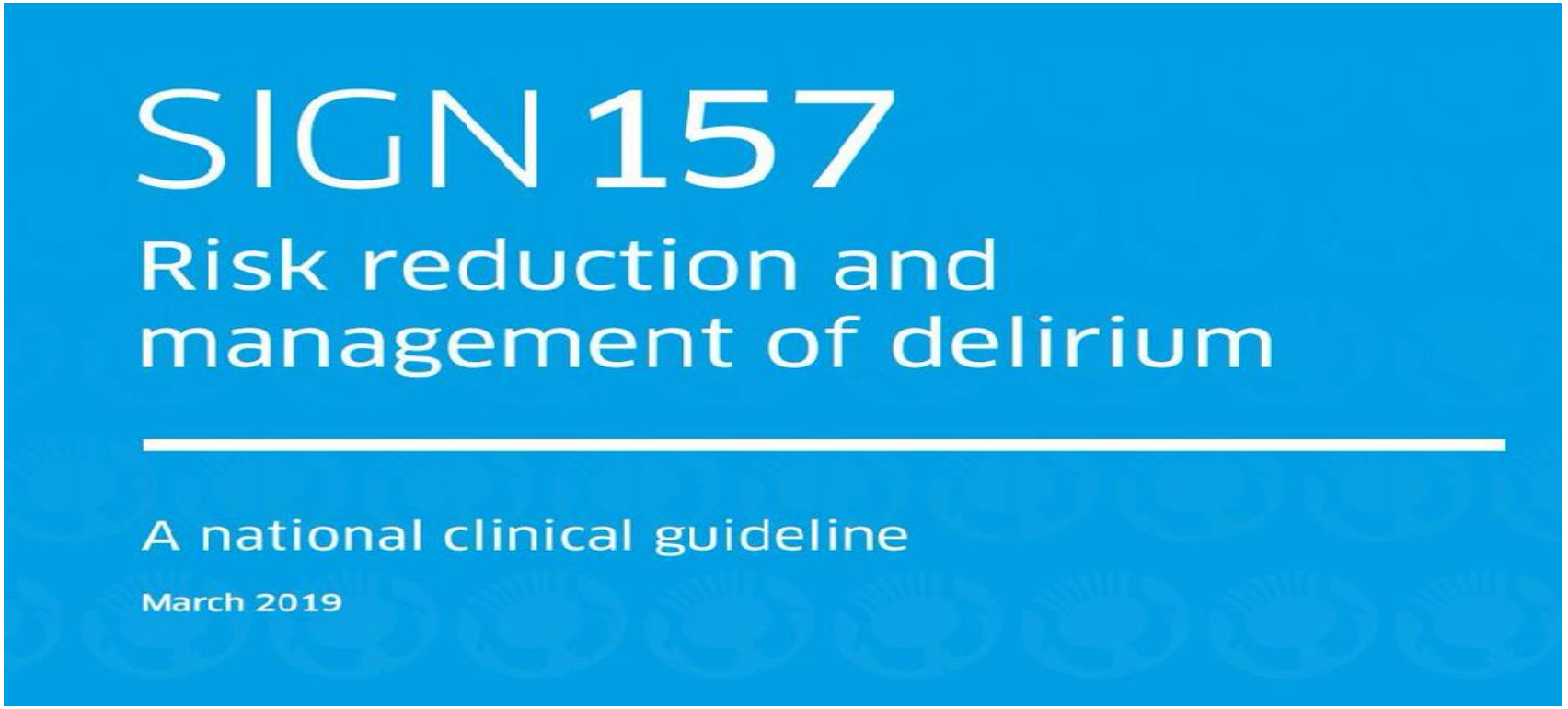


## *Overview of Session*

- 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

# 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?"

# *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
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# Learning outcomes

- Understand what is frailty?
- Risks
- Screening
- Assessment/care planning
- Prevention


DEFINITIONS
FUTURE
MANAGERS
DECISION
DATA
EFFECTIVE
MANAGEMENT
FACTORY
SERVICES
BUSINESS
RISK
FUTURE
FACTORY
CUSTOMER
DATA

# British Geriatric Society


‘Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves’

# Royal College of Nursing


‘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’

# NHS England

‘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’

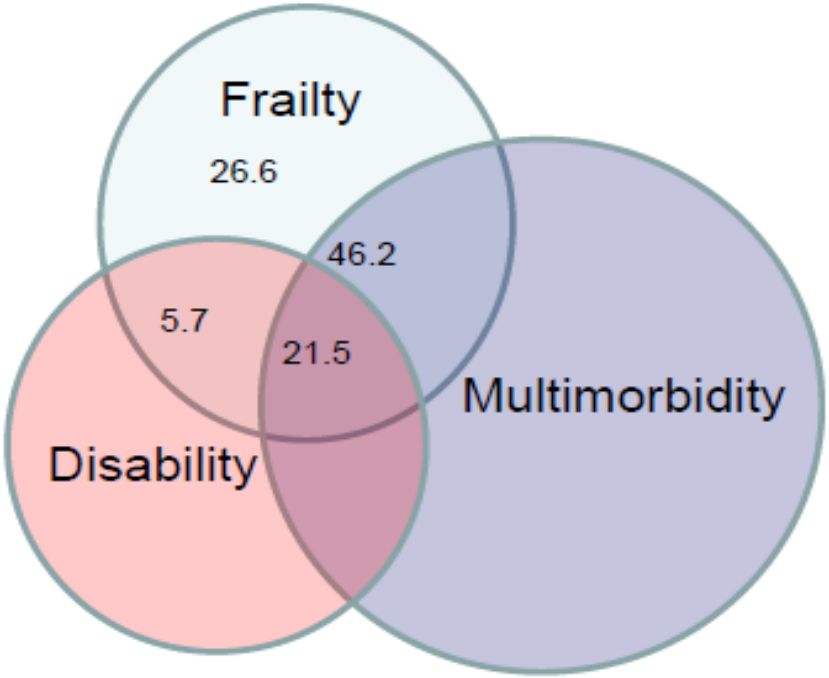
# Frailty

- 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?

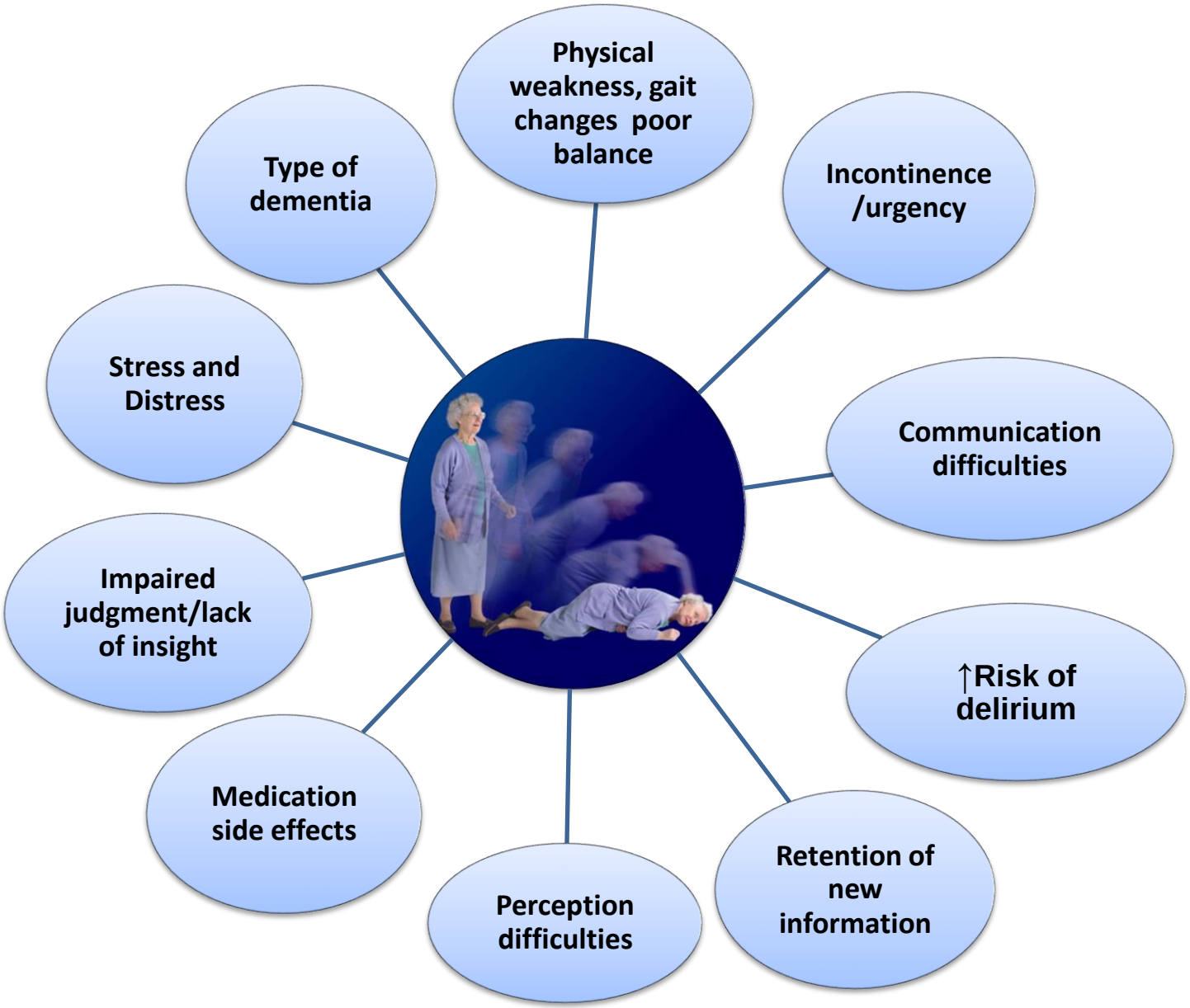
- Home care providers
- GPs
- AHPs
- Nurses
- Ambulance crew
- Community care teams
- Pharmacists
- Proactive assessment rather than reactive

# 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



# Psychotropics & sedation

| | | |
|---|---|---|
| **Sedatives: Benzodiazepines** | Temazepam, Nitrazepam, Diazepam, Chlordiazepoxide, Lorazepam, Clonazepam | Drowsiness, slow reactions, impaired balance.<br>Caution in patients who have been taking them long term. |
| **Sedatives: "Zs"** | Zopiclone, Zolpidem | Drowsiness, slow reactions, impaired balance. |
| **Sedating antidepressants (tricyclics and related drugs)** | Amitriptyline, Dosulepin<br>Lofepramine,<br>Mirtazapine,<br>Trazodone | All have some alpha blocking activity and can cause postural hypotension.<br>All are antihistamines and cause drowsiness, impaired balance and slow reaction times. |
| **Antipsychotics** | Haloperidol, Risperidone<br>Quetiapine, Olanzapine | All have some alpha blocking activity and can cause postural hypotension.<br>Sedation, slow reflexes, loss of balance.<br>Haloperidol best choice short term. |

# 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

| Type of drug | Use | Example |
|---|---|---|
| Antimuscarinics | Urinary frequency | Solifenacin, oxybutynin |
| Antiemetics | Nausea | Cyclizine, metoclopramide, prochlorperazine |
| Antihistamines (first generation) | Allergy, itch | Chlorphenamine, hydroxyzine |
| Antidepressants | Low mood | Amitryptiline |
| Analgesics | Pain | Tramadol and pethidine in particular |
| Antipsychotics | Aggression/ psychosis | Prochlorperazine |

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

- **F**ragility fracture – vertebral, humerus, wrist/radius, pelvis
- **F**unctional impairment (new) - Do they need new help to care for themselves on a daily basis?
- **R**esident in a care home
- **A**ltered mental state – Do they have delirium/new or worsening confusion?
- **I**mmobility/instability. Do they have new decline in mobility or have fallen?
- **L**iving at home with support more than 1 x daily (either professional or family support)

# Rockwood

## 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.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

# 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)

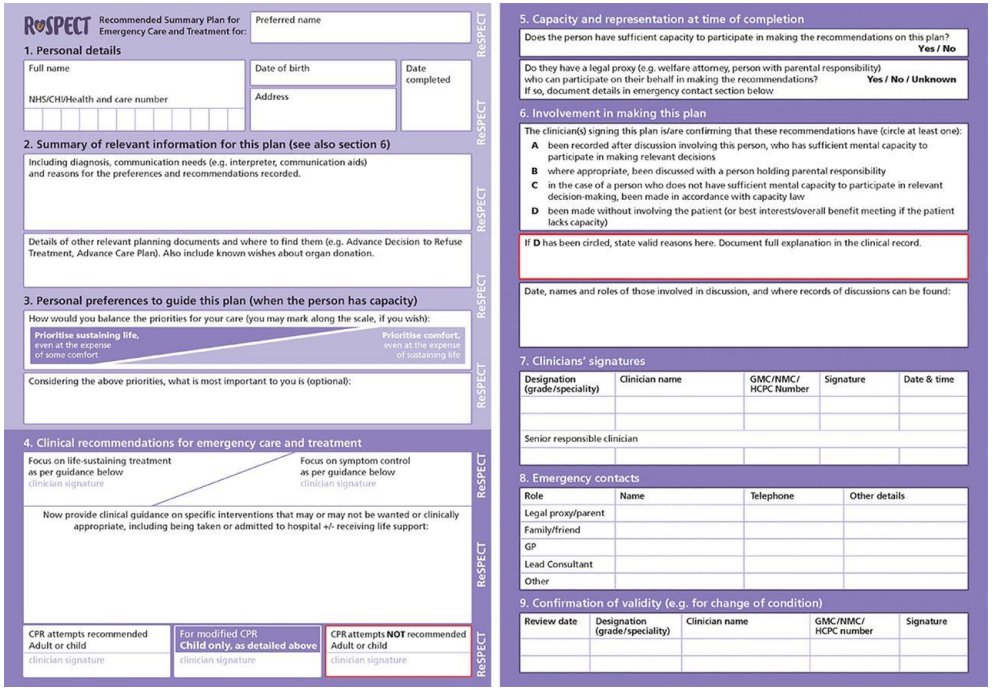
# Aims of CGA

- 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



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for: Preferred name

1. Personal details

Full name | Date of birth | Date completed

NHS/CHI/Health and care number | Address

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort — Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below — clinician signature

Focus on symptom control as per guidance below — clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended Adult or child — clinician signature

For modified CPR **Child only, as detailed above** — clinician signature

CPR attempts **NOT** recommended Adult or child — clinician signature

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

- **A** been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions
- **B** where appropriate, been discussed with a person holding parental responsibility
- **C** in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law
- **D** been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

7. Clinicians' signatures

| Designation (grade/speciality) | Clinician name | GMC/NMC/ HCPC Number | Signature | Date & time |
|---|---|---|---|---|
| | | | | |
| Senior responsible clinician | | | | |

8. Emergency contacts

| Role | Name | Telephone | Other details |
|---|---|---|---|
| Legal proxy/parent | | | |
| Family/friend | | | |
| GP | | | |
| Lead Consultant | | | |
| Other | | | |

9. Confirmation of validity (e.g. for change of condition)

| Review date | Designation (grade/speciality) | Clinician name | GMC/NMC/ HCPC number | Signature |
|---|---|---|---|---|
| | | | | |
| | | | | |

# 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/transfers/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"

***Stuck et al. Soc Sci Med. 1999***
***(Systematic review of 78 studies)***

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

**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

| | |
|---|---|
| 1 | **What are your top 3 (or more) learning points from todays session?** |
| | |
| 2 | **What can you take from today into your current role?** |
| | |
| 3 | **What will you do differently as a result of todays session?** |
| | |

# 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