# The Role of Acute Care Staff in Emergency Departments (EDs) and Hospitals for Persons Living with Dementia

## MODULE 14

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# Outline

- Prevalence and incidence of dementia in the United States
- Guidelines for a Geriatric ED
- Presentation of a person living with dementia (PLwD) to the ED
- Providing a safe, secure environment for the PLwD
- Recognizing and managing common behavioral disturbances within the ED
- Recognizing and managing delirium and other adverse events
- Successful discharge or transition from the ED

# Learning Objectives

After reviewing this module, acute care staff in EDs and hospitals will be able to:

- Discuss challenges faced by persons living with dementia (PLwD) when they present to the emergency departments (EDs).
- Discuss the challenges to ED staff in providing care for PLwD in the ED.
- Identify strategies that will help PLwD to minimize negative events experienced in acute care settings such as EDs and hospitals.

# Key Take-Home Messages

- A significant number of older adults who present with Alzheimer's disease or other dementia will present to the ED.
- Many ED visits by PLwD can be avoided with appropriate care coordination and assessment.
- Confusion, memory problems, personality changes, and agitation are some examples of the significant challenges for staff to manage and care for PLwD in the ED.
- PLwD may experience medical, psychological and behavioral complications while in the ED that can be difficult to assess.
- Consistent, calm, collaborative and compassionate care provides the PLwD with a safe and secure environment.

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# Prevalence of Alzheimer's Disease and Other Dementias

- Alzheimer's disease (AD) is the most common form of dementia in people over age 65.
- One in nine people aged 65 and older has AD and about one-third of people aged 85 and older have AD.
- Nearly two-thirds of PLwD are women.
- Alzheimer's disease is the sixth leading cause of death in the United States and the fifth leading cause of death worldwide.
- The incidence of dementia is expected to quadruple by 2050.
- In the United States, African-Americans are about twice as likely—and Hispanics one and a half times more likely—than older persons of European heritage to have Alzheimer's disease and other forms of dementia.
- Between 2000 and 2013, the proportion of deaths caused by heart disease, stroke and prostate cancer all decreased, while the proportion resulting from AD increased 71%.

(Alzheimer's Association, 2018; Kochanek, 2016; NINDS, 2015)

# Incidence of Persons Living with Dementia Seeking ED Care

- In 2016, approximately 476,000 individuals aged 65 or older will develop Alzheimer's disease in the United States, with someone being diagnosed with AD every 66 **SECONDS**.
- By 2050, this number is estimated to increase to every 33 seconds.
- Adults with Down syndrome are at high risk of Alzheimer's disease.
- Individuals with Alzheimer's disease and other dementias are more likely to be hospitalized for acute care than individuals without these conditions.
- 25% of hospitalizations of PLwD are preventable.
- These numbers underscore the importance of AD education for ED staff.

(Alzheimer's Association, 2018)

# Burden on Acute Care Settings of Persons Living with Dementia

- PLwD represent 57% of ED admissions, and 48% get admitted to the intensive care unit (ICU).
- PLwD have a typical length of stay that is 20% longer than younger populations.
- Fifty percent more lab/imaging services are used for PLwD.
- PLwD are 400% more likely to require home and community-based and social services.

(Alzheimer's Association, 2018)

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# The Need for Specialized ED: Why EDs are Difficult Care Settings for Persons Living with Dementia

The ED can be a frightening experience to a PLwD. It's a new environment filled with:

- Strange sights, odors and sounds
- Drastic change in their daily routine
- New medications and/or medical tests
- The PLwD may feel stressed due to fatigue
- The PLwD may be in pain or feel ill and unable to communicate that
- (Clissett et el., 2013; NIA, 2015; Holloman & Zeller, 2012)

(Clissett et el., 2013; NIA, 2015; Holloman & Zeller, 2012)

- Specialized EDs may be of benefit by optimizing patient-centered approaches to care.

# Physical Environment of a Geriatric ED

- Hospitals have recognized the risk to PLwD and have developed several ways of providing specialized care for the PLwD that include:

| Programs to Minimize Hazards for a PLwD in the ED/Hospital | |
|---|---|
| **Program** | **Description** |
| Delirium rooms | • "TA-DA" method, Tolerate, Anticipate, Don't Agitate |
| Delirium prevention programs | • Multiprofessional team vs interprofessional team – provide coordinated care |
| ABCDE bundle: https://innovations.ahrq.gov/qualitytools/implementing-abcde-bundle-bedside | • Tool kit of resources and guidelines to prevent unintended consequences of delirium |
| Companions/sitters | • Constant supervision through the use of a 1:1 aide |
| Communication training | • Encourages a warm and open approach to working with a PLwD |
| Acute Care for Elderly (ACE) Units | • Interprofessional model provides coordinated care from every field needed<br>• PLwD often have comorbid conditions and multiple medications—an interprofessional team provides coordinated care from every field needed<br>• Frequent rounds provide opportunity to recognize and manage changes in symptoms and issues |

# A Comprehensive Approach to Specialized Care for Person Living with Dementia: The Geriatric Emergency Department

- The Geriatric ED is focused on person-centered care.
- Geriatric EDs visualize the ED from an older adult's point of view, designing space and implementing policies to maximize patient comfort and satisfaction.

(Adams et al., 2013)

# Purpose for Geriatric Emergency Departments

The concept of a specialized, geriatric emergency department provides an acute care environment conducive to caring for PLwD. This concept helps to address the difficulties and challenges of an acute care setting for PLwD.

- Despite the time and disproportionate use of resources while in the ED, PLwD frequently leave the ED dissatisfied.
- The purpose of the Geriatric ED is to re-imagine the emergency department from the point of view of a PLwD.
- Guidelines for implementing a Geriatric ED: redesign the physical environment, train staff in geriatrics principles, and implement geriatric care models.
- The concept of the Geriatric ED will improve health outcomes, reduce costs to the health system, and improve the experience of care for these PLwDs.

(American College of Emergency Physicians, 2013; Adams et el., 2013;)

# Guidelines for the Physical Environment of a Geriatric ED

- **Physical Environment:** A Geriatric ED requires an environment with equipment designed for a patient population with specific needs. These specific needs can be met in an atmosphere or setting geared toward mobility, incontinence, and behavior problems. (American College of Emergency Physicians, 2013)

| | Physical Environment |
|---|---|
| **Visual Orientation** | • Soft lighting<br>• Control of the lighting in their space |
| **Acoustic Orientation** | • Sound-absorbing materials<br>• Portable hearing assist devices |
| **Furnishings** | • Sturdy armrests and beds<br>• Easily cleaned furniture surfaces<br>• Furnishings and devices that promote safety and comfort |

# Guidelines for the Staffing of a Geriatric ED

Staffing recommendations for the Geriatric ED should include an interprofessional team consisting of:

- Geriatric ED Medical Director
- Geriatric ED Nurse Manager
- Staff physicians, staff nurses
- Medical staff specialists for consultation in: geriatrics, cardiology, general surgery, GI, neurology, orthopedists, psychiatry (preferably with a geriatric specialty) and radiology
- Ancillary services including case management and social services, Advanced Practice Nurses (Nurse Practitioners and/or Clinical Nurse Specialists), Physician Assistants, occupational and physical therapists, and pharmacists

(American College of Emergency Physicians, 2013)

# The Geriatric ED: Consideration for Specific Policies and Procedures

The Geriatric ED should have policies, procedures, and protocols to address common problems such as:

- Assessment of delirium/agitation
- Geriatric medication management
- Urinary catheter placement guidelines

(American College of Emergency Physicians, 2013)

# "Do" Tips in Caring for Persons Living with Dementia

The Geriatric ED is focused on person-centered care. Some tips to help provide better care to PLwD in the ED:

- Label objects (i.e., closet, bathroom)
- Simplify the environment, minimize noise
- Obtain the person's history from a close care partner
- Get the person's attention before communicating
- Ask simple "yes" and "no" questions
- Watch for non-verbal communication of pain or discomfort
- Avoid painful exams
- Consider re-introducing yourself

(NIA, 2015d; NIA, 2015h)

# "Don't" Tips in Caring for Persons Living with Dementia

Some tips for what NOT to do of when caring for PLwD in the ED:

- Do not use intercom to communicate with PLwD, as it can be frightening and confusing when there is a disembodied voice in the room.
- Avoid arguing or trying to reason with the person. Instead, try "going with the flow" or responding to antagonistic phrases with neutral language such as "you don't say" "my goodness" or "I understand" before gently bringing up a new subject or distraction.
- Never talk about PLwD as if they are not there.
- Avoid surrounding PLwD with too many providers at one time.

(NIA, 2015d)

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# Why Do Persons Living with Dementia Present to the Emergency Department and Hospital?

- PLwD present to the ED for a variety of reasons, but the leading causes include:
  - Syncope
  - Ischemic heart disease
  - Gastrointestinal disease
  - Pneumonia
  - Delirium

(Rudolph et al., 2010)

# Risk Factors of Persons Living with Dementia for Admission to the ED

- Factors that increase the risk of hospitalization of the PLwD include:
  - High comorbidity
  - Previous acute hospitalization
  - Older age
  - Male sex
  - Shorter duration of dementia symptoms

(Rudolph et al., 2010)

# Co-Existing Conditions of Persons Living with Dementia for Admission to the ED or Hospital

PLwD also tend to have multiple co-existing medical conditions that further complicate diagnosis and care. These medical conditions include (American College of Emergency Physicians, 2013; Rudolph et al., 2010):

| Hospital Admission | Emergency Department Admission |
|---|---|
| • Chest pain | • Heart failure |
| • Dizziness, shortness of breath | • Traumatic injury |
| • Coronary artery disease | • Pneumonia |
| • Diabetes | • Septicemia |
| • Hypertension | • Hip fracture |
| • Chronic obstructive pulmonary disease (COPD) | • Stroke |
| • Cancer | • Congestive Heart Disease |
| • Gastrointestinal Disease | • Dehydration |
| • Fever or other unstable vitals | • Exacerbations of COPD |
| • Surgery | • Urinary Tract Infections |

# Adverse Outcomes in PLwD Under ED or Hospital Care

- Co-existing conditions, negative response to a dramatic shift in environment, and/or failure to recognize dementia can trigger adverse events. Common adverse outcomes of PLwD while under ED or hospital care include:
  - Delirium
  - Falls and other unintended injuries
  - Malnutrition
  - Deconditioning
  - Functional decline
  - Adverse response to medication
  - Incontinence
  - Agitation and other behavioral issues

(Office of the Assistant Secretary for Planning and Evaluation, 2014)

# Challenges to Clinical Emergency Department Management of Persons Living With Dementia: Reporting Somatic Symptoms

One challenge in clinical management is the impairment in the ability of the PLwD to report somatic symptoms. Further complications include:

- Even older adults not living with dementia are less likely to report symptoms than are younger adults, which can be related to insight of illness. An older adult living with dementia can add another layer to an already complicated case for ED staff.
- Loss of executive function causes PLwD underreport somatic issues.
- Clinical indicators of somatic diseases may be atypical: onset of acute illness or exacerbation of persistent disease may occur, rather than with classic signs and symptoms, along with confusion.
- Somatic diseases may occur with sudden onset or modification of behavioral problems: usually there is an increase in frequency and severity of behavioral and psychological symptoms of dementia (BPSD) such as agitation, insomnia, delirium, or hallucinations

(American College of Emergency Physicians, 2013)

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# The Clinical Assessment in the ED for Persons Living with Dementia

The first step to addressing the specific needs of a PLwD within the Geriatric ED is to gather a multidimensional assessment with information gathered from:

- The PLwD (if they are able to communicate)
- Care partners (if possible confirm all information from PLwD with a care partner)
- First responders
- Medical history from electronic medical records (EMRs)
- Staff at the facility from which they were transferred
- If the person has an intellectual disability, agency staff, or close family member should be accessed for relevant information

(American College of Emergency Physicians, 2013)

# Assessment Tips for ED Providers Caring for Persons Living with Dementia

Helpful tips for helping the PLwD and care partners manage the Emergency Department encounter, thus also helping the health care provider, include:

- Recognizing the stage of dementia may help the health care provider to identify and understand the person's needs and best strategies for care. There is a continuum of how the person will present, and the care partners/providers will need to assess how well the PLwD functions normally.
- Do not leave the PLwD alone. A family member, trusted care partner or friend should be present at all times. If no one is available, try putting PLwD in a room close to the nursing station or using a sitter.
- Continuous cueing to the environment and activity may be necessary. A family member or other care partner can assist with this and offer reassurance

(American College of Emergency Physicians, 2013)

# Assessment Tips for ED Providers Caring for Persons Living with Dementia (Continued)

These tips will help the reduce the challenges of PLwD entering the ED.

- Obtain the person's history from a close relative or care partner.
- Pay close attention to the care partner's descriptions of PLwD.
- Perform a complete head-to-toe assessment.
- Get PLwD's attention by calling name and making direct eye contact.
- Ask simple "yes" and "no" questions and make simple statements.
- Watch for non-verbal communication of pain or discomfort.
- Avoid repeating painful exams.
- Never talk as though the PLwD are not in the room.

(American College of Emergency Physicians, 2013)

# Providing the Essentials for PLwD while in the ED: A Comfortable Environment

Provide a comfortable environment.

- Communicate a sense of security, caring and respect.
- Use touch, eye contact, orienting information, simple activities.
- Offer to assist with eyeglasses, dentures and hearing aids.
- Make sure comfort items are within reach.

(NIA, 2015a)

# Providing the Essentials for PLwD while in the ED: A Safe Environment

Provide a safe environment:

- Provide a safe, structured environment.
- Provide consistent staff to attend PLwD.
- Place PLwD in a room that allows easy and careful observation.
- Place bed in low position.
- Don't leave anything at the bedside that might harm PLwD.
- Place PLwD in rooms where they have to pass the nursing station to reach an exit.
- Have a photo of PLwD on file.

(NIA, 2015a)

- Acute Care for Elders (ACE) units remain the gold standard for dementia-friendly design (Parke et el., 2017).

# Positive Approaches to Personal Care: Eating, Oral Hygiene, Bathing, & Toileting ADL

Consistent personal care is important for the health and dignity of PLwD. Use a person-centered approach or philosophy with all activities of daily living (ADL), which views PLwD first and foremost as individuals with unique attributes, personal values and history (NIA, 2015a).

| Personal Care | Person-Centered Approach |
|---|---|
| **Eating** | • Do not ask the PLwD to fill out a menu. Ask the care partner about food preferences. Simplify the food tray.<br>• PLwD at the late stage may chew, but will need frequent reminders to swallow. A light touch to the forearm increases food intake.<br>• Ask the care partner what the PLwD prefers to drink and offer these fluids frequently throughout the day. |
| **Oral Hygiene** | • Watch behaviors for signs of dental problems. This can include refusal to eat, frequent pulling at face, aggression.<br>• Mild resistance to dental care can be managed by allowing the PLwD to care for their mouth. Praise, simple cues and alerts, and engagement with the PLwD can help the individual relax and cooperate. |
| **Bathing** | • Bathe the PLwD at his/her "best" time of day.<br>• Allow the PLwD to do as much as possible. Break down the task into simple steps using verbal and visual cues.<br>• Use soft music, talking or snacks as pleasant distraction.<br>• Sounds amplify off tile walls. Running water can sound frightening. |
| **Toileting** | • Clear a path to the toilet. Place bed in view of toilet. Use a nightlight.<br>• Place a picture of a toilet or a written sign on bathroom door.<br>• Observe for signs of constipation. Ask questions about abdominal discomfort. Watch for non-verbal signs of discomfort such as grimacing or clutching. Do not ask if he has had a bowel movement. |

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# Behavioral Disturbances in PLwD

There are four categories of behavioral disturbances that can be seen in PLwD:

| Category | Common Disturbances Include: |
|---|---|
| Mood Disorders | • Depression: Seen in up to half of PLwD, often overlooked<br>• Apathy: Increases with severity of cognitive impairment<br>• Anxiety: usually presents in earlier phases of the illness, possibly with increasing dependency and overall confusion |
| Agitation | • Often include pacing or wandering<br>• Increase with severity of cognitive impairment<br>• Include verbal or physical behaviors<br>• Manifest as sexually inappropriate behaviors<br>• "Sundowning," an increase in agitation in later afternoon/evening |
| Sleep Disorders | • Insomnia<br>• Increased daytime sleepiness<br>• Altered circadian rhythms |
| Psychotic Symptoms | • Include delusions or hallucinations<br>• Occur later in AD, but often early in Lewy Body Dementia (LBD)<br>• Signal a more severe or rapidly progressive illness |

# Assessment Tools for Behavioral Challenges

Assessment should aim to:

- Identify the severity and type of behavioral disturbance.
- Identify triggers for the behavior—environment, pain, other.
- Ensure safety and security in the most dignified manner possible.
- Allow tracking of changes to measure progress.

(Desai et al., 2012; APA, 2016a, 2016b; The Dementia Collaborative Research Centres, 2016)

# Treatment of Behavioral Challenges: Non-pharmacologic Management

Non-pharmacological treatments are recommended as the primary mode of intervention for behavioral challenges in dementia. This may include:

- Reorientation of PLwD with the use of visible cues such as clocks and calendars in their room.
- Increased socialization and one-on-one time with care partners (both family member, care partners, and professionals).
- Listening to music or sensory stimulation.
- Exercise or walking with a family member or other care partner.
- The four Rs: Repeat, Reassure, Redirect, Re-approach

(Desai et al., 2012; NIA, 2015h)

# Treatment of Behavioral Challenges: Pharmacologic Management

There is currently no FDA-approved pharmacologic treatment for behavioral disturbances for dementia. As such, pharmacologic treatments should be considered as a last resort. However, it is critical to monitor the behavior and for potential adverse effects, and reassess benefit relative to risks. Some agents that can be tried include:

- Low dose benzodiazepines (n.b., may create a paradoxical effect in those with Lewy Body Dementia (LBD))
- Antipsychotic medication
- Haloperidol (n.b., do NOT use in those with LBD)
- Atypical antipsychotics
- "Start low; go slow"
- Consult with a pharmacist before prescribing anything.

(Desai et al., 2012; McCabe & Kennelly, 2015)

# Tips for ED Staff Working with Problem Behaviors

There are some general guidelines to consider with managing problematic behaviors in PLwD:

- Think of behaviors (no matter how unusual) as communication signals from PLwD that there is a problem or unmet need and try to figure out that signal.
- Remain calm.
- Protect the PLwD both physically and from embarrassment.
- Offer reassurance and appropriate assistance.
- Remember decreased communication does not mean decreased awareness; never talk about PLwD as if they are not there.
- Remind yourself that PLwD may be aware of and feel a great deal of distress about their increased loss of ability.
- If an intellectual disability is present, seek counsel from a staff or family member who knows the person well.

(Vista Continuing Education, 2016; NIA, 2015a)

# Strategies for Behavioral Challenges: Managing Sleep

Changes in sleep can be an exacerbating factor for behavioral problems. Consider the following potential causes for sleep issues:

| Changes in Sleep Patterns | |
|---|---|
| **Possible Causes:** | **Possible Strategies** |
| • Medications | • Review medications for possible side effect of restlessness. |
| • Pain | • Evaluate your PLwD for pain and treat if needed |
| • Not enough activity during the day | • Increase exercise or walking periods during the day |
| • Can't find the bathroom | • Provide nightlights to aid in finding the bathroom, and make sure the pathway is clear and well lit |
| • Too hot or too cold | • Attend to toilet needs right before bedtime |
| • May be hungry | • Provide a light snack before bedtime. |

# Strategies for Behavioral Challenges: Confusion

If the PLwD is already experiencing confusion before the ED visit, a visit to the ED can exacerbate it. Confusion can lead to behavioral issues, so consider the following:

| Confusion | |
|---|---|
| **Possible Causes** | **Possible Strategies** |
| • Unfamiliar environment | • Identify any potential dangers in the environment<br>• Use pictures (symbols) instead of written signs to assist with locating his room and bathroom.<br>• Place the person's name in large block letters on the door to his room. |
| • Medications | • Review medications for slide effect of confusion. |
| • Environment too noisy | • Decrease noise level if possible by avoiding paging systems and buzzing call lights. |
| • Unfamiliar or difficult task | • Simplify tasks. Break them down into smaller steps. |
| • Unable to understand directions | • Simplify communication. Use short sentences and avoid lengthy explanations.<br>• Ask the family member/care partner about the comfort strategies used at home. |

# Strategies for Behavioral Challenges: Wandering

- Wandering is a common behavioral issue that is often the result of another problem. Consider the unmet needs of the PLwD and if there could be a manageable cause behind the wandering. Wandering can frequently be addressed

| Wandering | |
|---|---|
| **Possible Causes** | **Possible Strategies** |
| • PLwD is stressed and anxious, possibly about their loss of function | • Plan activities with PLwD that they enjoy an will make them tired but not frustrated.<br>• Take time to talk with the PLwD.<br>• Offer a simple, meaningful activity such as folding clothes. |
| • Lifestyle related-previous work role or habits | • Keep work shoes and work clothes out of sight. Engage in typical weekend activities. |
| • Looking for security | • Place the PLwD in a room that is convenient for you to keep a watchful eye on and that is away from stairs or elevator.<br>• Adjust light levels. |
| • Pain | • Assess for pain and treat if needed |
| • Searching for something familiar | • Use distractions such as a snack or music.<br>. |

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# Special Circumstance – Recognizing Delirium

Delirium is a common issue with PLwD who are in the ED or hospital. Delirium needs to be recognized and managed quickly, so it is important that the dementia care team is aware of the different ways delirium can present.

- Delirium is an acute, abrupt change in the PLwD.
- Disorganized thinking—may ramble, seem incoherent, or become more than usually confused
- Perceptual disturbances—may hallucinate, picking at things that aren't really there
- Disorientation—likely to not know time, date, place
- Three types of delirium
  - Hypoactive delirium
  - Hyperactive delirium
  - Mixed delirium

(Han & Weber, 2016; McCabe & Kennelly (2015); Rudolph et al., 2011)

# Recognizing & Addressing Delirium in the ED

- It is important for ED doctors to have a working knowledge of screening tools when working with PLwD.
- Delirium is frequently overlooked in an ED setting.
- The most widely used assessment tool for the identification of delirium is the Confusion Assessment Method (CAM).
- A modified version of the CAM for the Intensive Care Unit (CAM-ICU) was developed for the ICU.

(Brummell et al., 2013)

# Screening Delirium in the ED

- The Intensive Care Unit (CAM-ICU) was developed for the ICU, and may be more appropriate for the ED setting.
- Features of the CAM-ICU include:
  - Administration time of 2 minutes
  - Evaluation features for mental status changes, inattention, disorganized thinking, and altered level of consciousness

(Brummell et al., 2013)

# Recognizing Dementia versus Delirium

Specific differences in the presentation of delirium include (American College of Emergency Physicians, 2013):

| | Dementia | Delirium |
|---|---|---|
| **Onset** | Chronic | Acute |
| **Course** | Deteriorating over a long period of time, few short-term fluctuations | Fluctuating minute to minute or hour to hour |
| **Duration** | Months to years | Hours to weeks |
| **Memory** | Short-term memory is affected—PLwD may not have good recollection of recent past or more remote past | Working memory is affected—PLwD may not be able to recall immediate or recent past, may not recall instructions |
| **Orientation** | Often oriented to time and place | Not oriented to time or place |
| **Perception** | Often intact, delusions, if present, are usually fixed | Hallucinations, changing delusions |
| **Psychomotor changes** | Often normal | Increased or decreased |

# Addressing Delirium in the Geriatric ED

- The Geriatric ED will have specific policies to address screening for delirium.
- Geriatric ED Guidelines recommend using the Delirium Triage Screen (DTS) and the Brief Confusion Method (bCAM).
  - The DTS is highly sensitive and the bCAM is highly specific.
- Geriatric ED Guidelines recommend use of The Short Blessed Test for ED Dementia Screening.

(American College of Emergency Physicians, 2013)

# Delirium in the Geriatric ED: Delirium Triage Screen

- The Geriatric ED will be prepared with assessment tools that are specific to identifying the onset of delirium in PLwD. The Delirium Triage Screen (DTS) is a two-step assessment for delirium in an acute care setting. It takes about 20 seconds to perform and measures level of consciousness and inattention.
- Level of consciousness is measured using the Richmond Agitation Sedation Scale (RASS)
- Inattention is measured by asking the PLwD to spell the word "LUNCH" backwards.
- If the individual has a RASS of 0 (normal) or makes 0 or 1 error on spelling "LUNCH" then the DTS is considered negative for delirium. If the RASS is anything other than 0 (altered consciousness) and the individual makes more than 1 error on spelling "LUNCH" the DTS is considered positive for delirium.

(American College of Emergency Physicians, 2013; Han et al., 2013)

# Delirium in the Geriatric ED: Brief Confusion Assessment Method

The Brief Confusion Assessment Method (bCAM) is a delirium assessment that takes no more than 2 minutes to administer:

- The PLwD is asked to recite the months backwards from December to July to test for inattention. If the individual makes more than 1 error, or is unable or refuses to take the assessment, then the result is positive for inattention.
- The PLwD is given the Richmond Agitation Sedation Scale (RASS). If the RASS is greater than 0, the result is positive for delirium.
- Finally, the PLwD is asked 4 common sense questions (i.e., "Are there fish in the sea?"). If there is any error, then the result is positive for delirium.

(American College of Emergency Physicians, 2013; Han et al., 2013)

# Review: Recognizing & Addressing Delirium in the Geriatric ED

| Feature | Delirium | Dementia |
|---|---|---|
| **Onset** | Acute | Insidious |
| **Course** | Fluctuating | Constant |
| **Attention** | Disordered | Generally Preserved* |
| **Consciousness** | Disordered | Generally Preserved* |
| **Hallucinations** | Often Present | May be Absent |

*Variable in Advanced Dementia

# Diagnosis of Acute Delirium: Identifying Etiology

Upon diagnosis of acute delirium, ED staff should pay attention to possible underlying causes including:

- Infections such as sepsis, UTIs, and pneumonia
- Medications, anti-cholinergic medications or sedatives/hypnotics/narcotics
- New medications
- Electrolyte imbalances
- Alcohol or drug use withdrawal
- New focal neurologic findings to guide an evaluation for stroke syndrome
- Fatigue, hunger, thirst
- Eyesight or hearing changes
- Constipation
- Excessive caffeine intake
- Change in routine

(McCabe & Kennelly, 2015; Holloman & Zeller, 2012; Zeller, 2012)

# Diagnosis of Acute Delirium: Identifying Etiology

The etiology of delirium can be identified using:

- Biochemical markers to identify electrolyte disturbances, uremia, and liver failure
- Arterial blood gas if hypercapnia is suspected in individuals with a history of chronic obstructive pulmonary disease
- Urinalysis in all individuals with delirium as UTIs are one of the most common causes of delirium
- Chest x-ray performed in the majority of individuals with delirium to identify potential pneumonia
- Lumbar puncture in select individuals where meningitis or encephalitis could explain delirium
- Computed tomography of the brain performed in select individuals, particularly those with a low level of consciousness, history of falls, or focal neurological deficits

(McCabe & Kennelly, 2015; Holloman & Zeller, 2012)

# Outline

- Prevalence and incidence of dementia in the United States
- Guidelines for a Geriatric ED
- Presentation of a PLwD to the ED
- Providing a safe, secure environment for the PLwD
- Recognizing and managing common behavioral disturbances within the ED
- Recognizing and managing delirium and other adverse events
- **Successful discharge or transition from the ED**

# Delirium Prevention Strategies, Management and Implications for Recovery and Function

Delirium results in poor outcomes for the person living with dementia. Persons living with dementia who experience delirium have worse cognitive function and higher rates of hospitalization, institutionalization and death (Fong et al, 2009.

- Non-pharmacological treatments for prevention and management of delirium are the first-line strategies and include:
  - Reorientation and behavioral intervention
  - Minimizing sensory impairments
  - Removing physical restraints
  - Providing a quiet, low-light environment
- Pharmacological strategies are not well studied but evidence suggests the different subtypes of delirium may require different treatments.

# Discharge A PLwD from the ED: High-Quality Discharge

Discharge from the ED does all of the following:

- It informs and educates PLWD on their diagnosis, prognosis, treatment plan, and expected course of illness.
- It supports PLwD in receiving post-ED discharge care, including medications, home care of injuries, use of medical devices/equipment, further diagnostic testing, and further health care provider evaluation.
- It coordinates ED care within the context of the health care system (other health care providers, home and community-based services, social services, etc.)

(Johns Hopkins University, Armstrong Institute for Patient Safety and Quality, 2014)

# Discharging a PLwD from the ED: What Does Discharge Failure Look Like?

Discharge failure can present in a variety of ways, including:

- ED revisits within specified timeframes (e.g., 48 hours, 72 hours, 7 days)
- Frequent ED revisits
- Frequent emergency medical services (EMS) utilization
- Hospital admission after ED discharge
- Poor comprehension of discharge instructions
- Poor access and adherence to prescribed medications
- Poor adherence to primary care follow-up
- Poor adherence to specialist follow-up
- Poor management of specific conditions, such as asthma symptoms, or poor adherence to care plan
- Death after ED visit.

(Johns Hopkins University, Armstrong Institute for Patient Safety and Quality, 2014)

# Discharging a PLwD from the ED: Risk Factors for Discharge Failure

- Multiple social and medical problems put PLwD at risk for ED discharge failure. They include:

| Risk Factors for Discharge Failure | |
|---|---|
| **Social Factors** | Medical Factors |
| • **Lack of insurance or inadequate insurance** | • Alcohol dependence |
| • **Homelessness** | • Drug use |
| • **Low income** | • Psychiatric illness |
| • **Lack of a primary care provider (PCP)** | • Physical or cognitive impairment |
| • **Poor comprehension or health literacy** | • Multiple medical conditions and chief complaints |
| • **Race/ethnicity** | • Advanced or young age |
| • **Lack of insurance or inadequate insurance** | • Male sex |

# Geriatric Emergency Department Guidelines for Discharge: Essential Information

Comprehensive discharge planning promotes safe transitions in care for PLwD. Essential information to facilitate continuity of care at discharge should include the following:

- Presenting complaints
- Test results and interpretation
- ED therapy and clinical response
- Consultation notes (in person or via telephone)
- Working discharge diagnosis
- ED physician note or copy of dictation
- New prescriptions and alterations with long-term medications
- Follow-up plan

(American College of Emergency Physicians, 2013)

# Geriatric Emergency Department Guidelines for Discharge: Follow-Up

The Geriatric ED should have a process in place that effectively provides appropriate outpatient follow-up either via:

- Provider-to-patient communication or the provision of direct follow up clinical evaluation.
- Although telephone follow up is the most commonly used, the use of newer technology, including telemedicine alternatives and home visits are also recommended.

(American College of Emergency Physicians, 2013)

# Geriatric Emergency Department Guidelines for Discharge: Community Resources

The Geriatric ED should obtain information about resources in the community that can be given to PLwD on discharge to facilitate care, including:

- Medical follow-up
- Primary MD or "medical home"
- Case Manager to assist with compliance with follow up
- Safety Assessments
- Mobility
- Access to care and medical transportation resources
- Medical equipment
- Prescription assistance and education
- Home health, including nurses and personal care resources
- Home and community-based services including including meal programs, adult day health care, etc.

(American College of Emergency Physicians, 2013)

# Discharge Planning for PLwD and their Care Partners: Important Considerations

When planning discharge for PLwD consider the following:

- Engage the PLwD and the care partners in the planning process.
- Social workers or case managers can create transition care plans from the acute care environment to home.
- Identify power of attorney for health care, and emphasize the importance of advance directives.
- Coordinate and work with timely data to achieve best plan of care for discharge planning and transitional care.
- Reconcile all medications and changes in medication
- Consider a financial assessment/planning to review private/public long-term care resources

(NIA, 2016; Rose & Lopez, 2012; NIA, 2015c; NASW, 2013; ARHQ, n.d.)

# Care Partners and Support for the Persons Living With Dementia in the ED/Hospital

- Care partners are the acute care provider's most valuable resource for information.
- A care partner may not always be present.
- Care partner physical/mental health may be impacted.
- Care partners need respite.
- Sitters can be hired to keep PLwD safe and prevent adverse events such as falls and behavioral disturbances while seeking acute care.

(NIA, 2015b)

# General Guidelines for Providing Consistent, Comfortable, and Safe Care for Hospitalized Persons Living with Dementia

When persons living with dementia are admitted to the hospital, rather than released back to home, special care should be provided, including:

- Ask the primary care partner for the person's usual routine and follow it as closely as possible.
- Encourage the use of favorite objects from home (i.e., favorite pillow or quilt or photo).
- Provide care by the same nurses and hospital staff as much as possible.
- Evaluate the PLwD for sources of potential pain and discomfort.
- When possible, schedule tests at a time of day when the PLwD is at his best and not fatigued.
- Discontinue asking orientation questions once the PLwD's level of comprehension is established.
- Cue the PLwD for sleep by darkening and quieting the room.

(NIA, 2015b; Gonçalves-Bradley et al., 2016)

# Health Systems and Providers' Successful Strategies to Manage Dementia Care and Reduce Hospitalizations

- Alzheimer's Disease Research Centers
- Integrated Medicine/Comprehensive Care Practice Redesign for Dementia: The UCLA Alzheimer's and Dementia Care Program
- Dementia Friendly Hospitals—Care Not Crisis
- Partner with Me Project -- *Video Partnering with Family Caregivers: A Guide for Hospitalization When Your Loved One has Dementia*
- P.A.C.E.—Program for All Inclusive Care for the Elderly

# Health Systems and Providers' Successful Strategies to Manage Dementia Care and Reduce Hospitalizations (continued)

- Rethinking Complex Care: Preparing the Healthcare Workforce to Foster Person Centered Care. (14th Annual Report to the Secretary of Health and Human Services and the U.S. Congress)

- The SHARE Approach—Achieving Patient-Centered Care with Shared Decision-making: A Brief for Administrators and Practice Leaders

- NIA *Going to the Hospital: Tips for Dementia Caregivers* http://www.nia.nih.gov/health/going-hospital-tips-dementia-caregivers

- Community resources, such as local chapters of the Alzheimer's Association, may be key community partners in improving care outcomes for hospitalized persons living with dementia.

# Evaluation

1. **Which statement about dementia in the United States is *false*?**
   a. Women are more likely than men to present with dementia
   b. Alzheimer's disease is the fifth leading cause of death in people over 65
   c. Adults with Down syndrome have a low risk of developing Alzheimer's disease.
   d. The incidence of dementia is expected to increase significantly by 2050.

2. **All but which of the following is considered a typical behavioral disturbance of dementia?**
   a. Increased pacing up and down the hallways in the evening
   b. Sudden onset of increased agitation towards people who are not really there
   c. Sexually inappropriate behaviors towards staff
   d. Excessive sleepiness during daytime and increased confusion upon waking

# Evaluation (continued)

3. **Persons living with dementia will experience difficulties adjusting to the unfamiliar environment of the emergency department. Which of the following is *not* a good practice?**
   a. Leave the PLwD alone until he/she calms down
   b. Speak simply, with easy-to-answer yes/no questions
   c. Always cue the PLwD before any activity or assessment
   d. None of the above are good practices

4. **The three types of delirium (which is a common issue with PLwD who are in the ED or hospital) are:**
   a. Hypoactive, Hyperactive, Delusional
   b. Mixed, Delusional, Hyperactive
   c. Hyperactive, Mixed, Hypoactive
   d. Delusional, Active, Mixed

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