Top Tips
Complex Elderly - Delirium, Dementia and Depression

Delirium occurs in 1-2% of patients aged 65 rising to nearly 50% of the over 85 age group
Diagnose early, reverse the reversible. Risk factors - previous delirium, underlying early dementia.

Conditions directly affecting the brain;	**Assessing Delirium; Mnemonic = DELIRIUMM**
Subdural (fall history?)	**Delirium; past history**
Abscess	**Ethanol and withdrawal**
CVA (frontal or rt parietal)	**Liver encephalopathy**
Tumour	**Infection (chest, UTI, cellulitis, discitis)**
Encephalitis	**Renal (dehydration, drug side effects)**
Drugs	**Iatrogenic**
Seizures	**Urinary retention (faecal impaction)**
	Medication (Steroids, anti-cholinergics, benzodiazepines)
	Metabolic (Na, Ca, Glucose)

Investigating: **Diagnosing Delirium:** http://patient.info/pdf/1714.pdf#

Managing

Needs multi-disciplinary approach. Good nursing care is vital. Aim to keep the patient orientated, well hydrated, safe and calm, regular assessment about use of the toilet (watching for retention and faecal impaction). If bed bound, nurses should give pressure care advice and be mindful of DVT. Hospital admission may be unavoidable but hospital is a "delirio-genic" environment.

Advance care plans involving the MDT and the carers so that a rapid response can be implemented in acute situations. "what if plan" "step up beds"

Pharmacological intervention in acute delirum may be required if the resulting behaviour is putting the patient or others at risk. - helpful guidance from NICE.

Anti-psychotics are used to dampen the dopamine activity in delirium. They should not be used if the patient has Parkinsons disease or Lewy Body Dementia. Haloperidol, Risperidone or Olanzapine started at the lowest dose are safe to use in the community. Lorazepam can be used if short fast acting sedation required but not suitable for regular or long term use.

Purpose of treatment; allow hydration, stabilise wake - sleep cycle, "take the edge off the situation" Vital not to over-sedate. Must be reviewed within 7 days.

Nice Guidelines

Delirium: http://www.nice.org.uk/guidance/cg103/resources/guidance-delirium-pdf
Dementia: http://www.nice.org.uk/guidance/cg42/resources/guidance-dementia-pdf

Detection/red flags - Frailty scores: http://www.bgs.org.uk/campaigns/fff/fff_full.pdf

Service provision - the ideal: http://www.jcpmh.info/wp-content/uploads/jcpmh-olderpeople-guide.pdf

Thinking about prevention: case finding, enhanced services, screening tools for frailty etc http://www.nhsiq.nhs.uk/media/2630779/toolkit_for_general_practice_in_supporting_older_people.pdf

Non pharmacological methods

Environmental factors exacerbating Delirium - be aware of things that may be open to misinterpretation eg Helium balloons. Observe for signs of pain, distress, fear.
"This is Me" - collateral history. completed in house useful for information to allow early raport with patient https://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=399
Liverpool history museum apps for ipad - vintage reminiscence
http://www.liverpoolmuseums.org.uk/about/mediacentre/2014/dementia-app-wins-top-award.aspx
Music/singing -Henry's Story - Oliver Sacks https://www.youtube.com/watch?v=EgNLLelQYwI
Alzheimer association leaflets for carers
https://www.alz.org/national/documents/brochure_activities.pdf
http://www.alz.org/health-care-professionals/patient-information-education-care-resources.asp#patient_resources

Communication Skills

Reassuring someone you are "safe"; introduce yourself and explain your role (show your stethoscope)
Have a conversation and get a sense of memory impairment (mild, moderate or severe) and mental state. Less confrontational and less distressing than formal assessment tools.
Gather information that can be used later showing that you know the person and can relate to them; Pictures (with labelling of names and who they are), occupation, past story.
Assess carer's ability to meet care needs.
Choose your battles - is getting up/dressed really essential?
Don't argue/confront - reasoning doesn't work in Delirium.
Tools such as mini mental score or MOCA are helpful in grading severity and monitoring progression but not essential in making diagnosis. Tools provide objective evidence to support observations but can be misleading in acute delirium, depression or low educational level.

Assistive technology:- Social Services - There is an assistive technology team to support patients and their carers with the latest technology.
https://www.cambridgeshire.gov.uk/site/custom_scripts/fid_details.aspx?ID=153006
https://www.safeandwell.co.uk/cambridgeshire/index.php

SOVA

Assess - can the care needs be met in the community?

Providing care - the Care Act 2014
http://www.ageuk.org.uk/home-and-care/the-care-act/
if there is reasonable belief that there may be abuse/neglect, then is a sova concern.
Self Neglect - category of abuse.
http://www.cambridgeshireandpeterboroughccg.nhs.uk/local-services/adult-safeguarding.htm
If not safe, and needing permanent care then may be held in hospital/care home, with a DOLS safeguardd (deprivation of liberty)
http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Widen the number of professionals involved - get a domiciliary mental health review. (Early diagnosis Important)
Refer to SS, carers assessed. (Early and continual support of carers) Alert - carer back up and burn out.
Capacity assessment,
MASH -
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Safeguarding%20Children/Multi%20Agency%20Safeguarding%20Hub%20-%20A%20Guide%20for%20professionals.pdf

Independent Domestic Violence Advisory Service (IDVA); need to have patient consent to make referral. If there is no consent and there are concerns refer to Social Services.

Advocacy, Independent mental capacity advisory service, (IMCA) -if no family.
Independent mental health advisor (IMHA) if there is an enduring mental health problem. the advisors can help when it is not possible to get consent about treatment or where the person lives and there is no LPA or close relative.
http://www.voiceability.org/in_your_area/cambridgeshire/independent_mental_capacity_advocacy_imca
Age UK - advocacy service
http://www.cambridgeshire.gov.uk/safeguardingmca - More training opportunities available here.

Patient Centred Care - Resources to learn about living with dementia
Developing empathy, communication skills and understanding of the needs of the elderly comes from things outside clinical knowledge and guidelines.
Here are a few things that the faculty have found helpful or inspiring -
Barbara's story: https://www.youtube.com/watch?v=DtA2sMAjU_Y
Films available on DVD: Still Alice, Amour, Iris
Novels: Elizabeth is Missing by Emma Healey
Ammonites and leaping fish by Penelope Lively

Books for children (http://www.alz.org/living_with_alzheimers_stories_for_grades_4_to_7.asp

Audit Ideas:

- Long term anticholinergic medication - STOPP START criteria http://www.cumbria.nhs.uk/ProfessionalZone/MedicinesManagement/Guidelines/StopstartToolkit2011.pdf
- Anti-psychotic prescribing in dementia; clear indication for appropriate use (not prescribed in Lewy body dementia) regular reviews and stopped if not effective or not required.
- Practice environment - ?dementia friendly - university of Stirling - environmental measures in dementia http://dementia.stir.ac.uk/information/design-resource-centre

things to consider: lighting, noise levels, signage, furniture, favourite smells, music