CHOPS

Care of the confused hospitalised Older person Study

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Population growth over 65yrs

• 13% of Australia’s population > 65 years
• By 2050 it will be 20%  AIHW, 2006
• 34% growth with the next 10 years
• Largest LHD growth area
  ▪ Southern NSW 50%
  ▪ MidNorth coast 49%
  ▪ South West Sydney 45%
  ▪ Northern NSW  43%
  ▪ Western Sydney 41%
Older people tend to use hospitals more than other age groups

Admission rate to hospital for over 65 years are three times higher than for younger age groups

ANF, 2004

Older people currently occupy two-thirds of all hospital beds

ANF, 2004

Life expectancy is increasing

- **Death rates**
  - 1860 to 2003
  - Standardised death rate
  - Crude death rate

- **Life expectancy**
  - 1886 to 2002
  - Females
  - Males

Source: Productivity Commission Research Report, Economic Implications of an Ageing Australia, 2005
CHOPs

Confusion is Identified, investigated, treated and appropriately managed

Hospitals provide safe and supportive environments

Older people are cared for by staff that have the right knowledge, skills and attitudes

Partnership with carers and person centred care are key aspects of quality care

Strategies and clear leadership roles are in place to deliver efficient and effective care for confused older people in hospital
Dementia

Not a normal part of ageing

1/5 people over 80 have moderate to severe dementia

1/2 over 90
Dementia in Australia

• **2012**: 300,000 people with dementia
• **2050**: 900,000 people with dementia
• >1200 new cases per week diagnosed
• At age 65: 1 in 12 people have dementia
• Approx 25,000 under age 65 with dementia
• Delaying onset of dementia by 5 years can halve the prevalence
Pain in the person with dementia

• Pain processing is
  ▲ normal in people with mild dementia
  ▲ May be impaired in severe dementia

• Dementia is likely to affect
  ▲ Response to pain
  ▲ Pain report
  ▲ Assessment
  ▲ Management

• Pain is often left untreated leaving the person in a world of pain

• Pain can have severe impact on patterns of behaviour
Agitation and Aggression

• Up to 80% of people with Alzheimer's disease experience agitation
• Aggression and agitation are two common causes for admission to residential care
• Agitation reduction rates are similar using pain relief and anti-psychotics
• Suggestions now raised for treating pain in everyone with dementia related agitation
Hospitalised older people with dementia

▲ Patients with advanced dementia treated for a # NOF received 3 times less opiate analgesia than cognitively intact patients

▲ People with dementia receive less frequent on demand analgesia

▲ Are more than twice as likely to experience an adverse event – falls most common
Delirium

• Acute confusion state secondary to a wide variety of bodily illnesses
• Manifest in either hyper or hypo delirium
• Risk increases with age and cognitive decline, dementia gives someone a five fold risk of developing delirium
• Pain is one of the biggest causes of delirium
• Medication most reversible cause
Delirium

30% of admissions

Up to 60% frail elderly patients

Under recognised / diagnosed

Preventable

Under reported

Increase risk of adverse events – inc Falls

Fatal if underlying cause not identified and treated (up to 76%)

Delirium is a medical emergency
CHOPs Key principles

- Cognitive Screening
- Risk and prevention
- Assessment
- Management
- Communication
- Education
- Environment
CHOPS pre-pilot data

- No systematic process for identifying patients with dementia or delirium
- Staff feel that their training is inadequate with less than half those surveyed having received training
- 80% staff exposed to aggression
- Minimal formal cognition screen
- Under reporting and thus coding of delirium
CHOPS pilot

**Patient**
- Cognition assessed on admission
- Including carers/family
- Delirium prevented / early identification and treatment
- Given success based individualised interventions
- Function maintained
- Kept safe

**Staff**
- Sharing of ideas and resources
- Knowing the patient
- Practical approaches to care
- Education and confidence building

**System**
- Built on existing strengths
- Identified areas of need
- DRG data
- Environment
Pilot outcomes

Significant increases in

- Education
- Screening
- Delirium risk Assessments
- Confidence in recognising delirium from ▲ 37% to 57%
- Confidence in managing patients with delirium ▲ 28% to 65%
CHOPs (phase two)

Aim to improve the identification and management of confusion in older people in NSW acute hospitals.

CHOPs will build on the key lessons learnt from the CHOPS pilot and the latest clinical evidence and expand the number of clinical teams, implementing the program in NSW.
Principle 1: Cognitive screening
Patients aged 65 years and over will be screened for confusion on admission or within 24 hours of admission using a validated screening tool.

Principle 2: Delirium risk identification and prevention strategies
Older people will be assessed for delirium risk. Interventions will be put in place for prevention of identified risks. Identified risks will be communicated to the older person, their carer, family and staff involved in their care.

Principle 3: Assessment of older people with confusion
Older people who are confused will be assessed. The cause of their confusion will be investigated to determine the appropriate management.

Principle 4: Management of older people with confusion
NSW hospitals will have programs in place for older people with confusion that align with these principles. The implementation will be in partnership with the older person, their carer and family.

Principle 5: Communication processes to support person-centred care
Communication processes and tools will support person-centred care for the older person throughout their hospital journey and at their transfer of care to the community.

Principle 6: Staff education on caring for older people with confusion
Staff are supported through training, education and leadership to enable them to deliver skilled, timely and knowledgeable care to the older person with confusion.

Principle 7: Supportive care environment for older people with confusion
NSW hospitals will provide a supportive care environment for the older person with confusion.
Screening

• Routine screening of cognition on admission or within 24hrs

• Falls risk screen – prompts for
  - Cog screen
  - CAM

Abbreviated Mental Test Score (AMTS)

Establish baseline cognition by completing the Abbreviated Mental Test OR MMSE for all presentations 85 years + (65+ ATS). Repeat with any change in cognition behaviour of LDC Score 1 for each correct answer.

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<td>1. How old are you?</td>
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<td>3. What year is it?</td>
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<td>5. Can the patient recall two relevant persons (eg. Name/doctor or relatives)?</td>
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<td>6. What is your date of birth?</td>
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<td>7. When was the second world war start? (1939)</td>
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<td>8. Who is the current Prime Minister?</td>
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<td>9. Count down backwards from 20 to 1</td>
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<td>10. Can you remember the address I gave you?</td>
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TOTAL SCORE

Signature:

* A score of 7 or less indicates cognitive impairment
* All patients require a Delirium Risk Assessment using (DRA) over age
RISK IDENTIFICATION

YOU Can Help Prevent Delirium

What is delirium?
Delirium is a sudden confused state of mind. It is a common problem in older people in the hospital. Delirium can be prevented and treated.

What does delirium look like?
People with delirium can act confused and may:
• be restless and upset
• slur their speech
• not make any sense
• act differently
• drift between sleep and wakefulness
• have trouble concentrating
• see and hear imaginary things
• be unaware of surroundings
• mix up days and nights
• be forgetful

What can you do?

Ways to Help

Promote Healthy Rest and Sleep

Promote Physical Activity

Promote Mental Stimulation

Promote Healthy Eating

Promote Healthy Vision

Health Promotion and Prevention Really Works!

• Identifying people at risk
• Flagging those at risk
• Prevention strategies
• Know your patient
• Communicate
Assessment

- Identify cause for confusion
- Comprehensive assessment
  - Include carer and family
  - GP and/or service provider
- Determine appropriate management strategy
- Communicate
Management

- Identify and treat the cause of delirium (if present)
- Develop referral pathways - support
- Non-pharmacological strategies first line
- Communicate
Know your patient

- Know history
- Gather personal life story
- Communicate with the carers/family
- Share the information
Carer and family involvement

- Involvement in assessment, care planning and decision making
- Staff to share information, verbal and written
- Recognise carer needs
Environment

• Review of local environment – ward audit tool

• New build and renovation considerations
Staff Training

Why is your patient confused?

DEMEN TIA vs DELIRIUM

CHRONIC ACUTE

Dementia is an umbrella term for a group of illnesses which cause progressive cognitive and functional decline.

Dementia:
- Is organic in origin
- Has a slow, gradual onset
- Causes decline in multiple cognitive functions
- Causes dysfunction in activities of daily living

Delirium has an acute onset, which has a fluctuating course and patients usually present with inattention and/or disorganised thinking.

Delirium:
- Can cause an altered level of consciousness (i.e. hyperactive such as agitated or hypoactive such as lethargic and sleepy)
- Is a medical emergency
- Is an independent predictor of adverse outcomes such as falls, increased length of stay, and death

DELIRIUM

What is delirium?

Delirium is sudden severe confusion and rapid changes in brain function that occur with physical or mental illness.

Delirium has a sudden onset, it can cause alterations in consciousness or awareness, if fluctuates, and usually causes disorientation.

What are some factors that can cause a delirium to develop?

- Any invasive procedure (catheter, IV, NG tube, surgery)
- New medication(s)
- Illness (physical or mental) or injury (e.g. Fall)
- An unpleasant environment change (e.g., Coming into hospital)
- Elimination malfunctions (UTI or constipation)
- Pain

Delirium is a medical emergency!

Its important to know:
- How does your patient usually behave?
- What is the patient’s usual level of functioning?
- What is the patient’s attention or concentration usually like?

If you manage the patients risk factors, you could prevent a delirium from developing!!!
Care of the Confused Hospitalised Older Person

Identification and Management

The management of Delirium includes treating the cause and managing the symptoms to keep the patient safe. The treatment for Delirium is to manage the cause. For this to happen Delirium needs to be identified and the earlier the better, to often delirium is not identified until the individual's behaviour escalates and then the focus becomes more on the behaviour than the cause of the actual delirium.

Identification and Management

Identifying Delirium
Education

Promote Awareness
- Posters
- Brochures
- Lanyards
- Newsletters

Ward Level
- 1:1 and Case presentation
- Short Inservices
- Scripted powerpoint

Medical Staff
- Grand Rounds
- Department meetings (Inc coders)
- Include in ward based education
- Undergraduate program

External
- Curtain University
- Dementia e-learning
- College of Nursing Grad Cert.
- University Post-Grad Programs
Next Steps

- Complete Key principles consultation and incorporate changes
- Site selection / Confirmation
- AIM training for all interested sites
- Implementation
  - Phase 1 April 2014
  - Phase 2 Aug/Sept 2014
  - Phase 3 February 2015
  - Statewide May 2015
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