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Translating guidelines into clinical practice – perioperative care of patients with dementia

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A manifesto for good perioperative dementia care

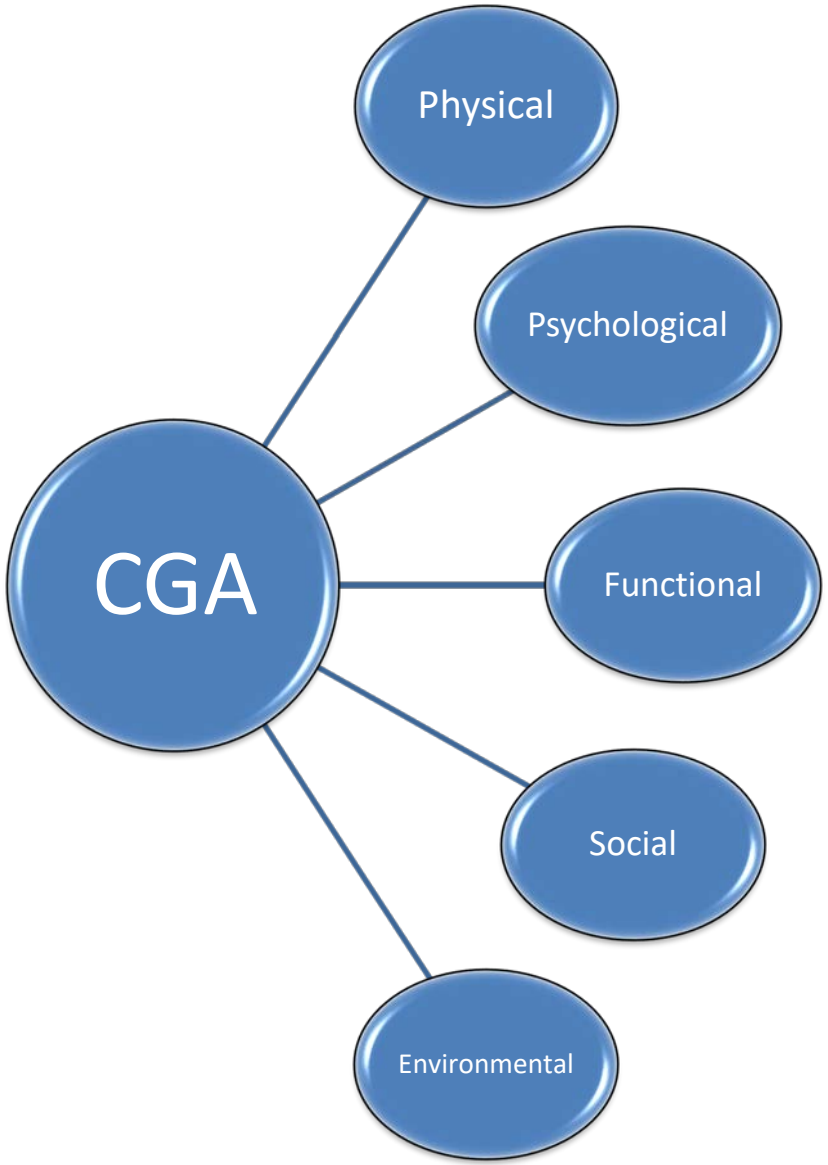
- Recognising the team members required
- Building core competencies
- Communicating effectively with patients and families

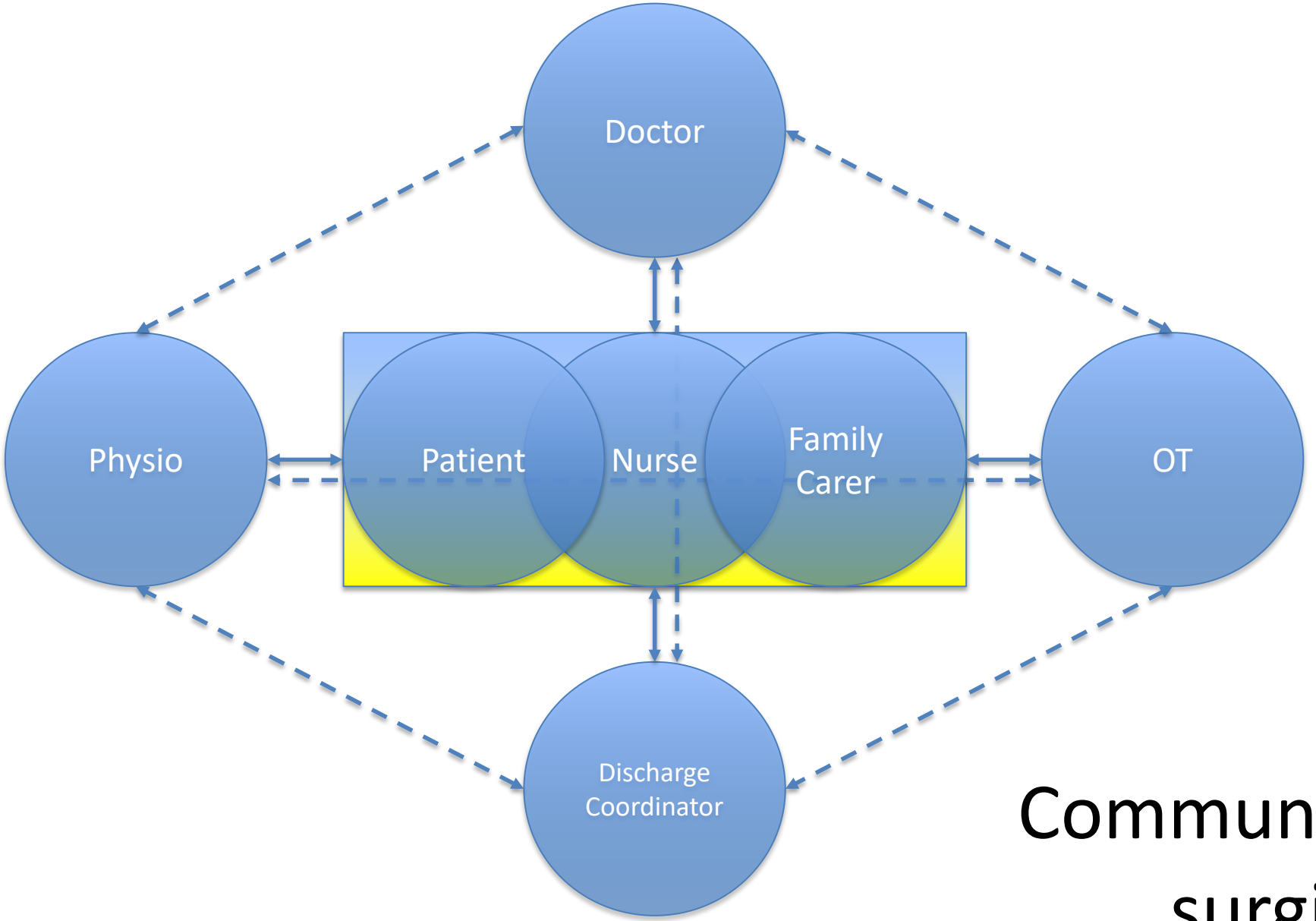
Excerpt from Adam's Diary – May 2019

Surgical registrar: "We need your help with planning this patient's discharge, we don't have the expertise because of her dementia and complex care needs"

I turned to the MDT entry and read him the paragraph where his ward OT had completed a detailed assessment and had started discharge planning.

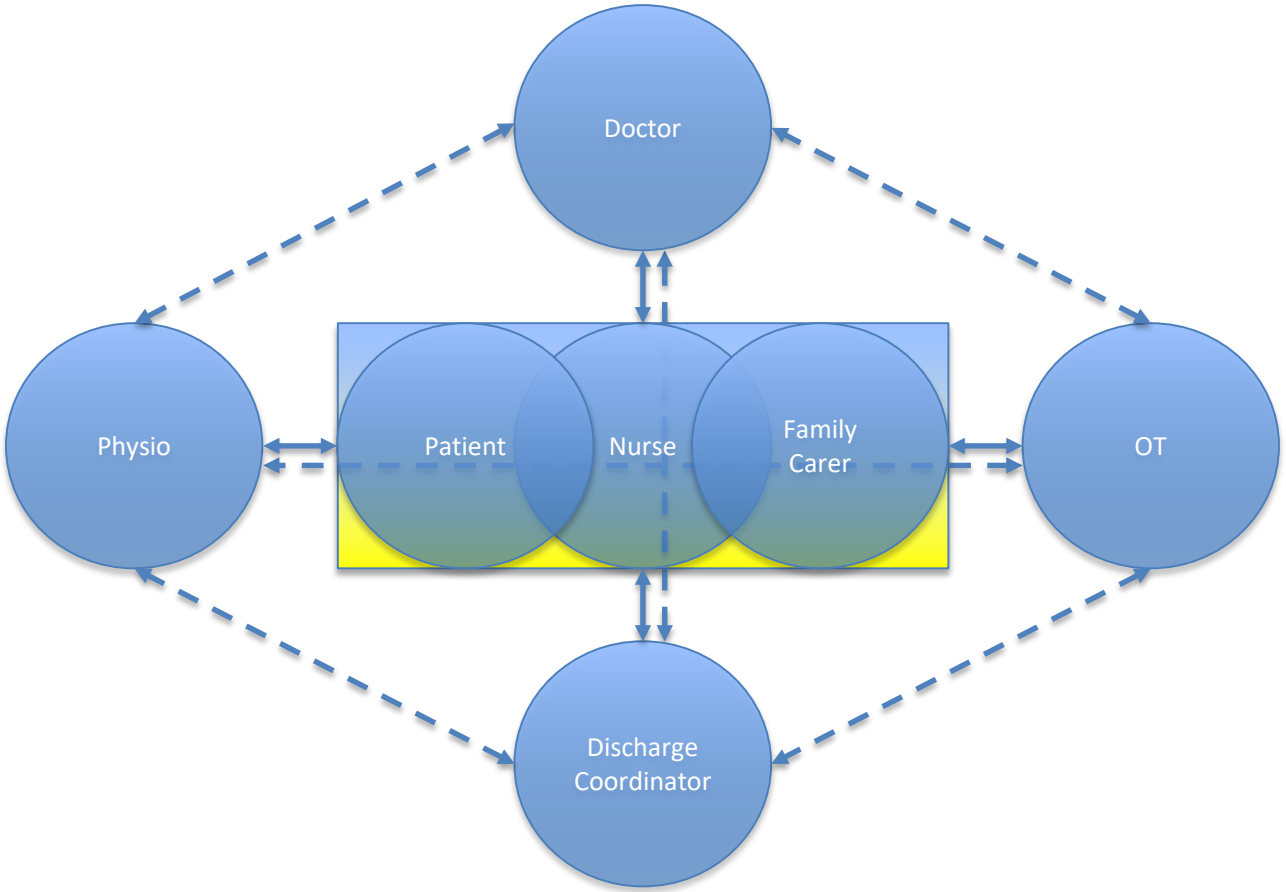
It turns out the relevant expertise was there all along. The registrar just didn't know what page it was on.


CGA
Physical
Psychological
Functional
Social
Environmental



Communication in the surgical MDT

Necessary Steps



- Recognise each other
  - Learn about each other's roles and responsibilities
- Flatten hierarchies
  - Listen to each other and share ideas and opinions
- Make time for each other
  - Identify a time in the working day where you can do this.

Complicated patients are the new norm….

- There are 1556 consultant geriatricians in the UK.
- This is 3% of the total consultant workforce.
- And our patients are the largest constituency in every part of the acute hospital and every sector of the NHS.
- Taking the University Hospitals of Derby and Burton as an example – there are 41 general surgeons, and 12 geriatricians.
- We cannot, and will never be able to, with the best will in the world, take your patients away when their care gets complicated, or when their acute surgical episode has finished.

It’s time to skill up folks….

Excerpt from Adam's Diary – March 2019

- I was asked to come back and see Mrs Smith on the surgical ward. She has working age dementia and a critically ischaemic foot.

- As I noted yesterday. Her operation is moderate risk. She doesn't have capacity to provide consent. Her family are uncertain and feel that her best interests are largely predicated upon an understanding of her surgical risk.

- The surgeon has refused to do the procedure until an IMCA is involved.

- Of course an IMCA won't help……

What skills are needed

- Medicolegal skills – particularly with relation to capacity and consent.
- Management of BPSD
- Prevention and management of Delirium
- Communication skills
- Effective use of available discharge pathways

Prevention of Delirium

Multi-component interventions have been shown to reduce the incidence of delirium among those at high risk.

Domain	Multi-component interventions in delirium
Sensory	Good lighting levels
	Reduced noise (pump alarms, pagers)
	Available and working sensory aids (spectacles, hearing aids, deaf aid communicators).
	Assess for verbal and non-verbal signs of pain, particularly in patients with communication difficulties.
	Commence pain relief and review appropriate management of pain.
	Attention to bowel and bladder. Avoid unnecessary catheterisation.
	Avoidance of physical restraints
Environment	Avoid movements between wards and rooms and
	Where possible ensure the continuity of care from staff that are familiar
	Regular and repeated visible and verbal reorientation (clocks, calendars and clear signs).
	Maintenance or restoration of normal sleep patterns whilst avoiding sedatives.
	Reduce noise and nursing and medical interventions during sleeping hours
	Encourage visits from family and friends.
Bodily Function	Encourage mobilisation for all patients particularly after surgery. Walking aids should be accessible at all times.
	Avoidance of dehydration. Consider sub-cutaneous or intravenous fluids if necessary. Seek advice re people with heart failure or Chronic kidney disease.
	Assess and monitor nutrition status involving the Dietitian where relevant. If the patient has dentures ensure they fit properly.
Medical	Assess and treat for infection.
	Assess for hypoxia and optimise oxygen saturation if necessary
Toxin	Carry out a medication review, taking into account the type and number of medications
	Consider Nicotine patches

Confusion Assessment Method (CAM)

Short form

island health

The diagnosis of delirium by CAM requires the presence of BOTH features ***A*** and ***B***		
C A M **Confusion Assessment Method**	**A.** **Acute onset** and **Fluctuating course**	Is there evidence of an acute change in mental status from patient baseline? Does the abnormal behavior: ➢ come and go? ➢ fluctuate during the day? ➢ increase/decrease in severity?
	B. **Inattention**	Does the patient: ➢ have difficulty focusing attention? ➢ become easily distracted? ➢ have difficulty keeping track of what is said?
	AND the presence of EITHER feature *C or D*	
	C. **Disorganized thinking**	Is the patient's thinking ➢ disorganized ➢ incoherent For example does the patient have ➢ rambling speech/irrelevant conversation? ➢ unpredictable switching of subjects? ➢ unclear or illogical flow of ideas?
	D. **Altered level of consciousness**	Overall, what is the patient's level of consciousness: ➢ alert (normal) ➢ vigilant (hyper-alert) ➢ lethargic (drowsy but easily roused) ➢ stuporous (difficult to rouse) ➢ comatose (unrousable)

Adapted with permission from: Inouye SK, vanDyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method: Training Manual and Coding Guide, Copyright © 2003, Hospital Elder Life Program, LLC.

Delirium is “acute brain failure”

- Urgent search for reversible causes.
- Urgent treatment of all reversible causes:
  - The mild dehydration
  - That anticholinergic they’ve been on for years
  - The slight electrolyte derangement
- Think of it like ICU when you’re not sure what the underlying pathology is – normalize as much as you can.

ABC (Antecedent, Behavior, Consequence) Chart Form

Date/Time	Activity	Antecedent	Behavior	Consequence
Date/Time when the behavior occurred	What activity was going on when the behavior occurred	What happened right before the behavior that may have triggered the behavior	What the behavior looked like	What happened after the behavior, or as a result of the behavior

Communication

- The patient's right to an opinion and information does not dwindle with their cognition or diminish as they lose capacity.

- Patients and families can adjust to delirium and/or post-operative cognitive dysfunction if:
  - It is discussed pre-operatively as part of the consent process
  - It is discussed openly and frequently and with honesty

Excerpt from Adam’s diary – March 2019

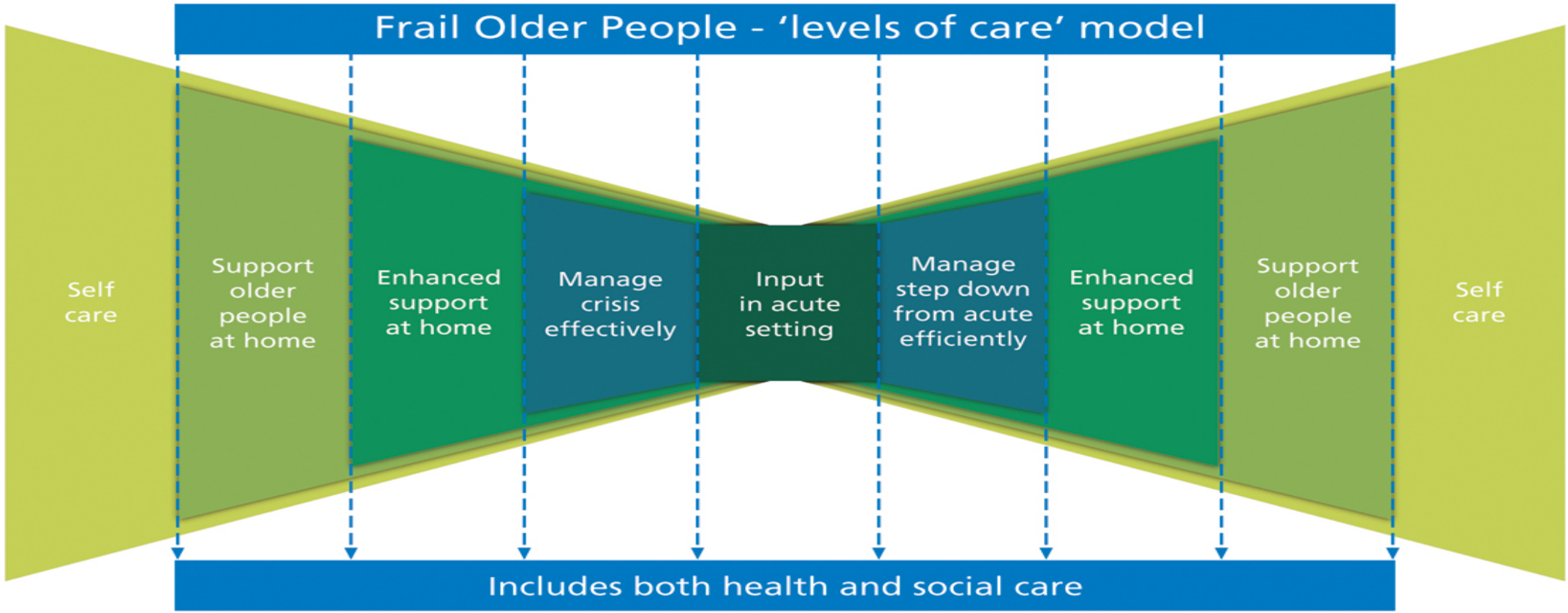
- I was asked to speak to Mrs Hughes family. They are angry.
- They want to know why their mum is being sent home whilst she’s still confused.
- They want to know why we’re not taking it seriously. She was normal before.

”Although many patients recover, up to half of people with delirium still have problems with thinking when they leave hospital”

“Some patients never fully recover”

“Time will tell”

”The longer delirium goes on, the less likely it is that there will be full recovery”


Frail Older People - 'levels of care' model
Self care
Support older people at home
Enhanced support at home
Manage crisis effectively
Input in acute setting
Manage step down from acute efficiently
Enhanced support at home
Support older people at home
Self care
Includes both health and social care

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