

Cognition

A focus on delirium



CEC Comprehensive Care - Minimising Harm model

Building Blocks for a Safe Ward

Safety Huddles

Post incident huddle
e.g. Post Fall huddle

Purposeful/intentional rounding

Clinical bedside handover

MDT bedside rounds

Transfer of care - clinical
handover

Data intelligence



Hydration and nutrition



Cognitive Impairment



Patient care
fundamentals



'what matters to me'
Engage patient, family, carer in
care planning



Safe and early
mobilisation



Medication review



End of life care

Patient Story – Mrs Betty Smith

83-year-old female presented to hospital post fall

Lives alone

Chronic medical conditions - currently stable

She has hearing and vision impairment

Painful right arm, poor medication compliance noted by NSW
Ambulance Service

Does this sound familiar?

You met Mrs Smith and assist her out of bed, manage to stand her up and assist with transfer into a chair - right colles #

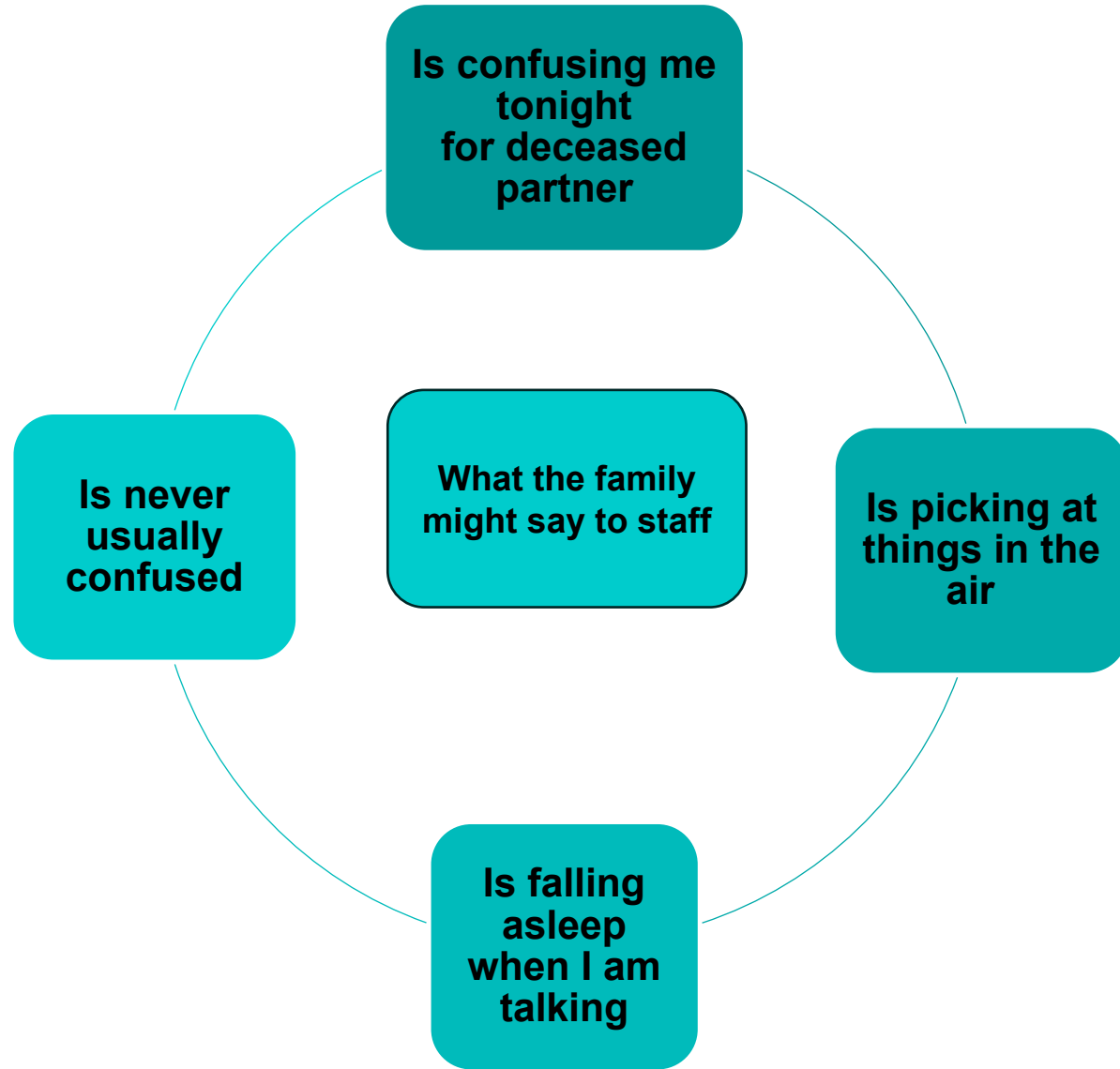
She insists she is ok but rather abrupt with you

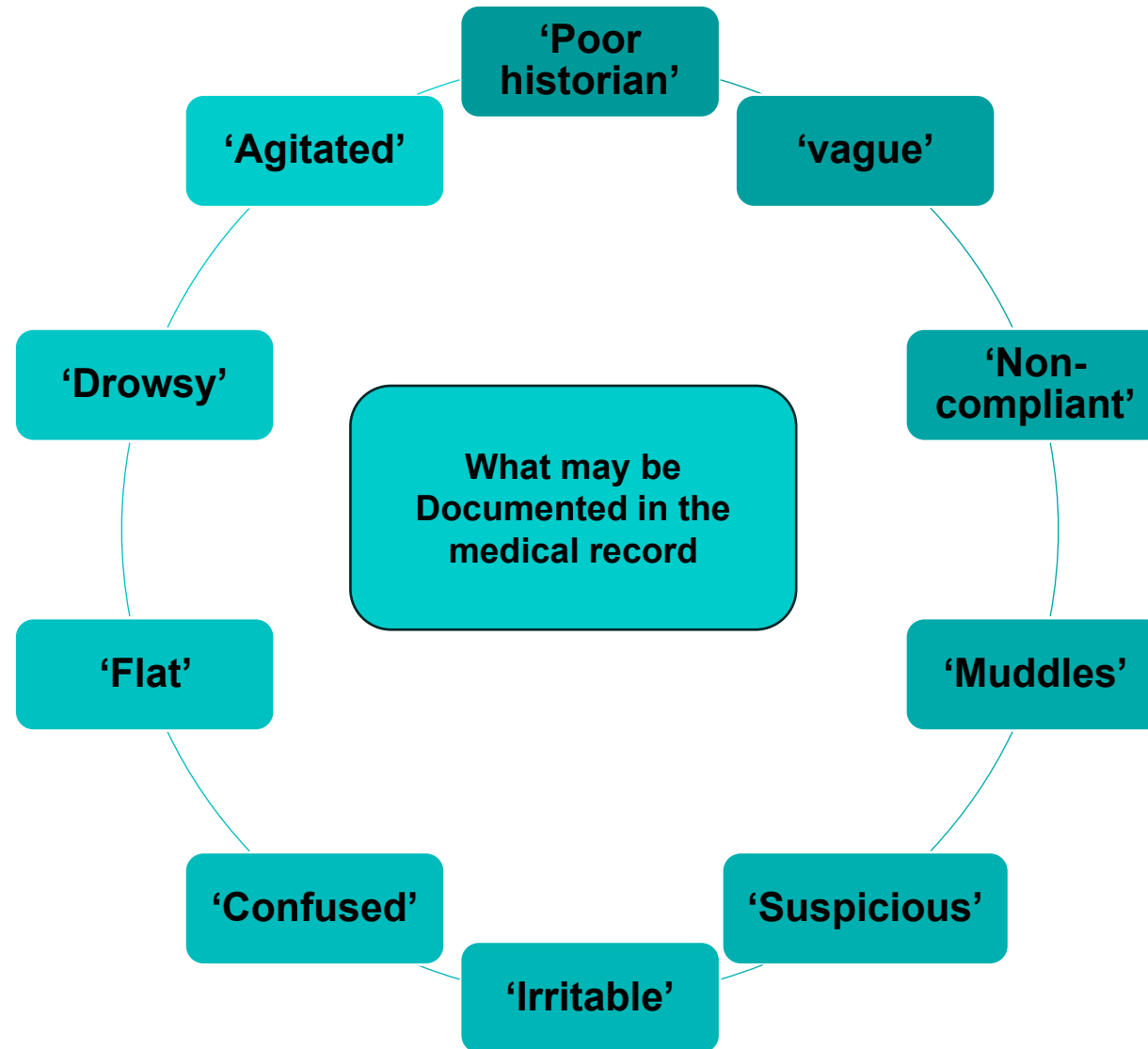
Mrs Smith is quite distracted with other noises and people in the room, looking around, talking to herself

When you return she asks “ who are you? when can I leave this jail?”

You note her breakfast is untouched







What is delirium?



*Delirium is an **ACUTE** change in mental status*



It is a medical emergency

It develops over a short period of time (hours to days)

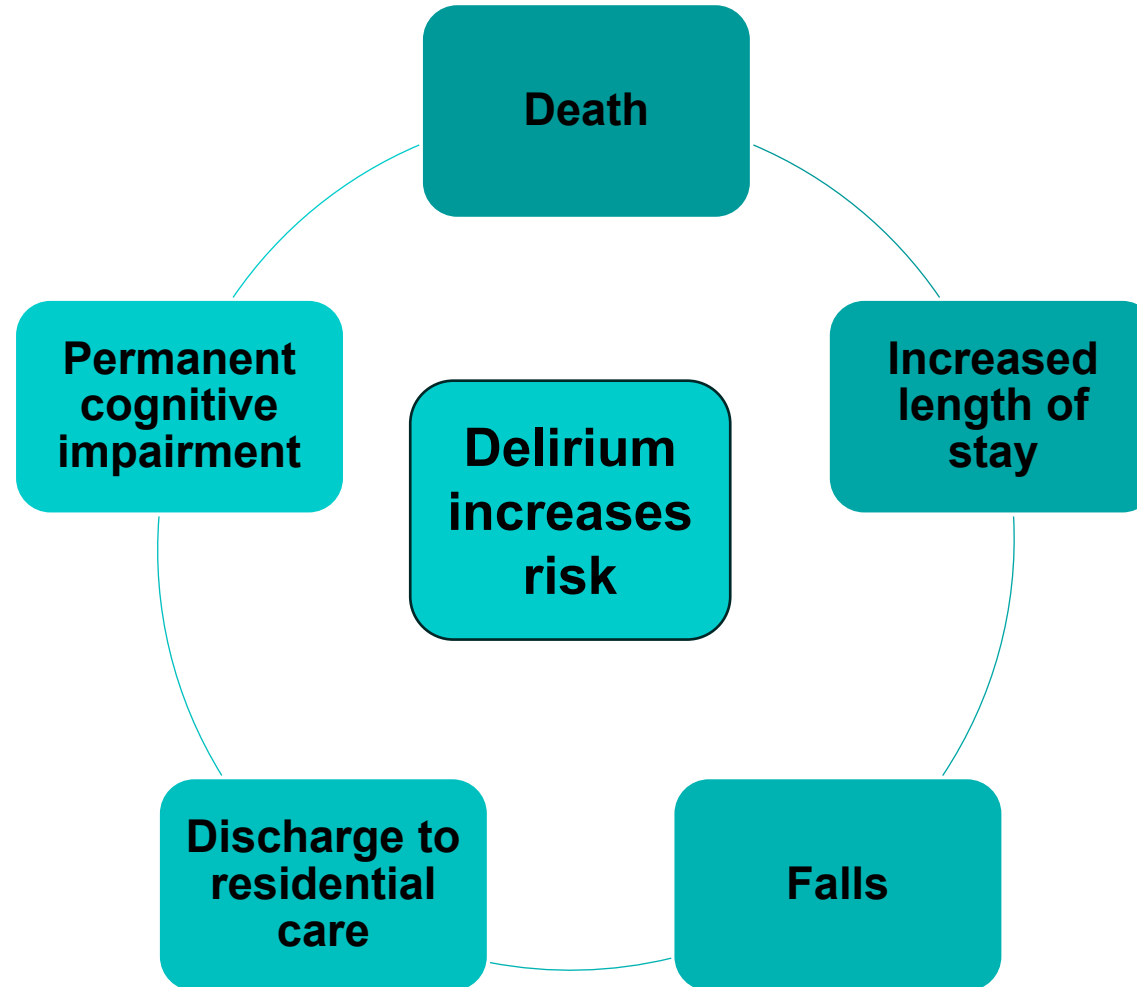
Change in consciousness, attention, cognition & perception

It is often under recognised

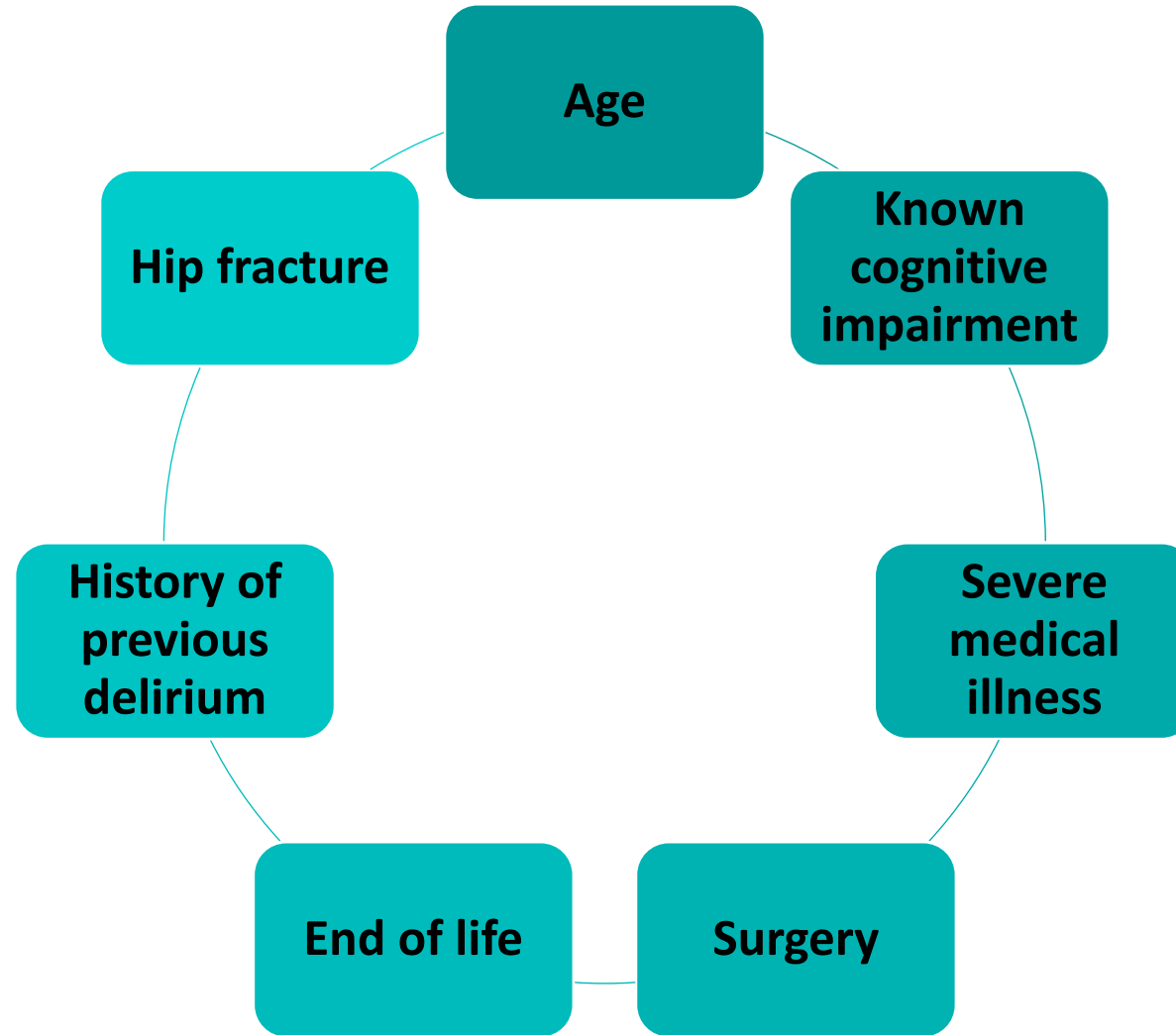
Types of delirium

Hyperactive delirium	Hypoactive delirium	Mixed delirium
		

Why is understanding delirium important?



Key risk factors for developing Delirium



When to screen for delirium

On Admission

Change in:

Condition
Function
Cognition
Concentration
Memory
Thinking
Decision making

A new onset of confusion, or new change in behaviour

Note ACVPU Alert;
Confusion/ change in behaviour, rousable by Voice; rousable only by Pain;
Unresponsive scale

Anyone can recognise a delirium using a validated screening tool e.g. 4AT

When a patient is identified with a delirium

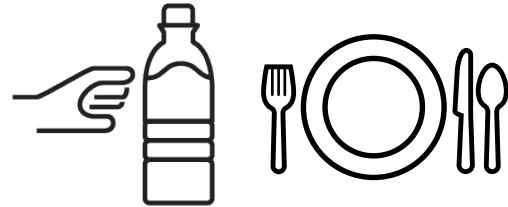
Communicate with multi-disciplinary team
Identify and implement strategies to address risk factors



Delirium management strategies to consider



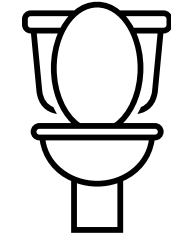
Pain



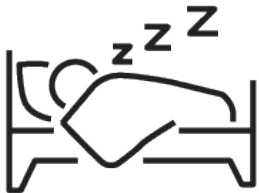
Hydration & Nutrition



Vision & Hearing



Bowels & Bladder



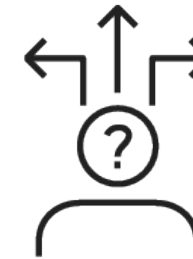
Sleep



Communication



Family/Carer Involvement



Orientation



Mobilise

Supporting patients with delirium

- Up out of bed, showered dressed in day clothes
- Mobilise and sit patients out of bed
- Assist with meals, offer regular fluids and dental hygiene
- Ensure bowel and bladder working
- Ensure use of aids to assist hearing and vision
- Pain and discomfort addressed
- Careful use of medicines, investigations and interventions
- Quiet calm environment and family presence if available

Note: Provide fundamental compassionate care



Be-Betty-Centred

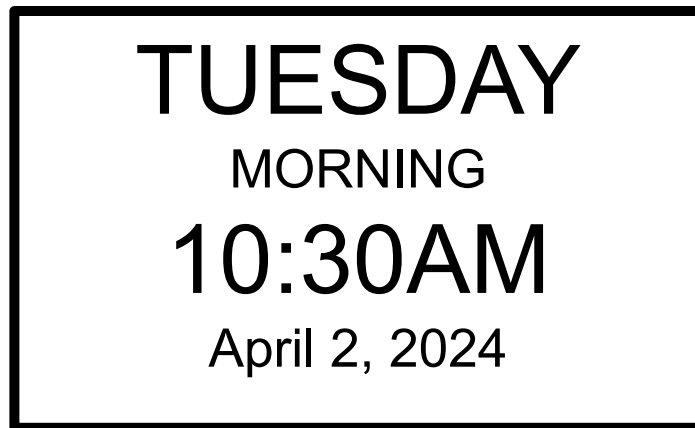
- Gently reassure, reorientate, distract and agree if necessary
- Involve family member/s –Top 5 / Sunflower
- Increased supervision
- Low lighting at night
- Remove all medical attachments, where possible
- Take Betty for regular walks
- Have familiar objects and provide sensory distraction



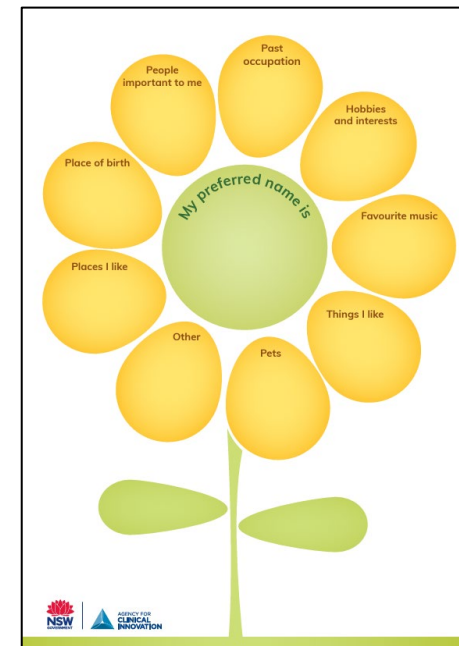
Tools to support communication

Showing visual pictures or objects can trigger understanding when words fail

e.g. cue cards, clocks that display day, date and time



Consider using a tools such as the sunflower or Top 5 tool



Resources

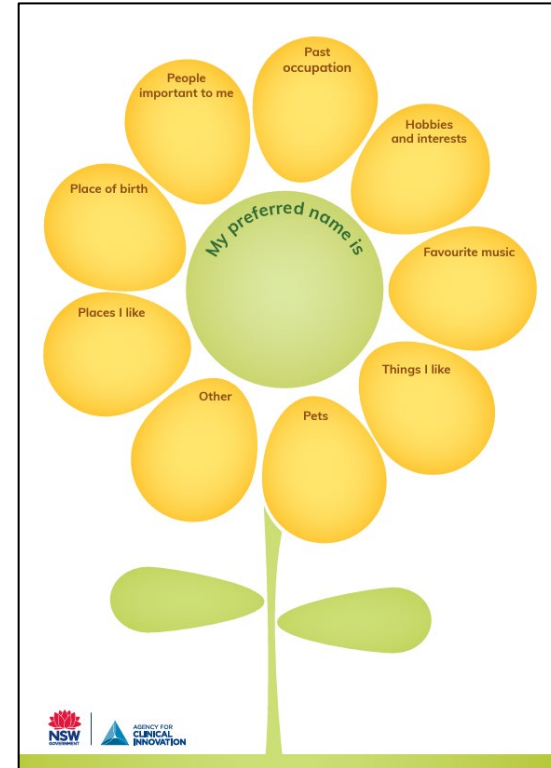
My Health Learning Delirium modules

Delirium Stage 1	233003664
Delirium Care Stage 2	266621954



- T** Talk to the Carer
- O** Obtain the information
- P** Personalise the care
- 5** 5 strategies developed

<https://www.cec.health.nsw.gov.au/improve-quality/teamwork-culture-pcc/person-centred-care/dementia-care>



www.aci.health.nsw.gov.au/networks/aged-health

